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SALUS POPULI SUPREMA LEX ESTO

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



JOHN R. ASHCROFT  
SECRETARY OF STATE

MISSOURI  
REGISTER

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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 see the website at [sos.mo.gov/adrules/pubsched](http://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–

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

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

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

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

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

### ***Code and Register on the Internet***

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The *Register* address is [sos.mo.gov/adrules/moreg/moreg](http://sos.mo.gov/adrules/moreg/moreg)

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

**R**ules 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.

**R**ules 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.

**A**ll 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 65—Missouri Medicaid Audit and Compliance Chapter 2—Medicaid

### EMERGENCY AMENDMENT

**13 CSR 65-2.020 Provider Enrollment and Application.** The department is amending sections (1)-(6) and (9), adding new sections (7), (11) and (12), and is renumbering accordingly.

*PURPOSE: This emergency amendment combines and clarifies the procedures found in this regulation and the procedure formerly found at 13 CSR 70-3.020, which is being rescinded. MO HealthNet providers will no longer have to look in two locations to find Medicaid provider enrollment requirements. The amendment clarifies the circumstances under which the department may deny a provider's enrollment application or terminate the participation of an enrolled provider. Additionally, the regulation now mirrors federal Medicaid program integrity regulatory requirements that Missouri must follow as a condition of its federal Medicaid funding.*

*EMERGENCY STATEMENT: The Department of Social Services, Missouri Medicaid Audit and Compliance Unit (MMAC) finds that this emergency amendment is necessary to preserve a compelling governmental interest. 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 Missouri Medicaid Audit and Compliance Unit*

*believes this emergency amendment is fair to all interested parties. The provider enrollment and application processes are necessary to ensure that all providers understand and follow the same instructions and requirements when enrolling as a Medicaid provider in Missouri. It also clarifies when Medicaid provider participation can be terminated. The procedures found in this regulation were formerly found at 13 CSR 70-3.020. 13 CSR 70-3.020 is being rescinded and the rescission goes into effect March 30, 2022. Based on the proposed provider enrollment and application rule, this emergency amendment will prevent the Medicaid program from experiencing a lack of authority to ensure enrollment and termination of providers as deemed necessary. This emergency amendment is necessary to ensure that policies of general applicability to the public are supported by regulation. (See *Young v. Children's Division, Dept. of Social Services*, 284 S.W.3d 553, 560 (Mo. Banc 2009). As a result, MMAC finds a compelling governmental interest, which requires emergency action. A proposed amendment which, covers the same material, is published in this issue of the *Missouri Register*. The emergency amendment was filed March 11, 2022, becomes effective March 30, 2022, and expires September 26, 2022.*

#### (1) Enrollment.

(C) [As required by 42 CFR Section 455.440, a] All claims for payment for items and services that were ordered, **prescribed**, or referred must contain the National Provider Identifier (NPI) of the provider who ordered, **prescribed**, or referred such items or services.

(D) All persons enrolled as MO HealthNet providers shall abide by the policies and procedures set forth in the MO HealthNet provider manual(s) applicable to the provider's provider type(s). The MO HealthNet provider manuals 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 the website [dss.mo.gov/mhd](http://dss.mo.gov/mhd), January 15, 2014] and available at <http://manuals.momed.com/manuals/>, August 20, 2021. This rule does not incorporate any subsequent amendments or additions. A MO HealthNet provider's breach of any MO HealthNet provider manual may result in imposition of sanctions, including but not limited to, termination.

#### (2) Applications

(A) All applying providers shall have a valid e-mail address and shall submit [an/a] MMAC approved application and any supplemental forms, information, and documentation required by MMAC for the appropriate provider type for which the person is applying.

(B) All information and documentation requested in the application and supplemental forms must be provided to MMAC prior to the application being [considered and screening being conducted pursuant to this rule] approved.

(C) Specific application instructions are modified as necessary for efficient and effective administration of the MO HealthNet Program as required by federal or state laws and regulations. Providers applying on or after the promulgation of this rule should refer to the appropriate MMAC [provider bulletins and] application filing instructions, [for specific application filing instructions and information,] which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Missouri Medicaid Audit and Compliance Unit, 205 Jefferson Street, Second Floor, Jefferson City, MO 65109, at its website [mmac.mo.gov](http://mmac.mo.gov), [January 15, 2014] August 20, 2021. This rule does not incorporate any subsequent amendments or additions.

