Volume 46, Number 7
Pages 597–686
April 1, 2021

SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

JOHN R. ASHCROFT

SECRETARY OF STATE

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

SECRETARY OF STATE

JOHN R. ASHCROFT

Administrative Rules Division

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

ISSN 0149-2942

The *Missouri Register* and *Code of State Regulations* (CSR) are available on the Internet. The Register address is sos.mo.gov/adrules/moreg/moreg and the CSR is sos.mo.gov/adrules/csr/csr. The Administrative Rules Division may be contacted by email at rules@sos.mo.gov.

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, PO Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.

MISSOURI REGISTER

April 1, 2021 Vol. 46 No. 7 **Pages 597–686**

IN THIS ISSUE:

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
December 1, 2020	**January 4, 2021**	January 29, 2021	February 28, 2021
December 15, 2020	**January 15, 2021**	January 29, 2021	February 28, 2021
January 4, 2021	**February 1, 2021**	February 28, 2021	March 30, 2021
January 15, 2021	**February 16, 2021**	February 28, 2021	March 30, 2021
February 1, 2021	**March 1, 2021**	March 31, 2021	April 30, 2021
February 16, 2021	**March 15, 2021**	March 31, 2021	April 30, 2021
March 1, 2021	**April 1, 2021**	April 30, 2021	May 30, 2021
March 15, 2021	**April 15, 2021**	April 30, 2021	May 30, 2021
April 1, 2021	**May 3, 2021**	May 31, 2021	June 30, 2021
April 15, 2021	**May 17, 2021**	May 31, 2021	June 30, 2021
May 3, 2021	**June 1, 2021**	June 30, 2021	July 30, 2021
May 17, 2021	**June 15, 2021**	June 30, 2021	July 30, 2021
June 1, 2021	**July 1, 2021**	July 31, 2021	August 30, 2021
June 15, 2021	**July 15, 2021**	July 31, 2021	August 30, 2021
July 1, 2021	**August 2, 2021**	August 31, 2021	September 30, 2021
July 15, 2021	**August 16, 2021**	August 31, 2021	September 30, 2021

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 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	*Code of State Regulations*	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

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

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

The *Register* address is sos.mo.gov/adrules/moreg/moreg

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. 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) business 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 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 90—Home Health Program

EMERGENCY AMENDMENT

13 CSR 70-90.010 Home Health-Care Services. The MO HealthNet Division is adding subsection (2)(C), updating sections (7) and (8), and adding section (9).

PURPOSE: This amendment allows the adult expansion group described in Article IV Section 36(c) of the ***Missouri Constitution*** *to receive habilitative services through the Missouri Home Health Program, and updates the incorporated by reference dates.*

EMERGENCY STATEMENT: This emergency amendment allows the expanded adult population to receive habilitative services, per Article IV Section 36(c) of the ***Missouri Constitution****. The State is legislatively mandated to implement these changes by July 1, 2021. Since Amendment 2, the approval of which created Article IV Section 36(c), was passed in August 2020, the department has been developing a package of coverage that will meet the federal requirements for this program. Article IV Section 36(c) requires the department to adhere to 42 USC 1396a(k)(1) or section 2001(a)(2) of the Patient Protection and Affordable Care Act (ACA). Under the ACA, the home health services identified by this amendment must be a part of the package of benefits that will be available to the adult expansion group. Also, extending these benefits to the adult expansion group will enable the department to secure a ninety percent (90%) federal medical assistance percentage, which is also required by Article IV Section 36(c). In order for the State to be in compliance with these requirements within the mandated timeframe, an emergency amendment is necessary. If an emergency is not enacted, the MO HealthNet Home Health program would not be in compliance with the* ***Missouri Constitution****. As a result, the MO HealthNet Division finds a compelling governmental interest which requires this emergency amendment. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The MO HealthNet Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed February 26, 2021, becomes effective July 1, 2021, and expires February 24, 2022.*

(2) Home health services include the following services and items:

(C) Physical, occupational, or speech therapy when the following conditions are met:

1. The participant is age nineteen (19) or over and under age sixty-five (65) and enrolled under the Medicaid eligibility criteria for the adult expansion group as described in Article IV Section 36(c) of the Missouri Constitution; and

2. Physical, occupational, or speech therapy is a habilitative service that will help the individual keep, learn, or improve skills and functioning for daily living, in accordance with limitations set forth in section (9) of this rule.

*[(C)]***(D)** Intermittent home health aide; and

*[(D)]***(E)** Supplies identified as specific and necessary to the delivery of a participant's nursing care and prescribed in the plan of care. Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one (1) individual, that are required to address an individual medical disability, illness, or injury. Medical supplies are classified as—

1. Routine—medical supplies used in small quantities for patients during the usual course of most home visits; or

2. Non-routine—medical supplies needed to treat a patient's specific illness or injury in accordance with the physician's plan of care and meet further conditions discussed in more detail below.

(7) To be reimbursed by MO HealthNet, all home health services and supplies must be provided in accordance with a written plan of care authorized by the participant's physician. The criteria for the development of the written plan of care and changes to the written plan of care through interim order(s) are described in the *MO HealthNet Division Home Health Provider Manual*. The *MO HealthNet Division Home Health Provider Manual* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at http://manuals.momed.com/manuals/, *[December 10, 2019]* **November 24, 2020**. This rule does not incorporate any subsequent amendments or additions. Plans of care and interim order(s) are to be maintained in the client record.

(8) Skilled therapy services **as described in subsection (2)(B)** will be considered reasonable and necessary for treatment if the conditions of paragraphs (8)(A)1.–4. are met.

(9) The combination of physical, occupational, and speech therapy as described in subsection (2)(C) of this rule is limited to a total of twenty (20) visits inclusive of services from all MO HealthNet providers per year.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016,

*and section 208.152, RSMo Supp. [2019] **2020**. This rule was previously filed as 13 CSR 40-81.056. Original rule filed April 14, 1982, effective July 11, 1982. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Feb. 26, 2021, effective July 1, 2021, expires Feb. 24, 2022. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

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

EXECUTIVE ORDER

21-04

WHEREAS, Executive Order 21-03 was issued on February 11, 2021, establishing a state of emergency and ordering that operators of commercial motor carriers who are assisting in the transportation of residential heating fuels are exempt from the hours of service requirements in Title 49, Code of Federal Regulations, Parts 390 through 399, as incorporated in state law, including but not limited to sections 307.400, 390.201, and 622.550, RSMo, for the duration of the Order; and

WHEREAS, Executive Order 21-03 is set to expire on February 21, 2021; and

WHEREAS, high demand for residential heating fuel such as propane, natural gas, and heating oil has continued and is anticipated to continue past February 21, 2021, and is needed to provide immediate emergency assistance and continuing emergency relief to residents and businesses in need of such services; and

WHEREAS, the State of Missouri remains in a state of emergency within the meaning of Title 49, Code of Federal Regulations Section 390.23; and

WHEREAS, the continued temporary suspension of current regulations on maximum driving times is critical to the safety and welfare of the citizens of the State of Missouri, in order to ensure that operators of commercial motor carriers who are assisting in the aforementioned emergency efforts within the State of Missouri can meet this emergency need for transportation of residential heating fuel; and

WHEREAS, Executive Order 20-17 was issued on September 24, 2020, establishing that conditions were necessary to declare the existence of an emergency pursuant to Chapter 44, RSMo, due to potential civil unrest in the cities of Kansas City, St. Louis, and other affected communities; and

WHEREAS, Executive Order 20-17 activated the Missouri National Guard to assist public safety officials, local jurisdictions, and other established agencies in providing for the safety and welfare of Missouri's residents, visitors, and to protect property; and

WHEREAS, the soldiers of the Missouri National Guard were released on November 9, 2020, after the need to assist public safety officials, local jurisdictions, and other established agencies for civil unrest had ended; and

WHEREAS, conditions do not currently exist warranting an emergency declaration due to civil unrest pursuant to Chapter 44, RSMo:

NOW THEREFORE, I, MIKE 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, hereby extend Executive Order 21-03, terminate Executive Order 20-17, and deactivate the Missouri National Guard to the extent activated under Executive Order 20-17. All other Executive Orders regarding the activation of the Missouri National Guard, including Executive Order 20-06, as extended by Executive Orders 20-10, 20-12, and 20-16, shall remain in effect.

The provisions of this Executive Order relating to the extension of Executive Order 21-03 shall continue in effect until February 28, 2021, unless extended in whole or in part.

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 19th day of February, 2021.

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 19th day of February, 2021.

MICHAEL L. PARSON
GOVERNOR

ATTEST:

JOHN R. ASHCROFT
SECRETARY OF STATE

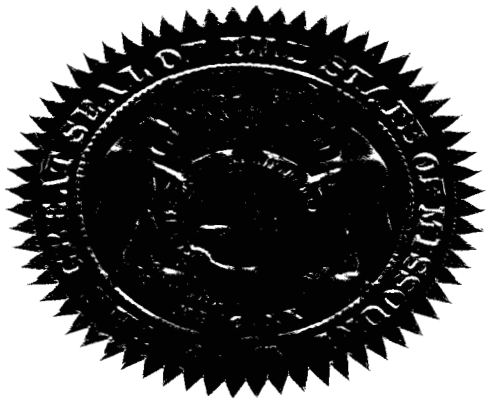
EXECUTIVE ORDER
21-05

WHEREAS, Section 105.454(5), RSMo, requires the Governor to designate those members of his staff who have supervisory authority over each department, division, or agency of state government for purposes of the application of such subdivision.

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 designate the following members of my staff as having supervisory authority over the following departments, divisions, or agencies of state government for the purposes of Section 105.454(5), RSMo:

Office of Administration	Andrew Bailey
Department of Agriculture	Kayla Hahn
Department of Conservation	Kayla Hahn
Department of Corrections	Jeff Earl
Department of Economic Development	Aaron Willard
Department of Elementary and Secondary Education	Robert Knodell
Department of Health and Senior Services	Jeff Earl
Department of Higher Education and Workforce Development	Robert Knodell
Department of Commerce and Insurance	Jeff Earl
Department of Labor and Industrial Relations	Jeff Earl
Department of Mental Health	Jeff Earl
Department of Natural Resources	Andrew Bailey
Department of Public Safety	Andrew Bailey
Department of Revenue	Jeff Earl
Department of Social Services	Robert Knodell
Department of Transportation	Aaron Willard
Missouri Housing Development Commission	Kayla Hahn
Boards Assigned to the Governor	Robert Knodell
Unassigned Boards and Commissions	Kyle Aubuchon

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 24th day of February, 2021.



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 symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

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

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

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

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

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

Title 8—DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
Division 20—Labor and Industrial Relations Commission
Chapter 7—Crime Victim Appeals

PROPOSED RESCISSION

8 CSR 20-7.010 Review of Decisions Issued by the Division of Workers' Compensation in Crime Victims' Compensation Cases. This rule outlined procedures for appeals from a decision made by the Division of Workers' Compensation in crime victims' compensation cases.

PURPOSE: This rule is being rescinded as the Crime Victim Compensation Program is no longer located within the Division of Workers' Compensation, and appeals are no longer taken to the Labor and Industrial Relations Commission. New rules for pursuing crime victim compensation appeals are being proposed to be located at 11 CSR 30-18.020.

AUTHORITY: section 286.050, RSMo 1986. Original rule filed Aug. 9, 1993, effective Jan. 13, 1994. Rescinded: Filed Feb. 26, 2021.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Public Safety, Office of the Director, Crime Victims' Compensation Program, Attn: Judy Murray, Administrative Rules Coordinator, PO Box 749, Jefferson City, MO 65102. 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 8—DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
Division 50—Division of Workers' Compensation
Chapter 6—Crime Victims

PROPOSED RESCISSION

8 CSR 50-6.010 Rules Governing Crime Victims. This rule set forth requirements for filing and pursuing claims under Chapter 595 of the Revised Statutes of Missouri.