(D) The application shall include all information required in the mandatory disclosures pursuant to section (3) of this rule. Upon submission of any application(s), supplemental form(s), information and documentation requested in the application(s) and supplemental form(s), MMAC may, at its discretion, request additional or supplemental information and documentation from the applying provider

prior to considering the application and/or conducting screening pursuant to this rule in order to clarify any information previously submitted and to verify that the provider meets all applicable requirements of state or federal laws and regulations.

(3) All providers, fiscal agents, *[and]* managed care entities, **and persons with an ownership or control interest in the provider** are required to disclose as follows:

(A) The following disclosures are mandatory:

1. The name and address of **the applying provider** and any person(s) with *[an]* ownership *[or control interest]* in the *[applying]* provider. The address *[for corporate entities]* must include *[as applicable]* **the provider's** primary business address, **each additional practice location(s)**, *[every business location, and]* **and any corresponding** PO Box addresses;

2. Dates of birth and Social Security numbers (in the case of a corporeal person);

3. Other tax identification number(s) of any person with *[an]* ownership *[or control interest]* in the *[applying]* provider or in any subcontractor in which the *[applying]* provider has a five percent (5%) or more interest;

4. Whether any person with *[an]* ownership *[or control interest]* in the applying provider is related to another person with ownership *[or control interest]* in the *[applying]* provider as a spouse, parent, child, or sibling;

5. Whether any person with *[an]* ownership *[or control interest]* in any subcontractor in which the *[applying]* provider has a five percent (5%) or more interest is related to another person with ownership *[or control interest]* in the *[applying]* provider as a spouse, parent, child, or sibling;

6. The name of any other provider(s) *[or applying provider]* in which an owner of the applying or enrolled provider has *[an]* ownership *[or control interest]*; and

7. The name, address, date of birth, and Social Security number of any managing employee of the *[applying]* provider;

(B) Disclosures from any provider *[or applying provider]* are due at the following times, and must be updated within *[thirty-five (35)]* **thirty (30)** days of any changes in information required to be disclosed:

1. Upon *[the provider or applying provider submitting an application]* **initial enrollment, reenrollment, or revalidation**; and

2. Upon request of MMAC;

(C) Disclosures from fiscal agents are due at the following times:

1. Upon the fiscal agent submitting *[the]* a proposal;

2. Upon request of MMAC;

3. Ninety (90) days prior to renewal or extension of *[the]* a contract; and

4. Within *[thirty-five (35)]* **thirty (30)** days after any change in ownership of the fiscal agent;

(D) Disclosures from managed care entities (managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and health insuring organizations), except primary care case management programs, are due at the following times:

1. Upon the managed care entity submitting a *[the]* proposal;

2. Upon request of MMAC; *[and]*

3. Ninety (90) days prior to renewal or extension of the contract; **and**

4. **Within thirty (30) days after any change in ownership;**

(E) Disclosures from Primary Care Case Management Programs (PCCM). PCCMs will comply with disclosure requirements under subsection (B) of this section;

(F) All Disclosures *[Must]* **must** be *[Provided]* **provided** to MMAC. Disclosures not made to MMAC will be deemed non-disclosed and not in compliance with this section; and

(G) *[Consequences for Failure to Provide Required Disclosures.]* **Administrative action(s) for failure to provide required disclosures.**

1. Any person's failure to provide, or timely provide, disclo-

tures pursuant to this section may result in deactivation, denial, rejection, suspension, or termination **of the provider's participation in the MO HealthNet program.** If the failure is inadvertent or merely technical, MMAC may choose not to impose *[consequences]* **administrative actions** if, after notice, the *[person]* **provider** promptly corrects the failure.

(4) Provider Revalidation.