PURPOSE: This rule is being rescinded as the Crime Victims Compensation Program is no longer located within the Division of Workers' Compensation. New procedures for pursuing crime victim compensation claims are being proposed to be located at 11 CSR 30-18.010.

AUTHORITY: sections 287.650 and 595.060, RSMo Supp. 1998. Original rule filed Dec. 14, 1982, effective March 11, 1983. Amended: Filed Dec. 28, 1990, effective June 10, 1991. Amended: Filed March 18, 1999, effective Oct. 30, 1999. Rescinded: Filed Feb. 26, 2021.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Public Safety, Office of the Director, Crime Victims' Compensation Program, Attn: Judy Murray, Administrative Rules Coordinator, PO Box 749, Jefferson City, MO 65102. 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 11—DEPARTMENT OF PUBLIC SAFETY
Division 30—Office of the Director
Chapter 18—Crime Victims' Compensation

PROPOSED RULE

11 CSR 30-18.010 Rules Governing Crime Victims' Compensation

PURPOSE: This rule sets forth requirements for filing and pursuing claims under Chapter 595, RSMo.

(1) Definitions.

(A) All terms in this rule shall have the same meaning as in Chapter 595, RSMo.

(B) A "compensable crime" is the crime that is the subject of a claim for compensation.

(2) Filing of Documents.

(A) Unless otherwise specified in this rule, any document filed with the Crime Victims' Compensation Program of the Department of Public Safety, Office of the Director (program) is considered filed on the date the document is received by the program.

(B) Documents received by mail are considered filed on the postmark date.

(C) Any document requiring a signature may be signed electronically.

(3) Review of Claims. It is the responsibility of the claimant to prove to the satisfaction of the program that it is more likely than not that the physical, emotional, or mental harm or trauma giving rise to the application, and the expense for which compensation is sought, is caused by a compensable crime under section 595.010.1(5), RSMo, that is the subject of the application.

(4) Supporting Documents.

(A) No compensation may be paid without proper documentation.

(B) Claimants are to produce any document or information requested by the program as necessary to support the claim.

(C) Following the initial filing of a claim, if a claimant fails to provide requested information, the claim may be denied.

(D) In cases involving the death of the victim, the claimant shall submit a death certificate.

(E) Claimants shall promptly provide, in writing, their current contact information, including mailing address, phone number and/or email address to the program. The claimant is responsible for informing the program of any change in contact information. Failure to do so may result in denial of the claim.

(5) Cooperation. All claimants are to cooperate with the program and its representatives. Lack of cooperation is grounds for claim denial.

(6) Reduction.

(A) Contributory conduct.

1. If, through consent, provocation, incitement, or negligence, the victim contributed to the infliction of the victim's injury or death, the claim shall be denied.

2. In order to ensure consistency in awards, no partial reduction in the amount of compensation may be made due to contributory conduct by the victim.

3. Factors to be considered when determining whether a victim contributed to the conduct include, but are not limited to:

A. Whether the victim's actions directly and substantially caused the offender's actions;

B. Whether the victim's misconduct was part of a continuous flow of events leading to the crime;

C. Whether it was reasonably foreseeable that the victim's actions would cause the offender to inflict an injury on the victim; and

D. Whether the victim indicated a willful desire to participate in the commission of a potential crime, rather than putting himself/herself in a vulnerable position.

4. Determinations regarding contributory conduct shall be made on basis of facts and substantial evidence.

(B) Fundraising and crowdsourcing.

1. Payments made to claimants shall be reduced by any amount received as a result of fundraising on behalf of the victim. Such sources include, but are not limited to, memorial funds, in-person fundraisers, and fundraising from websites such as GoFundMe.

2. In order to determine whether fundraising has been used to pay for otherwise compensable expenses, and thus constitutes a collateral source, the program may request any documentation necessary to determine the extent to which a claimant has received funding from such efforts. If the program cannot establish that the fundraising has paid for otherwise compensable expenses, then no reduction in payments may occur.

(C) Unrelated services. If expenses for services unrelated to a compensable crime are submitted by a claimant, those expenses shall not be reimbursed.

(7) Maximum Award Amounts. Maximum award amounts are set in Chapter 595, RSMo. The following are the current maximum award amounts:

(A) Reasonable and necessary expenses actually incurred for preparation and burial in the event of death, including funeral expenses: five thousand dollars ($5,000);

(B) Actual loss of earnings or support from gainful employment: four hundred dollars ($400) per week;

(C) Attorney fees related to filing of Crime Victims' Compensation (CVC) application: Up to fifteen percent (15%) of total award; and

(D) Total for any claim, including funeral expenses, lost earnings, out-of-pocket losses, attorney fees, and all other categories of expenses: twenty-five thousand dollars ($25,000).

(8) Determination of Lost Earnings or Support.

(A) In determining whether to award lost earnings or support to a victim or a dependent of a victim, the program shall consider whether the victim was gainfully employed at the time of the crime.

(B) In order to make this determination, the program may request and consider the following documentation:

1. Documentation of wages, including pay stubs;

2. Federal or state income tax returns, including any forms showing estimated taxes;

3. A document releasing the victim to return to work, signed by a medical provider or a psychiatric treatment or counseling service provider, who treated or examined the victim for injuries caused by a compensable crime; or

4. Any other document that would demonstrate gainful employment.

(C) Lost earnings or support may include compensation in instances where a victim is unable to maintain employment as a result of the crime.

(D) Lost earnings or support may include earnings lost by a claimant as a result of participating in the criminal justice process, such as earnings lost due to meeting with officers or attending or participating in court proceedings.

(9) Determination of Out-of-Pocket Loss.

(A) An "out-of-pocket loss" is an unreimbursed or otherwise unreimbursable expense or indebtedness reasonably incurred. Out-of-pocket loss does not include loss of earnings or support.

(B) The following items are eligible for reimbursement as out-of-pocket loss if incurred as a result of a compensable crime:

1. Temporary lodging.

A. Temporary lodging may be reimbursed when a reasonable claimant would feel fear or apprehension if the claimant were to return to the claimant's place of residence, and such fear or apprehension is related to a compensable crime.

B. Reimbursement may only be made for actual expenses of up to fourteen (14) days of temporary lodging, incurred at locations open to the general public that generally charge for accommodation. Examples of such locations are hotels; motels; bunkhouses; dormitories; campgrounds; and short-term rentals in private residences offered through electronic platforms such as Airbnb, HomeAway, or

VRBO.

C. No reimbursement may be made for lodging expenses exceeding the rate adopted by the State of Missouri, Office of Administration for state employee travel expenses or the General Services Association's Continental United States (CONUS) per diem rates, whichever is lower;

2. Replacement costs for clothing and bedding held as evidence;

3. Replacement or repair of locks at the victim's residence or other involved residence; and

4. Dependent care to allow victims to participate in criminal justice activities or secure medical treatment and rehabilitation services, when such care would not have been incurred but for the compensable crime. The care shall be provided by providers licensed by or registered with the Missouri Department of Health and Senior Services, the Missouri Department of Social Services, or a provider licensed by a similar entity to provide such care in the state in which the service is provided.

(C) The program shall develop a schedule of the amounts that are eligible for reimbursement pursuant to this section. This schedule shall be reviewed and updated at least once per state fiscal year.

(D) The following expenses shall not be allowed as out-of-pocket losses:

1. Pain and suffering;

2. Any expense not reasonably resulting from a compensable crime;

3. Any expense eligible for payment from another payer, such as insurance or other benefit programs, or fundraising or crowdsourcing; and

4. Any expense not listed in subsection (A) of this section.

(E) This section shall apply to any claim regarding a crime committed on or after the effective date of these rules. Claims arising from crimes committed prior to the effective date of this section are ineligible for reimbursement of losses under this section.

(10) Offer of Compensation and Award.

(A) Offer of compensation.

1. An "offer of compensation" or "offer" is notification of a determination as to the claimant's eligibility for compensation and the anticipated amount of such compensation, if any.

2. Once the program issues an offer, the offer is final.

3. The program may rescind an offer at any time for ineligibility.

4. Acceptance of an offer does not establish a contract between the claimant and the program.

5. The program shall adopt procedures to provide claimants adequate notification of offers and document such notification. Such procedures shall be made publicly available upon request.

(B) Disbursement of award.

1. When disbursing an award, proceeds are applied in the following order:

A. Compensation paid to claimants, in the following order:

(I) Loss of income or support; and

(II) Other expenses paid by the claimant; and

B. Outstanding crime-related expenses to be paid directly to providers.

(I) The program may prorate the remaining amount of the award among providers after other compensation awarded has been deducted.

(II) If no response is received by the program within thirty (30) days of issuing an offer of compensation, the program may pay expenses compensable under this paragraph. Such expenses shall be debited against the maximum award amount. Once the maximum award amount is reached, no further payment will be made.

2. The program is not bound by any agreements between providers and claimants regarding priority of expenses.

(C) If the victim is legally incompetent, the program may require that a conservatorship be established and the award be delivered to the conservator.

(11) Attorneys.

(A) Claimants may be represented before the program by a licensed attorney. The attorney is to file a notice of appearance.

(B) Completion of the attorney information section on the Application for Crime Victims' Compensation form is considered the same as filing a notice of appearance.

(C) If an award of attorney fees is made pursuant to section 595.025.4, RSMo, such fees are considered awarded concurrently with other compensation awarded in the order of priority set in section (9) of this rule. For administrative convenience, the program may choose to pay such compensation in a lump sum at any time prior to closing a claim.

(12) Death of Victim During Claims Process. If a person eligible for compensation pursuant to section 595.020.1(1) or (2), RSMo, files a claim for compensation and subsequently dies from causes unrelated to the crime, the program shall terminate proceedings on the claim, and no further compensation shall be paid.

(13) Expenses for Victims of Domestic Violence. The program shall consider compensation for victims of domestic violence, as such term is defined in section 455.010, RSMo, with a concern for their safety. No reduction in compensation may occur due to a potential collateral source of payment for expenses when—

(A) A claimant has insurance or other similar benefits provided as a result of the claimant's relationship with the offender (a "shared benefits plan"); and

(B) The claimant fears harm if the claimant requests payment of expenses through the shared benefits plan.

(14) Reporting of Crimes. The following terms contained in section 595.030, RSMo, are defined as follows:

(A) "Proper authorities" for reporting purposes are the following:

1. For crimes involving domestic violence, rape, sexual assault, human trafficking, or stalking: Law enforcement agencies, prosecuting attorneys, or the Address Confidentiality Program of the Missouri Secretary of State established pursuant to section 589.663, RSMo; and

2. For all other crimes: Law enforcement agencies or prosecuting attorneys; and

(B) "Official records" are court or law enforcement agency records.

(15) Statutory References. All statutory references in this section are to the Missouri Revised Statutes in effect on the effective date of this regulation. Any reference to a particular statute, regulation, or document shall be deemed to include its successor.

AUTHORITY: section 595.060, RSMo 2016. Original rule filed Feb. 26, 2021.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions one hundred forty-five thousand nine hundred thirty dollars and seventy cents ($145,930.70) 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 Public Safety, Office of the Director, Crime Victims' Compensation Program, Attn: Judy Murray, Administrative Rules Coordinator, PO Box 749, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. **Department Title:** Department of Public Safety
Division Title: Office of the Director
Chapter Title: Crime Victims' Compensation

Rule Number and Name:	**11 CSR 30-18.010 Rules Governing Crime Victims' Compensation**
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Public Safety	$145,930.70

III. WORKSHEET

See below.