*[(A) All enrolled MO HealthNet Program providers as of the effective date of this rule who are not on a closed-end provider agreement shall revalidate their enrollment as a MO HealthNet Program provider, on or before March 24, 2019, according to schedule as determined by MMAC, by submitting an MMAC-approved revalidation application, supplemental forms, information, and documentation requested by MMAC, along with any required application fee, hardship waiver request, or documentation showing that the provider has revalidated with Medicare or another state's Medicaid Program or CHIP within the previous twelve (12) months, if applicable.]*

*[(B)](A)* All *[MO HealthNet Program]* providers shall revalidate their enrollment *[as]* **with the MO HealthNet [providers] Division** at least every five (5) calendar years from the effective date of the provider's most recently executed provider agreement, in order to remain a MO HealthNet provider. For example, a provider whose initial or revalidated provider agreement *[is]* **was** effective on March 1, *[2014]* **2020** is required to revalidate *[his/her/its]* **their** enrollment no later than March 1, *[2019]* **2025**. **MMAC may request that the provider revalidate on an off-cycle revalidation period.**

*[(C)](B)* The MMAC-approved revalidation application, supplemental forms, information, and documentation requested by MMAC, along with the application fee and/or hardship waiver request, if applicable, shall be submitted no later than one-hundred twenty (120) days prior to the expiration of the effective provider agreement.

*[(D)](C)* Revalidating providers must comply with the requirements of this rule and will be subject to the screening process noted in this rule *[upon revalidation]* in order to have their applications for revalidation approved.

*[(E) MMAC may request that the provider revalidate on an off-cycle revalidation period as a result of information obtained by MMAC indicating documented patterns of local health care fraud, national initiatives, complaints, or other reasons that cause MMAC to question the compliance of the provider with MO HealthNet Program.]*

*[(F) All MO HealthNet provider agreements with effective dates on or before the effective date of this rule shall be terminated by MMAC pursuant to the terms of the provider agreement, effective March 25, 2016, if the provider has not revalidated or begun the process of revalidation.]*

(5) Application Fee.

(A) An application fee, hardship waiver request, and/or an exemption reason **provided in this rule** must accompany every *[institutional]* **organizational** provider's application.

(B) The application fee must be in the form of a cashier's check, money order, or an electronic payment acceptable to MMAC and for the correct application fee amount in effect as of the date of receipt by MMAC.

(C) Failure to submit the application fee in *[the form of a cashier's check, money order, or electronic payment acceptable to MMAC for the]* **an acceptable form and/or for the** correct amount *[will]* **may** result in the return of the fee to the provider and rejection of the application.

(D) Applying *[providers]* and *[MO HealthNet]* **revalidating** providers *[that are revalidating with the Missouri Medicaid Audit and Compliance Unit (MMAC)]* must submit an application fee, *[subject to the requirements of 13 CSR 65-2.020. The application fee is determined as]* **determined** as follows:

1. As of the effective date of this rule for calendar year [2015] **2021**, five hundred [fifty-three dollars (\$53)] **ninety-nine dollars (\$59.00)**; and

2. For calendar year [2016] **2022** and subsequent years—

A. The amount of the application fee shall be the amount for the preceding year adjusted by the percentage change in the consumer price index for all urban consumers for the twelve (12) month period ending with June of the previous year as published by the Bureau of Labor Statistics of the United States Department of Labor [If the adjustment sets the fee at an uneven dollar amount, MMAC will round the fee to the nearest whole dollar amount].

[B. The application fee will be effective from January 1 to December 31 of a calendar year.]

(E) [An institutional provider shall submit provider type for which the institutional provider is applying. If an application is denied and the institutional provider submits another application, an additional application fee shall be included with each, all, and every subsequent application.

(F) If MMAC determines that a person [as defined herein] is [considered to be] an [institutional provider as defined herein] **organizational provider**, that person is required to pay the **application** fee.

[(G)](F) Exemptions from Application Fee. [Providers who are enrolled in, and paid the application fee required by CMS for Medicare or another state's Title XIX or Title XXI program within two (2) years of the date the application to enroll as a MO HealthNet Provider shall be exempt from paying an application fee. Providers seeking an exemption from the application fee are responsible for notifying MMAC, in writing, that they qualify for exemption and for providing proof of such qualification.] MMAC may waive the application fee under the following conditions:

1. Providers who are enrolled in, and paid the application fee required by CMS for Medicare or another state's Title XIX or Title XXI program within two (2) years of the date the application to enroll as a MO HealthNet Provider shall be exempt from paying an application fee.