	$82,230.00	Lodging expenses
+	$34,692.00	Replacement clothing and bedding
+	$20,300.00	Replacement or repair of locks
+	$8,708.70	Dependent care expenses
=	$145,930.70	

IV. ASSUMPTIONS

a. Lodging expenses, pursuant to proposed 11 CSR 30-18.010(9)(B)(1).

The Department of Public Safety, Crime Victims' Compensation Program ("CVC") reviewed awards made in state fiscal year 2019 ("SFY19"), the most recent year for which complete records are available. CVC determined that there were approximately 980 awards that may have been eligible for lodging costs to be reimbursed pursuant to the proposed rule. Of these 980 awards, CVC anticipates that approximately 10 percent of these awards would utilize the lodging program, for an average of seven nights per claim.

The proposed regulation limits reimbursement for lodging expenses to the rate adopted by the State of Missouri, Office of Administration ("OA") for state employee travel expenses or the federal General Services Administration ("GSA") CONUS rates, whichever is lower. OA currently uses the GSA CONUS rates as a guideline for travel costs. CVC located these rates on the GSA's website, and averaged the amount for locations in Missouri to determine an anticipated per-night cost.

980 potentially eligible awards x 10 percent usage x $120 per night x 7 nights = $82,230

b. Replacement costs for clothing and bedding held as evidence, pursuant to proposed 11 CSR 30-18.010(9)(B)(2).

CVC reviewed awards made in SFY2019 and determined there were 980 awards that may have been eligible for reimbursement of replacement costs for clothing and bedding held as evidence. CVC estimates that 10 percent of these claims will seek reimbursement for the costs of clothing and bedding held as evidence.

Estimating clothing replacement costs is subjective. Because the proposed rule directs CVC to develop a schedule for reimbursement of out-of-pocket expenses, CVC will limit replacement clothing costs not to exceed $300 per claim.

CVC searched for basic replacement bed sets for a full/queen bed on the website of several major retailers, including Walmart, Target, Dollar General, and Amazon. It determined that the average cost for a bedding set was $54.

980 awards x 10 percent estimated usage x $54 per replacement bed set = $5,292
980 awards x 10 percent estimated usage x $300 per clothing maximum = $29,400
Total: $34,692

c. Replacement or repair of locks at the victim's residence or other involved residence, pursuant to proposed 11 CSR 30-18.010(9)(B)(3).

CVC reviewed awards made in SFY19, and determined that there were 1,015 awards that may have been eligible for replacement or repair of locks. CVC anticipates that 10 percent of these claims will seek reimbursement for the cost of replacement or repair of locks at the victim's residence or other involved residence.

Based on a search of retailer websites, including Home Depot, Lowes, Ace Hardware, and Amazon, the average cost for a basic chain or slide lock is approximately $6, while a basic door knob and deadbolt set is approximately $30. According to HomeAdvisor, the average cost for a locksmith call in Missouri is $128. Although this total is $164, because of the significant potential variation in both the cost of replacement hardware and installation, CVC has estimated the average charge for replacement and repair of locks as $200 per claim.

1,015 awards x 10 percent estimated usage x $200 per claim = $20,300

d. Dependent care to allow victims to participate in criminal justice activities or secure medical treatment and rehabilitation services, when such care would not have been incurred but for the compensable crime, pursuant to proposed 11 CSR 30-18.010(9)(B)(4).

CVC reviewed awards made in SFY19, and determined that there were 1,015 awards that may have been eligible for payment of dependent care. According to a United States Census Bureau estimate, the average number of people under 18 in a family household is 0.87. Because claimants will not be filing on a partial child, and to account for dependents who may not be under the age of 18, CVC rounded this up to one dependent per household.

CVC anticipates that 10 percent of eligible claims will request reimbursement for five days of dependent care.

CVC utilized an average daily dependent care rate of $17.16. CVC determined this amount by reviewing child care rate data from the Department of Social Services. CVC averaged the full day daytime child care rates for children in Boone, Dunklin, Greene, and Jackson counties, and the City of St. Louis, for infant, preschool, and school-age care, at both licensed and regulated faith-based facilities, and registered providers.

1,015 claims x 10 percent estimated usage x 1 dependent per household x 5 days x $17.16 per day = $8,708.70

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 30—Office of the Director
Chapter 18—Crime Victims' Compensation

PROPOSED RULE

11 CSR 30-18.020 Rules Governing Crime Victims' Compensation Appeals

PURPOSE: This rule sets forth requirements for pursuing appeals of determinations of crime victim compensation under Chapter 595, RSMo.

(1) Procedure for Initiating Appeal.

(A) If the claimant disagrees with the decision of the Crime Victims' Compensation Program (program), the claimant may appeal for an administrative review before the Director of the Department of Public Safety (director) by submitting a request in writing to the Program.

(B) The deadline to request an administrative review is thirty (30) days after the date of the letter containing the decision of the program. Any request for administrative review submitted after this date shall be denied as untimely. Administrative reviews denied for this reason may be reinstated for good cause shown by the claimant.

(C) A request for administrative review shall identify the specific reasons why the director should reverse the decision of the program. Requests that do not comply with this requirement shall be denied.

(2) Review by Director.

(A) The director shall review each request for administrative review and determine whether the decision should be affirmed or reversed on the basis of the evidence previously submitted in the case or may take additional evidence in reviewing the decision.

(B) If the director takes additional evidence in reviewing the decision, the director may specifically request such evidence be provided and resolve the administrative review on the basis of that evidence, or the director may set the case for a hearing where additional evidence may be submitted.

(C) The decision of the director is the final decision of the department for purposes of appeal under section 595.036.2, RSMo.

(3) Procedure for Hearings.

(A) Administrative reviews before the director are simple, informal, and summary.

(B) The program may receive as evidence any statements, documents, information, or material that it finds is relevant and of a nature to afford the claimant a fair hearing. The program may also accept law enforcement reports, hospital records and reports, physicians' reports, and other documentation as proof of the crime and injuries sustained, without requiring the presence of the investigating officer or attending physician at the administrative review.

(C) If the claimant fails to appear at the scheduled review before the director, the administrative review shall be dismissed. Administrative reviews dismissed for this reason may be reinstated for good cause shown by the claimant.

(D) Notice of the administrative review sent to a claimant's attorney at the attorney's last known address is deemed notice to the party.

(E) Administrative reviews may be heard in person, by phone, video conference, or any other manner approved by the director.

(4) Director's Designee: Pursuant to section 595.010, RSMo, the director may designate a person to carry out any of the director's duties in this rule.

AUTHORITY: section 595.060, RSMo 2016. Original rule filed Feb. 26, 2021.

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 Public Safety, Office of the Director, Crime Victims' Compensation Program, Attn: Judy Murray, Administrative Rules Coordinator, PO Box 749, Jefferson City, MO 65102. 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 10—Nursing Home Program

PROPOSED AMENDMENT

13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services. The division is amending the purpose and sections (3)–(10), (14), and (17) and adding section (22).

PURPOSE: This amendment removes or replaces obsolete processes, language, and terms; clarifies regulation language; revises the definition of audits; allows an extension for cost report filings for good cause shown; amends when cost reports are required for terminating providers or changes in providers; amends when payments will be withheld for late cost report submissions and terminating providers; establishes a required prior authorization process for any out-of-state nursing facility to be reimbursed for nursing facility services; and revises the methodology for determining prospective rates.

PURPOSE: This rule establishes a [payment] ***reimbursement*** *plan for [long-term care]* ***nursing facility services*** *required by the* ***Code of Federal Regulations****. The plan describes principles to be followed by Title XIX [long-term care]* ***nursing facility*** *providers in making financial reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.*

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.

(3) General Principles.

(A) Provisions of this reimbursement regulation shall apply only to facilities certified for participation in the *[Missouri Medical Assistance]* **MO HealthNet** (Medicaid) Program.

(D) The Medicaid Program shall provide reimbursement for nursing facility services based solely on the individual Medicaid-eligible *[recipient's]* **participant's** covered days of care, within benefit limitations as determined in subsections (5)(D) and (M) multiplied by the facility's Medicaid reimbursement rate. No payments may be collected or retained in addition to the Medicaid reimbursement rate for covered services, unless otherwise provided for in this *[plan]* **regulation**. Where third-party payment is involved, Medicaid will be the *[payor]* **payer** of last resort with the exception of state programs such as vocational rehabilitation and the Missouri Crippled Children's Services.

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid-eligible *[recipients]* **participants** during any time period in which the facility failed to have a Medicaid participation agreement in effect. A reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(J) Changes in ownership, management, control, operation, leasehold interest by whatever form for any facility previously certified for participation in the Medicaid Program at any time that results in increased capital costs for the successor owner, management, or leaseholder shall not be recognized for purposes of reimbursement *[and etc]*.

(L) Any facility which is involuntarily terminated from participation in the Medicare Program shall also be terminated from participation in the *[Medicaid]* **MO HealthNet** Program on the same date as the Medicare termination.

(M) No restrictions nor limitations shall, unless precluded by federal or state regulation, be placed on a *[recipient's]* **participant's** right to select providers of his/her own choice.

(O) The reimbursement rates authorized by this regulation may be reevaluated *[at least on an annual basis]* in light of the provider's cost experience to determine any adjustments needed *[to assure coverage of cost increases that must be incurred by efficiently and economically operated providers]*.

(Q) Medicaid reimbursement will not be paid for a Medicaid-eligible resident while placed in a non- certified bed in a nursing facility.

[(S) Each state fiscal year the department shall submit to the Office of Administration for consideration a budget item based on the HCFA Market Basket Index for Nursing Homes representing a statistical measure of the change in costs of goods and services purchased by nursing facilities during the course of one (1) year. The submission of the budget item by the department has no correlation to determining the costs that are incurred by an efficiently and economically operated facility. Any trend factor granted shall be applied to the patient care, ancillary and administration cost components, and the pass-through expenses included in the capital cost component per diem. For facilities with allowable costs from their 1992 desk audited and/or field audited cost report as determined in this regulation that are below the facilities' January 1, 1994 reimbursement rate, any granted trend factor shall be limited to the product of the new plan rate divided by the January 1, 1994, (old plan rate) times the facility's trend factor. For example:

New Plan Rate (1-1-95)	*$49.19*
January 1, 1994 Rate	*$54.32*
Proposed Trend Factor	*$ 1.88*
Adjusted Trend Factor	*$ 1.70*

*($49.19/$54.32) * $1.88*
*90.55% * $1.88 = $1.70*

The rate after the trend factor would be $56.02 ($54.32 + $1.70).]

*[(T)]***(S)** Rebasing.

1. The division based on its discretion shall pick at least one (1) cost report year from cost reports with fiscal years ending in 2001 or later to compare the allowable costs from the selected desk audited and/or field audited cost report year to the reimbursement rate in effect at the time of the comparison. The rebased rates shall be determined in accordance with section**(s)** (20)**-(21), as applicable**.

2. The asset value will be adjusted annually based on the R. S. Means Construction Index. The asset value as adjusted will be used only for determining reimbursement in section (11) for the year(s) selected above for rebasing and as determined in paragraphs (13)(B)6. and (13)(B)7.