2. MMAC, in consultation with other state of Missouri departments, divisions and units, determines that imposition of the application fee would impede Missouri Medicaid participants' access to care;

3. A provider is submitting a provider application as a result of a national or state public health emergency situation as lawfully declared by a federal or state authority; and

4. The provider is owned and operated by the state of Missouri or an agency of the state of Missouri.

(G) Providers seeking an exemption from the application fee are responsible for notifying MMAC, in writing, that they qualify for exemption and for providing proof of such qualification.

(6) Hardship Waiver Request.

(A) [Institutional providers may submit application fee hardship waiver requests when submitting their initial enrollment applications, their revalidation applications, and their applications to establish new practice locations.] Providers can request a hardship waiver of the application fee from the Centers for Medicare and Medicaid (CMS) when submitting their initial enrollment application or a revalidation application, but the request must be received by MMAC before the application will be processed by MMAC. A hardship waiver request will not be considered if it is received by MMAC after MMAC approves the application or revalidation. If CMS approves the hardship waiver, MMAC will refund the application fee to the provider.

(B) [A hardship waiver request may be granted if any of the following exists:

1. The provider demonstrates, via authenticated financial and legal records, hardship and MMAC, at its discretion,

determines that imposition of the application fee would result in a hardship for the provider subject to the following requirements:

A. All records submitted in support of a hardship waiver must be authenticated by an affidavit signed under oath by the applying provider's or provider's owner(s) and chief financial officer or chief executive officer. Records not meeting this requirement shall not be considered as evidence of hardship;

B. Providers applying for hardship waivers must permit, upon request, MMAC to inspect the provider's financial records and other records MMAC deems relevant to MMAC's determination of whether hardship exists, including, but not limited to, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, and tax returns. Any provider who does not permit MMAC to inspect such records upon MMAC's request shall be denied a hardship waiver. Any provider who is denied a hardship waiver request based upon the provider's failure to permit MMAC to inspect the provider's financial records and any other records MMAC deems relevant to MMAC's determination of whether a hardship exists, shall not be eligible for a waiver under paragraph (6)(B)1. for a period of five (5) years from the date of MMAC's letter notifying the provider that its hardship waiver request was denied due to the provider's failure to permit MMAC to inspect the provider's records; and

C. A provider who is granted a hardship waiver pursuant to paragraph (6)(B)1. shall not be granted a second waiver based upon paragraph (6)(B)1. for a period of five (5) years from the date of MMAC's letter notifying the provider that its most recent paragraph (6)(B)1. waiver request was granted;

2. MMAC, in consultation with other state of Missouri departments, divisions and units, determines that imposition of the application fee would impede Missouri Medicaid participants' access to care;

3. A provider is submitting a provider application as a result of a national or state public health emergency situation as lawfully declared by a federal or state authority; and

4. The provider is owned and operated by the state of Missouri or an agency of the state of Missouri.]A provider that requests a hardship waiver must submit a letter and supporting documentation that describes the hardship and why the hardship justifies an exception, including providing comprehensive documentation (which may include, but is not limited to, historical cost reports, recent financial statements such as balance sheets and income statements, cash flow statements, or tax returns).

(C) [Application fee hardship waiver requests shall be considered by MMAC on a case-by-case basis.] Factors that may suggest a hardship exception is appropriate include, but are not limited to, the following:

1. Considerable bad debt expenses,

2. Significant amount of charity care/financial assistance furnished to patients,

3. Presence of substantive partnerships with those who furnish care to a disproportionately low-income population,

4. Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

5. Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster area under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.

(D) [Application fee hardship waiver requests are subject to approval by CMS.] Upon receipt of a hardship waiver request with an application, MMAC will send the request and all accompanying documentation to CMS. CMS will determine if the

request should be approved. CMS will communicate its decision to the institutional provider and MMAC via letter.

**(7) Appeal of the Denial of a Hardship Waiver Request.** A provider may file a written reconsideration request with CMS within sixty (60) calendar days from the date of the notice of initial determination. The request must be signed by the individual provider, a legal representative, or any authorized official within the entity. The procedures for submitting an appeal will be provided on the denial letter from CMS.