*[(U)]***(T)** Effective for dates of service beginning April 1, 2010, reimbursement of Medicare/Medicaid crossover claims (crossover claims) for Medicare Part A and Medicare Advantage/Part C inpatient skilled nursing facility benefits shall be as follows:

1. Crossover claims for Medicare Part A inpatient skilled nursing facility benefits in which Medicare was the primary payer and the MO HealthNet Division is the payer of last resort for the coinsurance must meet the following criteria to be eligible for MO HealthNet reimbursement:

A. The crossover claim must be related to Medicare Part A inpatient skilled nursing facility benefits that were provided to MO HealthNet participants also having Medicare coverage; and

B. The crossover claim must contain approved coinsurance days. The amount indicated by Medicare to be the coinsurance due on the Medicare allowed amount is the crossover amount eligible for MO HealthNet reimbursement. The coinsurance amount is based on the days for which Medicare is not the sole payer. These days are referred to as coinsurance days and are days twenty-one (21) through one hundred (100) of each Medicare benefit period; and

C. The Other Payer paid amount field on the claim must contain the actual amount paid by Medicare. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MO HealthNet for payment. Providers submitting crossover claims for Medicare Part A inpatient skilled nursing facility benefits to the MO HealthNet program must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Part A plan's remittance advice. Any amounts paid by MO HealthNet that are determined to be based on inaccurate data will be subject to recoupment; and

D. The nursing facility's Medicaid reimbursement rate multiplied by the approved coinsurance days exceeds the amount paid by Medicare for the same approved coinsurance days;

2. Crossover claims for Medicare Advantage/Part C (Medicare Advantage) inpatient skilled nursing facility benefits in which a Medicare Advantage plan was the primary payer and the MO HealthNet Division is the payer of last resort for the copay (coinsurance) must meet the following criteria to be eligible for MO HealthNet reimbursement:

A. The crossover claim must be related to Medicare Advantage inpatient skilled nursing facility benefits that were provided to MO HealthNet participants who also are either a Qualified Medicare Beneficiary (QMB Only) or Qualified Medicare Beneficiary Plus (QMB Plus); and

B. The crossover claim must be submitted as a Medicare UB-04 Part C Institutional Crossover claim through the division's online Internet billing system; and

C. The crossover claim must contain approved coinsurance days. The amount indicated by the Medicare Advantage plan to be the coinsurance due on the Medicare Advantage plan allowed amount is the crossover amount eligible for MO HealthNet reimbursement. The coinsurance amount is based on the days for which the Medicare Advantage plan is not the sole payer. These days are referred to as coinsurance days and are established by each Medicare Advantage plan; and

D. The Other Payer paid amount field on the claim must contain the actual amount paid by the Medicare Advantage plan. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MO HealthNet for payment. Providers submitting crossover claims for Medicare Advantage inpatient skilled nursing facility benefits to the MO HealthNet program must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Advantage plan's remittance advice. Any amounts paid by MO HealthNet that are determined to be based on inaccurate data will be subject to recoupment; and

E. The nursing facility's Medicaid reimbursement rate multiplied by the approved coinsurance days exceeds the amount paid by

the Medicare Advantage plan for the same approved coinsurance days;

3. MO HealthNet reimbursement will be the lower of—

A. The difference between the nursing facility's Medicaid reimbursement rate multiplied by the approved coinsurance days and the amount paid by either Medicare or the Medicare Advantage plan for those same coinsurance days; or

B. The coinsurance amount; and

4. Nursing facility providers may not submit a MO HealthNet fee-for-service nursing facility claim for the same dates of service on the crossover claim for Medicare Part A and Medicare Advantage inpatient skilled nursing facility benefits. If it is determined that a MO HealthNet fee-for-service nursing facility claim is submitted and payment is made, it will be subject to recoupment.

(4) Definitions.

(D) Allowable cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in this regulation. The allowability of costs shall be determined by the *[Division of Medical Services]* **MO HealthNet Division** and shall be based upon criteria and principles included in this regulation, the *Medicare Provider Reimbursement Manual* (HIM-15) and GAAP. Criteria and principles will be applied using this regulation as the first source, the *Medicare Provider Reimbursement Manual* (HIM-15) as the second source and GAAP as the third source.

(G) Audit. The examination or inspection of a provider's cost report, files, and any other supporting documentation by the MO HealthNet Division or its authorized contractor. The MO HealthNet Division or its authorized contractor may perform the following types of audits:

1. Level I Audit - Requires a limited review of provider cost reports, files, and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The limited review may include, but is not limited to, items such as a comparative analysis of a provider's cost report data to industry data, a review of a provider's prior year data to determine any outliers that may warrant further review, requesting additional details of the reported information, all of which could lead to potential adjustment(s) after such further review, as well as making any standard adjustments. Level I audits may be provided off-site;

2. Level II Audit - Requires a desk review of provider cost reports, files, and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The desk review may include, but is not limited to, review procedures in a Level I Audit, plus a more detailed analysis of a provider's cost report data to identify items that would require further review including requesting additional details of the reported information or documentation to support amounts reflected in the cost report. Level II audits may be provided off-site; and

3. Level III Audit – Requires an in depth audit, including, but not limited to, an on-site review of provider cost reports, files, and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The Level III Audit will require an in depth analysis of a provider's cost report data and an on-site verification of cost report items deemed necessary through a risk assessment or other analyses. Level III audits will require some portions of the provider's records review be provided on-site.

*[(G)]***(H)** Average private pay rate. The usual and customary charge for private patient determined by dividing total private patient days of care into private patient revenue net of contractual allowances for the same service that is included in the Medicaid reimbursement rate. This excludes negotiated payment methodologies with state or federal agencies such as the Veteran's Administration or the Missouri Department of Mental Health. Bad debts, charity care, and other miscellaneous discounts are excluded in the computation of the average private pay rate.

*[(H)]***(I)** Bad debt. The difference between the amount expected to be received and the amount actually received. This amount may be written off as uncollectible after all collection efforts are exhausted. Collection efforts must be documented and an aged accounts receivable schedule should be kept. Written procedures should be maintained detailing how, when, and by whom a receivable may be written off as a bad debt.

*[(I)]***(J)** Capital. This cost component will be calculated using a fair rental value system (FRV). The fair rental value is reimbursed in lieu of the costs reported on the following lines of the cost report:

1. Version MSIR-1 (7-93): lines 106–112, except for amortization of organizational costs; and

2. Version MSIR-1 (3-95): lines 102–109.

*[(J)]***(K)** Capital asset. A facility's building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in HIM-15. Motor vehicles are excluded from this definition.

*[(K)]***(L)** Capital asset debt. The debt related to the capital assets as determined from the desk audited and/or field audited cost report.

*[(L)]***(M)** Ceiling. The ceiling is the maximum per diem rate for which a facility may be reimbursed for the patient care, ancillary and administration cost components, and is determined by applying a percentage to the median per diem for the patient care, ancillary**,** and administration cost components. The percentage is one hundred twenty percent (120%) for patient care, one hundred twenty percent (120%) for ancillary, and one hundred ten percent (110%) for administration.

*[(M)]***(N)** Certified bed. Any nursing facility or hospital based bed that is certified by the Department of Health and Senior Services to participate in the Medicaid Program.

*[(N)]***(O)** Change of ownership. A change in ownership, control, operator, or leasehold interest, for any facility certified for participation in the Medicaid Program.

*[(O)]***(P)** Charity care. Offset to gross billed charges to reduce charges for free services provided to specific types of residents, (i.e. charity care provided to meet Hill Burton Fund obligations or care provided by a religious organization for members, etc.).

*[(P)]***(Q)** Contractual allowance. A contra revenue account to reduce gross charges to the amount expected to be received. Contractual allowances represent the difference between the private pay rate and a contracted rate which the facility contracted with an outside party for full payment of services rendered (i.e. Medicaid, Medicare, managed care organizations, etc.). No efforts are made to collect the difference.

*[(Q)]***(R)** Cost components. The groupings of allowable costs used to calculate a facility's per*[-]* diem rate. They are patient care, ancillary, capital, and administration. In addition, a working capital allowance is provided.

*[(R)]***(S)** Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in paragraph (10)(A)7. of this regulation, and all worksheets supplied by the division for this purpose. The cost report shall detail the cost of rendering both covered and noncovered services for the fiscal reporting period in accordance with this regulation and the cost report instructions and shall be prepared on forms *[or diskettes]* provided by and/or as approved by the division.

1. Cost Report version MSIR-1 (7-93) shall be used for completing cost reports with fiscal years ending prior to January 1, 1995 and shall be denoted as CR (7-93) throughout the remainder of this regulation.

2. Cost Report version MSIR-1 (3-95) shall be used for completing cost reports with fiscal years ending on or after January 1, 1995 and shall be denoted as CR (3-95) throughout the remainder of this regulation.

*[(S)]***(T)** Data bank. The data from the rate base year cost reports excluding the following facilities: hospital based, state operated, pediatric, HIV, terminated**,** or interim rate. If a facility has more than

one (1) cost report with periods ending in the rate base year, the cost report covering a full twelve- (12-) month period ending in the rate base year will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in the rate base year will be used.

1. The initial rate base year shall be 1992 and the data bank shall include cost reports with an ending date in calendar year 1992. The 1992 initial base year data shall be used to set rates effective for dates of service beginning January 1, 1995 through June 30, 2004. The 1992 initial base year data is adjusted for the **Health Care Finance Administration (**HCFA**)** Market Basket Index for 1993 of 3.9%, 1994 of 3.4%, and nine (9) months of 1995 of 3.3%, for a total adjustment of 10.6%.

2. The rate base year used for rebasing shall be 2001 and the data bank shall include cost reports with an ending date in calendar year 2001. The 2001 rebase year data shall be used to set rates effective for dates of service beginning July 1, 2004 through such time rates are rebased again or calculated on some other cost report as set forth in regulation. The 2001 rebase year data is adjusted for the CMS Market Basket Index for SFY 2002 of 3.2%, SFY 2003 of 3.4%, SFY 2004 of 2.3%, and SFY 2005 of 2.3%, for a total adjustment of 11.2%.

*[(T)]***(U)** Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

*[(U)]***(V)** Department of Health and Senior Services. The department of the state of Missouri responsible for the survey, certification, and licensure of nursing facilities as prescribed in Chapter 198, RSMo. Previously, the agency responsible for these duties was the Division of Aging within the Department of Social Services.

[(V) Desk audit. The Division of Medical Services' or its authorized agent's audit of a provider's cost report without a field audit.

(DD) Field audit. An on-site audit of the nursing facility's records performed by the department or its authorized agent.]

*[(EE)]***(DD)** Generally accepted accounting principles (GAAP). Accounting conventions, practices, methods, rules, and procedures necessary to describe accepted accounting practice at a particular time as established by the authoritative body establishing such principles.

*[(FF)]***(EE)** HCFA Market Basket Index. An index showing nursing home market basket indexes. The index is published quarterly by DRI/McGraw Hill. The table used in this regulation is titled "DRI Health Care Cost—National Forecasts, HCFA Nursing Home Without Capital Market Basket." HCFA became known as the Center for Medicare and Medicaid Services (CMS) and the table name changed accordingly. The publication and publisher have also changed names but the publication still provides essentially the same information. The publication is known as the Health-Care Cost Review and it is published by Global Insight. The same or comparable index and table shall continue to be used, regardless of any changes in the name of the publication, publisher, or table.

*[(GG)]***(FF)** Hospital based. Any nursing facility bed licensed and certified by the Department of Health and Senior Services, Section for Health Facilities Regulation, which is physically connected to or located in a hospital.

*[(HH)]***(GG)** Interim rate. The interim rate is the sum of one hundred percent (100%) of the patient care cost component ceiling, ninety percent (90%) of the ancillary and administration cost component ceilings, ninety-five percent (95%) of the median per diem for the capital cost component, and the working capital allowance using the interim rate cost component. The median per diem for capital will be determined from the capital component per diems of providers with prospective rates in effect on January 1, 1995 for the initial rate base year; July 1, 2004 for the 2001 rebased year; and March 15, 2005 for the revised rebase calculations effective for dates of service beginning April 1, 2005 and for the per diem rate calculation effective for dates of service beginning July 1, 2005 forward.

*[(II)]***(HH)** Licensed bed. Any skilled nursing facility or intermediate care facility bed meeting the licensing requirement of the Missouri Department of Health and Senior Services.