**[(7)](8)** MMAC shall use the application fee to offset the costs associated with the provider screening program in its entirety. This includes, but is not limited to, the following:

(A) Implementation and augmentation of MMAC's provider enrollment system; and

(B) Any other administrative costs related to the provider screening program, which include costs associated with processing fingerprints and conducting criminal background checks. The application fee does not cover the cost associated with capturing fingerprints and a provider may be charged additional costs for this purpose in addition to the application fee.

**[(8)](9)** Refund of the Application Fee.

(A) If an institutional provider is granted a hardship exception pursuant to this rule or if the application is rejected because it was not properly signed or is missing other information required to be provided on the application itself, and an application fee was included with the application and the hardship waiver request, the application fee shall be returned to the applying provider.

(B) Once the screening process has begun, regardless whether the application goes through part or all of the screening process, the application fee is non-refundable.

**[(9)](10)** Screening.

(A) The screening requirements contained in this section apply to all applying providers and to all persons disclosed, or required to be disclosed, in the application.

(B) MMAC shall conduct pre-enrollment screening and post-enrollment monthly screenings. Screenings *[shall]* may include the following:

1. Screening pursuant to 42 CFR sections 455.410(a), (b); 42 CFR 455.412; 42 CFR 455.432; 42 CFR 455.436; and 42 CFR 455.452;

2. Screening to ensure that the providers meet all enrollment criteria for their provider type;

3. *[Unannounced]* **Announced or unannounced** pre- and post-approval site visits; and

4. For screening purposes, utilization of databases and other sources of information to prevent enrollment of *[non-existent]* **fictional** providers, to ensure that spurious applications are not processed, and to prevent fraud, waste, and abuse in the MO HealthNet Program.

(C) *[The screening procedures and requirements in this rule shall be implemented as of the effective date of this rule.*

*[(D)]* The *[new]* screening procedures and requirements *[will be]* applicable to all enrolled *[MO HealthNet Program]* or **applying** providers *[and applying providers as of the effective date of this rule]*. All *[enrolled MO HealthNet]* providers are required *[to revalidate according to the schedule of revalidation. After being screened pursuant to this rule, MO HealthNet Program providers will be required]* to revalidate **their MO HealthNet enrollment(s) at least** every five (5) years *[from the date of their most recent revalidation]*.

*[(E)]* Upon the effective date of this rule, no provider shall be allowed to enroll or revalidate in the MO HealthNet Program without being screened pursuant to this rule. On or

*before March 25, 2016, all providers in, and applying providers to, the MO HealthNet Program shall be screened pursuant to this section. By operation of law, any provider who has not been screened pursuant to this section on or before March 25, 2016, shall have his/her/its provider number deactivated at 5:00 p.m. on March 25, 2016. Such deactivation shall remain in effect until the provider or applying provider has been screened pursuant to this rule.]*

*[(F)](D)* The following screening categories are established for MO HealthNet providers, as required by federal law and regulation for Medicare and Medicaid providers under 42 CFR section 424.518 and section 1902(kk)(1) of the Social Security Act. There are three (3) levels of screening: limited, moderate, and high. Each provider type is assigned to one (1) of these screening levels. If a provider could fit within more than one (1) screening level described in this section, the highest risk category of screening is applicable.

1. Limited Risk Category.

A. The following providers pose a limited risk of fraud, waste, and abuse to the MO HealthNet Program and are subjected to limited category screening:

(I) Physicians *[, dentists,]* or non-physician practitioners (except as otherwise listed in another risk category) and medical groups or clinics *[with the exception of physical therapists and physical therapy(ist) groups];*

(II) Ambulatory surgical centers (ASCs);

(III) Competitive acquisition program/Part B vendors;

(IV) End-stage renal disease (ESRD) facilities;

(V) Federally qualified health centers (FQHCs);

(VI) Histocompatibility laboratories;

(VII) **Home infusion therapy suppliers;**

*[(VIII)](VIII)* Hospitals, including critical access hospitals (CAHs);

*[(VIII)](IX)* Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act *[(IHS)];*

*[(IX)](X)* Mammography screening centers;

*[(X)](XI)* Mass immunization roster billers;

**(XII) Opioid treatment programs (if 42 CFR 424.67(b)(3)(ii) applies);**

*[(XI)](XIII)* Organ procurement organizations (OPOs);

*[(XII)](XIV)* Pharmacies;

(XV) Radiation therapy centers (RTCs);

*[(XIII)](XVI)* Religious nonmedical health care institutions (RNHCIs);

*[(XIV)](XVII)* Rural health clinics (RHCs); **and**

*[(XV)](XVIII)* **Radiation therapy centers**

*[(XVI)](XVIII)* Skilled nursing facilities (SNFs).

*[(VII)](XVII)* **Occupational therapists;**

*(XVIII)* **Speech language pathologists;**

*(XIX)* **Rehabilitation agencies; and**

*(XX)* **Community mental health centers (CMHC's)]**

B. The providers in the limited category are subject to the following screening requirements:

(I) Verification that the applying provider, and all persons disclosed or required to be disclosed, meet all applicable federal regulations and MO HealthNet Program requirements for the provider type;

(II) Verification that the applying provider, and all persons disclosed, have a valid license, operating certificate, or certification if required for the provider type, and that there are no current limitations on such licensure, operating certificate, or certification which would preclude enrollment;

(III) Verification that the applying provider's, and that of all persons disclosed, license(s) held in any other state has/have not expired and that there is/are no current limitations on such license(s)



which would preclude enrollment;

(IV) Confirmation of the identity of the applying provider and determination of the exclusion status of the applying provider and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of the following federal databases:

- (a) Social Security Administration's Death Master File;
- (b) National Plan and Provider Enumeration System;
- (c) List of Excluded Individuals/ Entities;
- (d) The Excluded Parties List System;
- (e) Medicare Exclusion Database; and

*[(f) Department of the Treasury's Debt Check Database; and*

*(g) Department of Housing and Urban Development's (DHUD) Credit Alert System or Credit Interactive Voice Response System;]*

(f) Any such other databases as the Secretary of the United States Department of Health and Human Services has prescribed as of September 30, 2021, pursuant to Section 455.436 of Title 42, *Code of Federal Regulations*, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 7 G Street, NW, Suite A-734, Washington, DC 20401, and available at its website <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.436>. This rule does not incorporate any subsequent amendments and additions.

*[(V) Database checks of the Missouri Department of Revenue; ]*

*[(VI)](V) Database check of the National Sex Offender Public Website;*

*[(VII)](VI) The information from these databases shall be used to determine eligibility of the MO HealthNet provider and for verification of: the identity of the applying person; the Social Security number; the National Provider Identifier (NPI); the National Practitioner Data Bank (NPDB) licensure; and any exclusion by the Department of Health and Human Services, Office of Inspector General; [the taxpayer identification number; any Missouri tax delinquencies and death of the applying provider and all other persons disclosed in the applications and supplemental forms;] and*

*[(VIII)](VII) MMAC may conduct preapproval site visits prior to acceptance of an applying provider's application.*

## 2. Moderate Risk Category:

A. The following providers pose a moderate risk of fraud, waste, and abuse to the MO HealthNet Program and are subject to moderate screening requirements:

*[(I) Comprehensive outpatient rehabilitation facilities (CORFs);*

- (II) Hospice organizations;*
- (III) Independent diagnostic testing facilities (IDTFs);*
- (IV) Independent clinical laboratories;*
- (V) Ambulance service suppliers;*
- (VI) Physical therapists including physical therapy groups;*

*(VII) Portable x-ray suppliers;*

*(VIII) Revalidating home health agencies;*

*(IX) Revalidating durable medical equipment*

*providers;*

*(X) Adult day care waiver providers;*

*(XI) Personal care providers, including providers billing under the Consumer Directed Services program;*

*(XII) Entities established under sections 205.968-205.973, RSMo;*

*(XIII) Prosthetics, orthotics, and supplies suppliers (DMEPOS) (this includes an existing pharmacy durable medical equipment supplier that seeks to add a new DMEPOS supplier store, new practice locations, and those that are owned by occupational or physical therapists); or*