*[(JJ)]***(II)** Miscellaneous discounts/other revenue deductions. A contra revenue account to re*[-]*duce gross charges to the amount expected to be received. These deductions represent other miscellaneous discounts not specifically defined as a bad debt. Written policies must be maintained detailing the circumstances under which the discounts are available and must be uniformly applied.

*[(KK)]***(JJ)** Median. The middle value in a distribution, above and below which lie an equal number of values. The distribution for purposes of this regulation includes the per diems calculated for each facility based on or derived from the data in the data bank. The per diem for each facility is the allowable cost per day which is calculated by dividing the facility's allowable costs by the patient days. For the administration cost component, each facility's per diem included in the data bank and used to determine the median shall include the adjustment for minimum utilization set forth in subsection (7)(O) by dividing the facility's allowable costs by the greater of the facility's actual patient days or the calculated minimum utilization days.

*[(LL)]***(KK)** Nursing facility (NF). Effective October 1, 1990, skilled nursing facilities, skilled nursing facilities/intermediate care facilities**,** and intermediate care facilities as defined in Chapter 198, RSMo participating in the Medicaid Program will all be subject to the minimum federal requirements found in section 1919 of the Social Security Act.

*[(MM)]***(LL)** Occupancy rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the desk audited and/or field audited cost report. For a distinct part facility **that only has part of its total licensed beds certified for participation in the MO HealthNet program and** that completes a worksheet one**, version MSIR (7-93) or (3-95)** of **the** cost report, *[version MSIR (7-93) or (3-95),]* determine**s** the occupancy rate from the total actual patient days from the certified portion of the facility divided by the total bed days from the certified portion for the same period, as determined from the desk audited and/or field audited cost report.

*[(NN)]***(MM)** Patient care. This cost component includes the following lines from the cost report:

1. Version MSIR-1 (7-93): lines 45–60, 77–85; and
2. Version MSIR-1 (3-95): lines 46–70.

*[(OO)]***(NN)** Patient day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. "Patient day" includes the allowable temporary leave-of-absence days per subsection (5)(D) and hospital leave days per subsection (5)(M). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

*[(PP)]***(OO)** Per diem. The daily rate calculated using this regulation's cost components and used in the determination of a facility's prospective and/or interim rate.

*[(QQ)]***(PP)** Provider or facility. A nursing facility with a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing nursing facility services to Title XIX-eligible *[recipients]* **participants.**

*[(RR)]***(QQ)** Prospective rate. The rate determined from the rate setting cost report.

*[(SS)]***(RR)** Rate setting period. The period in which a facility's prospective rate is determined. The cost report that contains the data covering this period will be used to determine the facility's prospective rate and is known as the rate setting cost report. The rate setting period for a facility is determined from applicable regulations on or after July 1, 1990.

*[(TT)]***(SS)** Reimbursement rate. A prospective or interim rate.

*[(UU)]***(TT)** Related parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and such benefits exceed those

which are usual and customary in such dealings;

2. An entity has an ownership or controlling interest in another entity; and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership, or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity directly, or through a subsidiary, operates a facility; and

3. As used in this regulation, the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock, or in the profits of an entity. Ownership or controlling interest is when an entity—

(I) Has an ownership interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership; and

C. Relative means person related by blood, adoption, or marriage to the fourth degree of consanguinity.

*[(VV)]***(UU)** Replacement beds. Newly constructed beds never certified for Medicaid or previously licensed by the Department of Health and Senior Services and put in service in place of existing Medicaid beds. The number of replacement beds being certified for Medicaid shall not exceed the number of beds being replaced.

*[(WW)]***(VV)** Renovations/major improvements. Capital cost incurred for improving a facility excluding replacement beds and additional beds.

*[(XX)]***(WW)** Restricted funds. Funds, cash, cash equivalent, or marketable securities, including grants, gifts, taxes, and income from endowments which must only be used for a specific purpose designated by the donor.

*[(YY)]***(XX)** Total facility size. Facility size plus increases minus decreases of licensed nursing facility beds plus calculated bed equivalents for renovations/major improvements.

*[(ZZ)]***(YY)** Unrestricted funds. Funds, cash, cash equivalents, or marketable securities, including grants, gifts, taxes, and income from endowments, that are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items, and Services. All supplies, items, and services covered in the reimbursement rate must be provided to the resident as necessary. Supplies and services *[which]* **that** would otherwise be covered in a reimbursement rate but which are also billable to the Title XVIII Medicare Program must be billed to that program for facilities participating in the Title XVIII Medicare Program. Covered supplies, items, and services include, but are not limited to, the following:

(A) Services, items, and covered supplies required by federal or state law or regulation *[which]* **that** must be provided by nursing facilities participating in the Title XIX program;

(C) Private room and board when it is necessary to isolate a *[recipient]* **participant** due to a medical or social condition examples of which may be contagious infection, loud irrational speech*[, etc.]*;

(D) Temporary leave of absence days for Medicaid *[recipients]* **participants**, not to exceed twelve (12) days for the first six (6) calendar months and not to exceed twelve (12) days for the second six (6) calendar months. Temporary leave of absence days must be specifically provided for in the *[recipient's]* **participant's** plan of care and prescribed by a physician. Periods of time during which a *[recipient]* **participant** is away from the facility visiting a friend or relative are considered temporary leaves of absence.

(6) Noncovered Supplies, Items, and Services. All supplies, items, and services which are either not covered in a facility's reimbursement rate or are billable to another program in Medicaid, Medicare**,** or other third-party *[payor]* **payer**. Noncovered supplies, items, and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a *[recipient]* **participant** due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc. Unless a private room is necessary due to such a medical or social condition, a private room is a non**-**covered service and a Medicaid *[recipient]* **participant** or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. Medicaid *[recipients]* **participants** may not be placed in private rooms and charged any additional amount above the facility's Medicaid reimbursement rate unless the *[recipient]* **participant** or responsible party specifically requests in writing a private room prior to placement in a private room and acknowledges that an additional amount not payable by Medicaid will be charged for a private room;

(7) Allowable Cost Areas.

(D) Vehicle Costs. Costs related to allowable vehicles shall be accounted for as set forth below. Allowable vehicles are vehicles *[which]* **that** are a necessary part of the operation of a nursing facility*[.]* **and are limited as follows:** One (1) vehicle per sixty (60) licensed beds is allowable. For example, one (1) vehicle is allowed for a facility with zero to sixty (0–60) licensed beds, two (2) vehicles are allowed for a facility with sixty-one to one hundred twenty (61–120) licensed beds, and so forth. **Vehicles subject to the limit include cars, trucks, vans, sport utility vehicles (SUVs), and shuttle buses. Golf carts, utility terrain vehicles (UTVs), all terrain vehicles (ATVs), and other vehicles not aforementioned in this subsection shall not be included in the total vehicle count for the limit.** Costs related to vehicles that are disallowed shall also be disallowed and adjustments made accordingly.

1. Depreciation.

A. An appropriate allowance for depreciation on allowable vehicles is reported on line 139 of the cost report, version MSIR-1 (7-93) and on line 133 of CR (3-95).

B. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the vehicle and prorated over the estimated useful life of the vehicle in accordance with American Hospital Association depreciable guidelines using the straight line method of depreciation from the date initially put into service.

C. The basis of vehicle cost at the time placed in service shall be the lower of—

(I) The book value of the provider;

(II) Fair market value at the time of acquisition; or

(III) The recognized Internal Revenue Service (IRS) tax basis.

D. The basis of a donated vehicle will be allowed to the extent of recognition of income resulting from the donation of the vehicle. Should a dispute arise between a provider and the division

as to the fair market value at the time of acquisition of a depreciable vehicle, an appraisal by a third party is required. The appraisal cost will be the sole responsibility of the nursing facility.

E. Historical cost will include the cost incurred to prepare the vehicle for use by the nursing facility.

F. When a vehicle is acquired by trading in an existing vehicle, the cost basis of the new vehicle shall be the sum of undepreciated cost basis of the traded vehicle plus the cash paid.

2. Interest. Interest cost on vehicle debt related to allowable vehicles shall be reported on line 139 of CR (7-93) and line 134 of CR (3-95).

3. Insurance. Insurance cost related to allowable vehicles shall be reported on line 140 of CR (7-93) and line 135 of CR (3-95).

4. Rental and leases. Lease cost related to allowable vehicles shall be reported on line 139 of CR (7-93) and on line 135 of CR (3-95).

5. Personal property taxes. Personal property taxes related to allowable vehicles shall be reported on line 112 of CR (7-93) and on line 109 of CR (3–95).

6. Other miscellaneous maintenance and repairs. Other miscellaneous maintenance and repairs related to allowable vehicles shall be reported on line 139 of CR (7-93) and on line 135 of CR (3-95).

(F) Interest and Borrowing Costs on Capital Asset Debt. Allowable interest and borrowing costs, as set forth below, are reimbursed as part of the capital cost component per diem detailed in subsection (11)(D).

1. Interest will be reimbursed for necessary loans for outstanding capital asset debt from the rate setting cost report at the prime rate plus two (2) percentage points, as set forth in paragraph (11)(D)3.

2. Loans (including finance charges, prepaid costs, and discounts) must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required. The loan costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed, and must be necessary for the acquisition and/or renovation of the provider's facility.

3. Necessary means that the loan be incurred to satisfy a financial need of the provider and for a purpose related to *[recipient]* **participant** care. Loans which result in excess funds or investments are not considered necessary.

4. A provider shall capitalize borrowing costs and amortize them over the life of the loan on a straight-line basis. Borrowing costs include loan costs (that is, lender's title and recording fees, appraisal fees, legal fees, escrow fees, and other closing costs), finance charges, prepaid interest, and discounts. Finder's fees are not allowed.

5. If loans for capital asset debt exceed the facility asset value, the interest and borrowing costs associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

6. An illustration of how allowable interest and allowable borrowing costs is calculated is detailed in paragraphs (11)(D)3. and 4.

(8) Non-allowable Costs. Costs not reasonably related to nursing facility services shall not be included in a provider's costs. Non-allowable costs include, but are not limited to, the following:

(P) Owner's compensation in excess of the applicable range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers as published in the updated *Medicare Provider Reimbursement Manual* Part 1, Section 905.2 and based upon the total number of working hours.

1. The applicable range will be determined as follows:

A. Number of licensed beds owned or managed; and

B. *[Owners/administrators]* **Owners acting as administrators** will be adjusted on the basis of the high range. Owners included in home office costs or management company costs will be adjusted on the high range. All others will be calculated on the median range.

2. The salary identified above will be apportioned on the basis of hours worked in the facility(ies), home office, or management company as applicable to total hours in the facility(ies), home office, or management company;

(9) Revenue Offsets.

(A) Other revenues must be identified separately in the cost report. These revenues are offset against expenses. Such revenues include, but are not limited to, the following:

1. Income from telephone services;
2. Sale of employee and guest meals;
3. Sale of medical abstracts;
4. Sale of scrap and waste food or materials;
5. Cash, trade, quantity, time, and other discounts;
6. Purchase rebates and refunds;
7. Recovery on insured loss;
8. Parking lot revenues;
9. Vending machine commissions or profits;
10. Sales from supplies to individuals other than nursing facility *[recipients]* **participants**;
11. Room reservation charges other than covered therapeutic home leave days and hospital leave days;
12. Barber and beauty shop revenue;
13. Private room differential;
14. Medicare Part B revenues*[;]***.**

A. Revenues received from Part B charges through Medicare intermediaries will be offset*[;]***.**

B. Seventy-five percent (75%) of the revenues received from Part B charges through Medicare carriers will be offset;

15. Personal services;
16. Activity income; and
17. Revenue recorded for donated services and commodities.

(10) Provider Reporting and Record Keeping Requirements.

(A) Annual Cost Report. The cost report (version MSIR-1 (3-95)) and cost report instructions (revised 3*[/]*/95) are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[August 1, 2008]* **March 1, 2021**. This rule does not incorporate any subsequent amendments or additions.

1. Each provider shall adopt the same twelve- (12-) month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the division **or its authorized contractor** an annual cost report, including all worksheets, attachments, schedules, and requests for additional information from the division **or its authorized contractor**. The cost report shall be submitted on forms provided by the division **or its authorized contractor** for that purpose. Any substitute or computer generated cost report must have prior approval by the division **or its authorized contractor**.

3. All cost reports shall be completed in accordance with the requirements of this regulation and the cost report instructions. Financial reporting shall adhere to GAAP, except as otherwise specifically indicated in this regulation.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment for capital expenditures is made under GAAP.

5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period. **A provider may request, in writing, a reasonable extension of the cost report filing date for circumstances that are beyond the control of the provider and that are not a product or result of the negligence or malfeasance of the nursing facility. Such circumstances may**

include public health emergencies; unavoidable acts of nature such as flooding, tornado, earthquake, lightning, hurricane, natural wildfire, or other natural disaster; or, vandalism and/or civil disorder. The division may, at its discretion, grant the extension.

6. If a cost report is more than ten (10) days past due, payment *[shall]* **may** be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's MO HealthNet participation agreement and if terminated retain all payments which have been withheld pursuant to this provision.

7. Copies of signed agreements and other significant documents related to the provider's operation and provision of care to MO HealthNet participants must be attached (unless otherwise noted) to the cost report at the time of filing unless current and accurate copies have already been filed with the division **or its authorized contractor**. Material which must be submitted or available upon request includes, but is not limited to, the following:

A. Audit prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the division, the department, or its *[agents]* **authorized contractor**;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, if requested by the division, the department, or its *[agents]* **authorized contractor**;

G. Leases and/or rental agreements related to the activities of the provider if requested by the division, the department, or its *[agents]* **authorized contractor**;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

K. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

8. Cost reports must be fully, clearly, and accurately completed. All required attachments must be submitted before a cost report is considered complete. If any additional information, documentation, or clarification requested by the division or its authorized *[agent]* **contractor** is not provided within fourteen (14) days of the date of receipt of the division's request, payments may be withheld from the facility until the information is submitted.

9. Under no circumstances will the division accept amended cost reports for rate determination or rate adjustment after the date of the division's notification of the final determination of the rate.

10. Exceptions. A cost report *[may]* **is** not *[be]* required for the following *[if a provider requests a waiver in writing. Upon review of the provider's request, the division shall provide a written response, indicating its decision as to whether a waiver shall be granted.]***:**

A. Hospital based providers which provide less than one thousand (1,000) patient days of nursing facility services for Missouri Title XIX *[recipients]* **participants**, relative to their fiscal year.

B. Change in provider status. **The cost report filing requirement for the cost report relating to the terminating provider from a change of control, ownership, or termination of participation in the MO HealthNet program is not required, unless the terminating cost report is a full twelve- (12-) month cost report. If a rebase is done for a year in which there is no cost report, the cost report for the year prior to the change of control, ownership, or termination shall be used in the rebase calculation. A trend from the prior year cost report to the rebase year may be applied, if applicable.**

[(I) Providers which provide less than one thousand (1,000) patient days of nursing facility services for Missouri Title XIX recipients, relative to their fiscal year, and have less than a twelve- (12-) month cost report due to a termination, change of ownership, or being newly MO HealthNet certified.

(II) Beginning in SFY-04, the division may waive the cost report filing requirement for the cost report resulting from a change of control, ownership, or termination of participation in the MO HealthNet program if the old/terminating provider can show financial hardship in providing the cost report. The old/terminating provider must submit a written request to the division, indicating and providing documentation for the financial hardship caused by filing the cost report.

(III) Beginning in SFY-07, the division may waive the cost report filing requirement for the cost report resulting from a change of control or ownership of participation in the MO HealthNet program if the old and new providers can provide assurances satisfactory to the division that the new providers will submit a cost report in the calendar year in which the change occurred and that the cost report will cover at least a three- (3-) month period. A written request jointly submitted by the old and new providers, indicating the new provider's fiscal year end and the dates that the cost report will cover, may provide adequate assurances.]

11. *[Cost report requirements]* **Notification of change in provider status** and withholding of funds for a change in provider status. A provider shall provide written notification to the assistant deputy director of the Institutional Reimbursement Unit of the division prior to a change of control, ownership, or termination of participation in the MO HealthNet program. *[If a provider does not qualify for an exception for filing a cost report as detailed above in subparagraph (10)(A)10.C., the division may withhold payments due to the provider pending receipt of the required cost report. The cost report must be prepared in accordance with this regulation with all required attachments and documentation and is due the first day of the sixth month after the date of change of control, ownership, or termination. Upon receipt of the fully completed cost report, any payments withheld will be released, less any amounts owed to the division such as unpaid NFRA, overpayments, etc.]* **The division may withhold funds due to a change in provider status as follows:**

A. If the division receives notification prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division will withhold a minimum of thirty thousand dollars ($30,000) of the remaining payments from the old/terminating provider**.** *[until the cost report is filed. Upon receipt of the cost report prepared in accordance with this regulation, any]* **After six (6) months, any** payments withheld will be released to the old/terminating provider, less any amounts owed to the division such as unpaid NFRA, overpayments, etc.**; or**

B. If the division does not receive notification prior to a change of control or ownership, the division will withhold thirty thousand dollars ($30,000) of the next available MO HealthNet payment from the provider identified in the current MO HealthNet participation agreement *[until the required cost report is filed]*. If the MO HealthNet payment is less than thirty thousand dollars ($30,000), the entire payment will be withheld. *[Upon receipt of the cost report prepared in accordance with this regulation, any]* **After six (6) months, any** payments withheld will be released to the provider identified in the current MO HealthNet participation agreement, less any amounts owed to the division such as unpaid

NFRA, overpayments, etc.

[C. The division may, at its discretion, delay the withholding of funds specified in subparagraphs (10)(A)11.A. and B. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the old and new provider may provide adequate assurances. The new provider must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold thirty thousand dollars ($30,000) if the cost report is not timely filed.]

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the division or its authorized *[agent]* **contractor** for additional information.

2. Each of a provider's funded accounts must be separately maintained with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized *[agent]* **contractor** at the same site at which the services were provided or at the central office/home office if located in the state of Missouri. Copies of documentation and records shall be submitted to the division or its authorized *[agent]* **contractor** upon request.

4. Each facility shall retain all financial information, data, and records relating to the operation and reimbursement of the facility for a period of not less than seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to **a Level III Audit (also known as a** field audit**)** by the division or its authorized *[agent]* **contractor**.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the state of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the division or its authorized *[agent]* **contractor** for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

4. Those providers initially entering the program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering, at a minimum, the first two (2) full twelve- (12-) month fiscal years of their participation in the Medicaid Program, in accordance with GAAP and generally accepted auditing standards. The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings, and Statement of Cash Flow. For example, a provider begins participation in the Medicaid program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September. That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full twelve- (12-) month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve- (12-) month cost report, shall be audited. The audits shall be done by an independent certified public accountant. **The independent audits of the first two (2) full twelve- (12-) month fiscal years may be performed at the same time. The provider may submit two (2) independent audit reports (i.e., one for each year) or they may submit one (1) combined independent audit report covering both years. The independent audit report(s) for combined audits are due with the filing of the second full twelve- (12-) month cost report. If the independent audits are combined, the provider must notify the division of such by the due date of the first full twelve- (12-) month cost report.**

(14) Exceptions.

[(A) For those Medicaid-eligible recipients who have concurrent Medicare Part A skilled nursing facility benefits available, Medicaid reimbursement for covered days of stay in a qualified facility will be based on this coinsurance as may be imposed under Title XVIII.]

(A) Requirements for Placement of MO HealthNet Participants in Out-of-State Nursing Facilities and Reimbursement for Out-of-State Nursing Facilities.

1. In order to provide nursing facility services to MO HealthNet participants when there is no Missouri nursing facility with a suitable bed available that meets the medical needs of the participant, the division may authorize placement of a MO HealthNet participant in an out-of-state facility.

2. The division will only authorize placement of a MO HealthNet participant into an out-of-state facility if—

A. No Missouri nursing facility bed is available that meets the medical needs of the participant;

B. In-state alternatives for providing services have been exhausted; and

C. Prior approval for placement into an out-of-state nursing facility is requested from and approved by the division.

3. Once a Missouri nursing facility bed meeting the medical needs of the participant is available, the participant must return to Missouri. If the participant does not return to Missouri, the division may withhold payments for nursing facility services, unless the participant's health would be endangered if required to travel to Missouri. Participant's physician would need to certify that the participant's health would be endangered from the travel to Missouri.

4. No fiscal year-end Missouri Medicaid cost report will be required from the out-of-state nursing facility nor will there be any requirement for Missouri-conducted periodic audits.

*[(B)]***5.** The Title XIX reimbursement rate for out-of-state providers shall be set as follows:

*[1.]***A.** For out-of-state providers which provided services for Missouri Title XIX *[recipients]* **participants**, the reimbursement rate shall be *[the rate paid for comparable services and level of care by the state in which the provider is located. The reimbursement rate will remain in effect until]* **the lower of—**

(I) The weighted average MO HealthNet rate for comparable services at the beginning of the state fiscal year in which the provider enters the MO HealthNet program; or

(II) The rate paid to the out-of-state nursing facility for comparable services by the state in which the provider is located. The out-of-state provider must notify the division of any reimbursement changes made by its state Medicaid agency. The provider must also include a copy of the rate letter issued by their state Medicaid agency detailing the rate and effective date. The effective date of the rate change is as follows:

*[A.]***(a)** Rate increases—*[The division receives written notification of an increase in the provider's rate as issued by the state MO HealthNet agency in which the provider is located. The provider must also include a copy of the rate letter issued by their state detailing the rate and effective date.]* If the provider notifies the division within thirty (30) days of receipt of notification from their state of the per diem rate increase, the effective date of the rate increase for purposes of reimbursement from Missouri shall be the same date as indicated in the issuing state's rate letter. If the division does not receive written notification from the provider within thirty (30) days of the date the provider received notification from their state of the rate increase, the effective date of the rate increase for purposes of reimbursement from

Missouri shall be the first day of the month following the date the division receives notification; or

*[B.]***(b)** Rate decreases—*[The division receives written notification of a decrease in the provider's rate as issued by the state Medicaid agency in which the provider is located including a copy of the rate letter issued by their state detailing the rate and effective date.]* The effective date of the rate decrease for purposes of reimbursement from Missouri shall be the same date as indicated in the issuing state's rate letter.

*[(C)]***(B)** The Title XIX reimbursement rate for hospital based providers*[, which]* **that** provide services of less than one thousand (1,000) patient days for Missouri Title XIX *[recipients]* **participants**, relative to their fiscal year, **and that** are exempt from filing a cost report as prescribed in section (10)*[.]* **shall be determined as follows:**

1. For hospital based nursing facilities that have less than one thousand (1,000) Medicaid patient days, the rate base cost report will not be required. The prospective rate will be the sum of the ceilings for **the** patient care, ancillary**,** and administration*[,]* **cost components, plus the** working capital allowance*[,]* and the median per diem for capital. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted*[.]***; and**

2. For hospital based nursing facilities with a provider agreement in effect on December 31, 1994, a prospective rate shall be set by one (1) of the following:

A. The hospital based nursing facility requests, in writing, that their prospective rate be determined from their rate setting cost report as set forth in this regulation; or

B. The sum of the ceilings for patient care, ancillary, administration and working capital allowance, and the median per diem for capital from the permanent capital per diem in effect January 1, 1995 for the initial rate base year; July 1, 2004 for the 2001 rebased year; and March 15, 2005 for the revised rebase calculations effective for dates of service beginning April 1, 2005 and for the per diem rate calculation effective for dates of service beginning July 1, 2005 forward. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted.

(17) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid *[recipients]* **participants**, the amount paid in accordance with these regulations and other applicable payments.

(22) Prospective Rate Determination Beginning November 1, 2020. Prospective rates determined on or after November 1, 2020 shall be calculated as follows:

(A) Prospective Rate Determination for Nursing Facilities Newly Medicaid Certified after June 30, 2004. As set forth in subsection (12)(F), a nursing facility never previously certified for participation in the Medicaid program shall receive an interim rate upon entering the Medicaid program. The nursing facility shall have its prospective rate set on its second full twelve- (12-) month cost report following the facility's initial date of certification, referred to as the rate setting cost report. The period to which the rate setting cost report relates is referred to as the rate setting period;

(B) The prospective rate shall be calculated in accordance with the provisions of the regulation in effect from the beginning of the facility's rate setting period through the date the prospective rate is determined, as detailed below. If industry-wide rate changes were implemented during this period the provision of the regulation relating to the effective date of the rate change shall be the governing regulation for those dates of service; and

(C) The prospective rate shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed in subsections (21)(A)-(L), except for the following:

1. Paragraphs (21)(L)2. and (21)(L)3. shall not be applied in determining the prospective rate; and

2. The total rate determined from the rate setting cost report shall be adjusted by any global per diem adjustments granted after the beginning of the facility's rate setting period through the effective date of the prospective rate; and

3. The effective date for a facility's prospective rate is as follows:

A. The effective date for facilities with a rate setting cost report period that begins prior to November 1, 2020 shall be November 1, 2020; and

B. The effective date for facilities with a rate setting cost report period that begins after November 1, 2020 shall be the beginning of the rate setting cost report period; and

4. The total rate that has been trended shall be limited to a cap, referred to as the total rate cap. The total trended rate shall be limited to the total rate cap that is in effect on the effective date of the prospective rate, as follows:

A. The total rate cap in effect on November 1, 2020 is one hundred ninety dollars ($190); and

B. The total rate cap set forth above, one hundred ninety dollars ($190), shall be adjusted by any global per diem adjustments granted after November 1, 2020; and

5. Once the prospective rate is finalized, a retroactive payment shall be made back to the effective date, if applicable; and

6. The prospective rate determined in (22)(C)1.-5. shall be adjusted by any global per diem adjustments set forth in 13 CSR 70-10.016 that are granted after the effective date of the prospective rate.

AUTHORITY: [section 208.159, RSMo 2000, and sections 208.153 and 208.201, RSMo Supp. 2013] ***sections 208.153, 208.159, 208.201, and 660.017, RSMo 2016****. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Feb. 26, 2021.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately $2.15 million annually beginning in SFY 2021.

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.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 10 - Nursing Home Program

Rule Number and Name:	13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Social Services MO HealthNet Division	Beginning in SFY 2021, the Estimated Annual Cost = $2,152,033
Non-State Government Owned Nursing Facilities (43)	No estimated annual costs of compliance

III. WORKSHEET

Description	Nursing Facility Rate Increase	Hospice Nursing Home Room & Board	Total Impact
Estimated Annual Days for Nursing Facilities Needing to have Prospective Rate Set	43,957	4,634	
Estimated Per Diem Increase for New Prospective Rate Setting Methodology	$44.53	$42.00	
Estimated Annual Impact	$1,957,405	$194,628	$2,152,033
State Share (34.867%)	$682,488	$67,861	$750,349
Federal Share (65.133%)	$1,274,917	$126,767	$1,401,684

IV. ASSUMPTIONS

Department of Social Services, MO HealthNet Division: The above impact to DSS, MHD was calculated using the following assumptions:

Estimated Paid Days:

Nursing Facility:

The average number of days paid for SFY 2020 for all nursing facilities that need to have a prospective rate set was multiplied by 5; this assumes that 5 nursing facilities will have prospective rates set each year.

Hospice:

The SFY 2020 paid days for nursing facilities that need to have a prospective rate set was divided by the total 2020 paid days for all nursing facilities to determine the percentage of total nursing facility days that relate to nursing facilities that need to have a prospective rate set. That percentage (0.5%) was multiplied by the total SFY 2020 hospice days to determine the estimated annual hospice days relating to nursing facilities that need to have a prospective rate set.

Non-State Government Owned Nursing Facilities (43): This proposed amendment results in an increased prospective rate for nursing facilities that need to have a prospective rate set so there are no costs of compliance to Medicaid enrolled non-state government owned nursing facilities.

Hospice: Hospice providers may be impacted by this regulation because reimbursement for hospice services provided in nursing facilities is based on the nursing facility per diem rate. MHD conducted a fiscal analysis using 13 CSR 70-50.010 to estimate the impact to hospice. Please note this is an estimated analysis with the assumption of hospice appropriation authority.

Hospice Nursing Home Room and Board services are reimbursed 95% of the nursing facility per diem rate. The estimated increase in the prospective rate for nursing facilities that need to have a prospective rate set is $44.53 which results in an estimated increase to hospice reimbursement rates relating to those nursing facilities resulting from this amendment of $42.00 ($44.53 x 95%).

Impact on Home and Community Based Services (HCBS):

HCBS provided on a monthly basis are limited to a percentage of the average monthly nursing facility payment, referred to as the HCBS cost cap. The HCBS cost cap for a given SFY is based on the average monthly nursing facility payments for the 12 months ending in April of the previous SFY. Therefore, the estimated increase in the per diem rate for nursing facilities that need to have a prospective rate set of $44.53 will not impact the HCBS cost cap for SFY 2021 but may result in a slight increase in the HCBS cost cap beginning in SFY 2022. This may increase the amount of services, and the payments, for MO HealthNet participants that are at the cap.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 25—Physician Program

PROPOSED AMENDMENT

13 CSR 70-25.110 Payment for Early Periodic Screening, Diagnostic, and Treatment Program Services. The department is amending sections (1), (3), (4), (5), and (6), is removing sections (2) and (7), and renumbering as necessary.

PURPOSE: This amendment updates language and removes an obsolete statutory reference.

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 Department of Social Services shall administer an Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. In Missouri the EPSDT Program is administered as the Healthy Children and Youth (HCY) Program. The EPSDT/HCY Program provides *[for thorough physical and dental examinations]* **comprehensive and preventive health care services** for MO HealthNet-eligible persons under *[the age of]* twenty-one (21) years *[and for all persons under the age of twenty-one (21) years]* **of age including those** in the legal custody of the Department of Social Services or any division of the department at no cost to the child or to the parents or guardians if they accept the offer of this service. *[Funding for EPSDT services is through Title XIX of the federal Social Security Act (Medicaid) and Missouri.]* **The services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the division and shall be included in the MO HealthNet provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website http://manuals.momed.com/manuals, November 25, 2020. This rule does not incorporate any subsequent amendments or additions.**

[(2) EPSDT services are available to participants under the age of twenty-one (21) years who are eligible to receive medical assistance benefits under the provisions of sections 208.151, 208.162, and 208.204, RSMo.]

*[(3)]***(2)** The EPSDT Program shall make a general physical examination available to eligible participants *[under the age of twenty-one (21) years]*. The components of the general physical examination shall include a **comprehensive** health **and developmental** history, a*[n]* **comprehensive** unclothed physical examination, appropriate **immunizations,** laboratory tests, *[immunizations, a developmental/mental health screen,]* **health education,** a vision screen, *[and]* a dental screen**, and hearing services**. These screens will be made available at the frequency recommended by *[the]* **Bright Futures**/American Academy of Pediatrics and the American Academy of Pediatric Dentists.

(A) Interperiodic screenings outside the recommendations of *[the]* **Bright Futures**/American Academy of Pediatrics or the American Academy of Pediatric Dentists are available when medically indicated.

(B) Partial screens for vision, hearing, dental, unclothed physical examination, an interval history, *[and]* appropriate laboratory tests *[and]***,** immunizations, developmental/mental health assessment, and anticipatory guidance shall be reimbursable services.

*[(4)]***(3)** Providers of the screening services must be enrolled MO HealthNet providers **operating within their legal scope of practice**.

*[(5)]***(4)** *[Reimbursement for medically necessary treatment services identified as a result of a screening shall be provided by the Department of Social Services, MO HealthNet Division, if the services are available under Section 1905(a) of the Social Security Act. These services shall be limited by medical necessity. Experimental services are not covered.]* **The MO HealthNet program will provide reimbursement for prescribed, medically necessary treatment identified as a result of the screening if the treatment is a covered service under Section 1905(a) of the Social Security Act. "Medically necessary" is defined as service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could not have been omitted without adversely affecting the participant's condition or the quality of medical care rendered; and the service(s) is (are) furnished in the most appropriate setting. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.** Any service authorized must be effective in addressing the participant's need. Services may *[be]* **require** prior-authoriz*[ed]***ation** to assure medical necessity.

*[(6)]***(5)** Medical and dental services *[which]* **that** Section 1905(a) of the Social Security Act permits to be covered under MO HealthNet and *[which]* **that** are **medically** necessary to treat or ameliorate defects, physical, and mental illness, or conditions identified by an EPSDT screen are covered regardless of whether *[or not]* **the Medicaid state plan covers** the services *[are covered under the Medicaid state plan]*. Services provided under this program will be sufficient in amount, duration, and scope to reasonably achieve their purpose. *[The services are limited due to medical necessity. Services identified as needed as the result of a screening which are beyond the scope of the Medicaid state plan require a]* **Services beyond the scope of the Medicaid state plan that a screening identifies as needed require** a plan of care**. The plan of care must** identify*[ing]* the treatment needs of the child in regard to amount, scope, and prognosis. *[Prior authorization of services may be required for these service needs and for services of extended duration unless otherwise noted in the benefits and limitations section of the provider manual of the appropriate provider of the service. Examples of services beyond the scope of the state Medicaid Plan are—orthodontic services; physical, occupational, and speech therapy evaluations and services; psychology and counseling services; private duty nursing services; and medical supplies.]* **Certain services and equipment require approval prior to provision of the service as a condition of reimbursement. Prior authorization is used to promote the most effective and appropriate use of available services and to determine the medical necessity of the service.** Services may be made available in an inpatient, outpatient office, or home setting depending upon the medical condition of the participant and availability of services.

[(7) Services must be provided by enrolled MO HealthNet providers operating within their legal scope of practice.]

*AUTHORITY: section[s] 208.152, **RSMo Supp. 2020, and sections** 208.153, [and] 208.201, [RSMo Supp. 2007] **and 660.017, RSMo 2016**. This rule was previously filed as 13 CSR 40-81.015. Original rule filed Jan. 15, 1985, effective April 11, 1985. Amended: Filed Jan. 13, 1992, effective Sept. 6, 1992. Amended: Filed Aug. 15, 2008, effective Feb. 28, 2009. Amended: Filed Feb. 26, 2021.*

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 Department of Social Services, MO HealthNet Division, PO Box 6500, Jefferson City, MO 65102. 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 90—Home Health Program

PROPOSED AMENDMENT

13 CSR 70-90.010 Home Health-Care Services. The MO HealthNet Division is adding subsection (2)(C), updating sections (7) and (8), and adding section (9).

*PURPOSE: This amendment allows the adult expansion group described in Article IV Section 36(c) of the **Missouri Constitution** to receive habilitative services through the Missouri Home Health Program, and updates the incorporated by reference dates.*

(2) Home health services include the following services and items:

(C) Physical, occupational, or speech therapy when the following conditions are met:

1. The participant is age nineteen (19) or over and under age sixty-five (65) and enrolled under the Medicaid eligibility criteria for the adult expansion group as described in Article IV Section 36(c) of the *Missouri Constitution*; and

2. Physical, occupational, or speech therapy is a habilitative service that will help the individual keep, learn, or improve skills and functioning for daily living, in accordance with limitations set forth in section (9) of this rule;

*[(C)]***(D)** Intermittent home health aide; and

*[(D)]***(E)** Supplies identified as specific and necessary to the delivery of a participant's nursing care and prescribed in the plan of care. Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one (1) individual, that are required to address an individual medical disability, illness, or injury. Medical supplies are classified as—

1. Routine—medical supplies used in small quantities for patients during the usual course of most home visits; or

2. Non-routine—medical supplies needed to treat a patient's specific illness or injury in accordance with the physician's plan of care and meet further conditions discussed in more detail below.

(7) To be reimbursed by MO HealthNet, all home health services and supplies must be provided in accordance with a written plan of care authorized by the participant's physician. The criteria for the development of the written plan of care and changes to the written plan of care through interim order(s) are described in the *MO HealthNet Division Home Health Provider Manual[. The MO HealthNet Division Home Health Provider Manual]* **which** is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at http://manuals.momed.com/manuals/, *[December 10, 2019]* **November 24, 2020**. This rule does not incorporate any subsequent amendments or additions. Plans of care and interim order(s) are to be maintained in the client record.

(8) Skilled therapy services **as described in subsection (2)(B)** will be considered reasonable and necessary for treatment if the conditions of paragraphs (8)(A)1.–4. are met.

(9) The combination of physical, occupational, and speech therapy as described in subsection (2)(C) of this rule is limited to a total of twenty (20) visits inclusive of services from all MO HealthNet providers per year.

*AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. [2019] **2020**. This rule was previously filed as 13 CSR 40-81.056. Original rule filed April 14, 1982, effective July 11, 1982. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Feb. 26, 2021, effective July 1, 2021, expires Feb. 24, 2022. Amended: Filed Feb. 26, 2021.*

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 17—BOARDS OF POLICE COMMISSIONERS
Division 10—Kansas City Board of Police Commissioners
Chapter 2—Private Security

PROPOSED RESCISSION

17 CSR 10-2.010 Regulation and Licensing In General. This rule established procedures, testing requirements and license fees for those persons required to be licensed.

PURPOSE: Board wishes to rescind this rule and adopt a new rule in its place to clarify the language in the rule and insure compliance with the applicable law.

*AUTHORITY: section 84.720, RSMo 2000. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the **Code of State Regulations**. Rescinded: Filed March 1, 2021.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in

support of or in opposition to this proposed rescission with the Board of Police Commissioners of Kansas City, Missouri, 1125 Locust St., Kansas City, Missouri 64106. 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 17—BOARDS OF POLICE COMMISSIONERS
Division 10—Kansas City Board of Police Commissioners
Chapter 2—Private Security

PROPOSED RULE

17 CSR 10-2.010 Regulation and Licensing In General

PURPOSE: Under the provisions of sections 84.420 and 84.720, RSMo, the Board of Police Commissioners of Kansas City, Missouri (board) has the authority and duty to regulate and license all private security and proprietary private investigative personnel, serving or acting as such within Kansas City, Missouri (city). This rule establishes procedures, testing requirements, and license fees for those persons required to be licensed.

(1) Any corporation, partnership, or other entity that provides private security services and proprietary private investigative services is fully responsible for the acts and omissions of its employees acting in the course and scope of their duties. Training is the responsibility of the entity hiring such employees. The board is a licensing agency, not an employer, and assumes no responsibilities for the acts or omissions of any entity or individual providing such services. The board's functions are limited to licensing and regulating any entity or individual who perform such services. The board shall have the power and duty to enforce the provisions of these rules and upon complaint of any person or on its own initiative to investigate violations, or to investigate the business, business practices, or business method of any person, firm, company, partnership, corporation, or political subdivision applying for or holding a license for providing private security services and proprietary private investigative services if, in the opinion of board, the investigation is warranted. Each entity or individual applicant shall be obligated to supply the information, books, papers, or records as reasonably may be required concerning proposed business practices or methods. Failure to comply with any reasonable request of the board shall be grounds for denying an application for a license or for revoking, suspending, or failing to renew a license issued under these rules. Those licensed must maintain the records that the board requires which include, but are not limited to, records of contract accounts, employment records, time records, and assignment records along with records required to be kept by federal and state law.

(2) Any license granted under section 84.720, RSMo, shall constitute a privilege to do business and shall not invest the one licensed with any contractual interest, inherent right, or property interest.

(3) Those licensed to perform private security services or proprietary private investigative services have police powers limited to the property which they have been lawfully assigned to protect. With the exception of those licensed as airport police and park rangers, whose authority is set out in 17 CSR 10-2.030(1)(A)5-6., those licensed under these provisions have no authority to enforce ordinances, statutes, or rules on the public streets of city or at any location other than on the property they have been assigned to protect.

(4) Private Officers Licensing Unit (POLU) is responsible for investigating, processing, licensing, inspecting, and the regulation of all persons working or acting as licensed private security or proprietary private investigators. The POLU is further responsible for issuing and transferring all such licenses, for reinstatements, and for periodic inspection of license holders.

(5) Private security and proprietary private investigator licenses are required for each of the following:

(A) Any individual providing private security services or proprietary private investigative services within the city whether for a licensed private security business or otherwise (collectively a security officer);

(B) Any firm, company, partnership, or corporation that provides private security services or proprietary private investigative services (collectively a security firm);

(C) Any direct supervisor of a security officer; and

(D) Any political subdivision, sole proprietorship, firm, company, partnership, or corporation that employs personnel to provide private security services or proprietary private investigative services.

(6) The board's licensing requirements do not apply to persons acting as bouncers, process servers, bondsmen, surety recovery agents (bounty hunters), or investigators for attorneys unless acting in a private security capacity as defined in these rules.

(7) No license is required for any peace officer authorized to exercise police powers in the city who holds a valid Peace Officer Standards and Training (POST) certificate.

(8) The board shall perform its functions under statute and under these regulations through the POLU of the Kansas City, Missouri Police Department (department). All private officers and proprietary private investigators are subject to inspection by employees of the board and members of the department. The purpose of such inspections is to ensure that the licensee is in compliance with the provisions of this rule. Failure to cooperate with an employee of the board or member of the department may result in penalties being assessed as set out in 17 CSR 10-2.060(9).

AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the ***Code of State Regulations****. Rescinded and readopted: Filed March 1, 2021.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions ten thousand two hundred forty dollars ($10,240) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities four hundred ninety-four thousand seven hundred fifteen dollars ($494,715) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Board of Police Commissioners of Kansas City, Missouri, 1125 Locust St., Kansas City, Missouri 64106. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 17
Division Title: 10
Chapter Title: 2

Rule Number and Name:	17 CSR 10-2.010 – Regulation and Licensing in General
Type of Rulemaking:	Proposed Rulemaking

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
City of Kansas City, Missouri	**$4485.00**
Jackson County, Missouri Family Court	**$560.00**
Kansas City International Airport Police	**$4365.00**
Housing Authority of Kansas City, Missouri	**$830.00**
Total	**$10,240.00**

III. WORKSHEET

The City of Kansas City, Missouri licenses forty (40) armed security officers and nine (9) unarmed security officers. Jackson County, Missouri Family Court licenses four (4) unarmed officers. The Kansas City International Airport Police currently licenses seventeen (17) armed officers and thirty-nine (39) unarmed officers. The Housing Authority of Kansas City, Missouri currently licenses three (3) armed officers and four (4) unarmed officers. The rates for new armed licenses will be one hundred forty-five dollars ($145.00) per year. The rate for new unarmed licenses will be ninety dollars ($90.00) per year.

The yearly renewal fees for armed licenses will be ninety dollars ($90.00) per year. The yearly renewal fees for unarmed licensees will be sixty-five dollars ($65.00) per year. The number of current licensees in each category was multiplied by the corresponding increases in renewal fees charged in order to assess the fiscal impact to the current licensees.

The City of Kansas City, Missouri, the Jackson County, Missouri Family Court, the Kansas City International Airport Police and the Housing Authority of Kansas City, Missouri all pay a company fee in the amount of three hundred dollars ($300.00) per year.

The City of Kansas City, Missouri will incur costs in the amount of ninety dollars ($90.00) per renewal of armed licenses (40) for a cost of three thousand six hundred dollars ($3600.00) yearly. The City of Kansas City, Missouri will incur costs of sixty-five dollars ($65.00) per renewal of each of its unarmed licenses (9) for a cost of five hundred eighty-five dollars ($585.00) yearly. A company fee in the amount of three hundred dollars ($300.00) is paid by the City of Kansas City, Missouri. The total fiscal impact to the City of Kansas City, Missouri is four thousand one hundred eighty-five dollars ($4485.00) per year. A range fee is assessed to the City of Kansas City, Missouri's armed licensees in the amount of eighty-five dollars ($85.00) per licensee. This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying public and private fiscal notes.

Jackson County, Missouri Family Court will incur costs of sixty-five dollars ($65.00) per renewal of each of its unarmed licenses (4) for a cost of two hundred sixty dollars ($260.00) yearly. A company fee in the amount of three hundred dollars ($300.00) is paid by the Jackson County, Missouri Family Court. The total fiscal impact to Jackson County, Missouri is two hundred sixty dollars ($560.00) per year.

The Kansas City International Airport Police will incur costs in the amount of ninety dollars ($90.00) per renewal of each of its armed licenses (17) for a cost of one thousand five hundred thirty dollars ($1530.00) yearly. The Kansas City International Airport Police will incur costs in the amount of sixty-five dollars ($65.00) per renewal of each of its unarmed licenses (39) for a cost of two thousand five hundred thirty-five dollars ($2535.00) yearly. The total fiscal impact to the Kansas City International Airport Police for renewals is four thousand sixty-five dollars ($4065.00) per year. The Kansas City International Airport Police also pay a company fee of three hundred dollars ($300.00) per year under the Proposed Rules for a total fiscal impact of four thousand three hundred sixty-five dollars ($4365.00) per year. A range fee is assessed to the Kansas City International Airport Police's armed licensees in the amount of eighty-five dollars ($85.00) per licensee. This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying public and private fiscal notes.

The Housing Authority of Kansas City, Missouri will incur costs in the amount of ninety dollars ($90.00) per renewal of each of its armed licenses (3) for a cost of two hundred seventy dollars ($270.00) yearly. The Housing Authority of Kansas City, Missouri will incur costs in the amount of sixty-five dollars ($65.00) per renewal of each of its unarmed licenses (4) for a cost of two hundred sixty dollars ($260.00) yearly. The Housing Authority of Kansas City, Missouri also pays a company fee of three hundred dollars ($300.00) per year under the Proposed Rules for a total fiscal impact of eight hundred thirty dollars ($830.00) per year. A range fee is assessed to the Housing Authority of Kansas City, Missouri's armed licensees in the amount of eighty-five dollars ($85.00) per licensee. This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying public and private fiscal notes.

IV. ASSUMPTIONS

This rule requires that those providing security services be licensed as either armed or unarmed security officers. Other fees assessed are provided for in other sections of this chapter and the fiscal impact of those fees will be outlined in the fiscal notes prepared for those sections. These figures assume that the agencies will renew the licenses of all those currently licensed and will not switch the classifications of the persons they are licensing,

i.e., from unarmed to armed or vice versa. These figures also assume that the agencies pay the license fees for those they license, rather than the individual paying the fees themselves. These cost calculations take into account only yearly renewal fees for existing licensees. If the entities license additional persons, additional costs for new licenses will be incurred in the amounts set out above for new licenses and for the State/NCIC/FBI fingerprinting fee discussed in 17 CSR 2.040.