*(XIV) Non-emergency transportation providers; and]*

**(I) Adult Day Care providers (ADCs);**

**(II) Ambulance service suppliers;**

**(III) Community Mental Health Centers (CMHCs);**

**(IV) Comprehensive outpatient rehabilitation facilities (CORFs);**

**(V) Hospice organizations;**

**(VI) Independent clinical laboratories (ICLs);**

**(VII) Independent diagnostic testing facilities (IDTFs);**

**(VIII) Non-emergency transportation providers (NEMTs);**

**(IX) Personal care providers, including providers billing under the Consumer Directed Services program;**

**(X) Physical therapists including physical therapy groups;**

**(XI) Revalidating Diabetes Prevention Program providers (DPPs)**

**(XII) Portable x-ray suppliers (PXSs);**

**(XIII) Revalidating home health agencies (HHAs);**

**(XIV) Revalidating durable medical equipment suppliers (DMEPOS);**

**(XV) Revalidating opioid treatment programs; and**

**(XVI) Entities established under sections 205.968-205.973, RSMo.**

B. In addition to the screening requirements for the limited risk category in paragraph *[(9)](F)***(10)(D)1.**, the providers in the moderate risk category shall be subject to *[pre-approval]* site visits prior to acceptance of an applying provider's application and are additionally subject to unannounced *[pre- and]* post-enrollment site visits.

*[(I) To determine and ensure that the provider is operational at the practice location found on the enrollment application. For these purposes, "operational" means the provider has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicaid claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider specialty, or the services or items being rendered), to furnish these items or services; and]*

*[(II) To verify established provider standards or performance standards other than conditions of participation subject to survey and certification by MMAC, where applicable, to ensure that the provider remains in compliance with program requirements.]*

## 3. High Risk Category.

A. The following providers pose a high risk of fraud, waste, and abuse to the MO HealthNet Program and are subject to high risk screening requirements:

**(I) [Prospective (newly enrolling)] Newly enrolling or reenrolling home health agencies; [and]**

**(II) [Prospective (newly enrolling)] Newly enrolling or reenrolling DMEPOS suppliers; [and]**

**(III) Newly enrolling or reenrolling DPP suppliers; and**

**(IV) Newly enrolling or reenrolling opioid treatment programs that have not been fully and continuously certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) since October 23, 2018.**

B. In addition to the screening requirements for the limited and moderate risk categories *[category]* in paragraphs **(9)(F)1.** and **2.** of this rule, *[and for the moderate risk category in paragraph (9)(F)2. Of this rule,]* the providers and their owners *[in the high risk category]* must submit to *[, or subject individuals with ownership or control interests to]* a fingerprint-based criminal history report check of the Federal Bureau of Investigations (FBI) Integrated Automated Fingerprint Identification System—

**(I)** A revalidating provider who has already submitted fingerprints once will not be required to submit fingerprints a second

time unless required by FBI protocols;

(II) Pursuant to 42 CFR section 455.434(b), the provider is responsible for the cost of *[taking] supplying* the fingerprints *[and supplying the fingerprints,]* and the state and federal government will share the cost of the processing of the fingerprints and the background check; and

(III) This fingerprint-based criminal history report check applies to all persons in this risk category applying to be a provider (whether as a billing or performing provider), or an individual with a five percent (5%) or greater direct or indirect ownership interest in such provider, or a managing employee;

(G) MMAC must adjust the categorical risk level from “limited” or “moderate” to “high” when any of the following occurs:

1. MMAC imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse by the provider; the provider has an existing Medicaid overpayment; or the provider has been excluded by the Department of Health and Human Services, Office of Inspector General or another state’s Medicaid program within the previous ten (10) years. The upward adjustment of the provider’s categorical risk level for a payment suspension or overpayment shall continue only so long as the payment suspension or overpayment continues; or

2. MMAC or CMS in the previous six (6) months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six (6) months from the date the moratorium was lifted.

(H) If a person has been screened by Medicare or by another state Medicaid agency and paid Medicare or another state Medicaid agency’s application fee, within two (2) years of the date of the application to MMAC, such person will not be subject to the screening requirements or application fee provided for by this rule except those screening requirements and application fee imposed pursuant to subsection (G) of this section.

(I) Any MO HealthNet Program provider not categorized by this regulation as within the limited, moderate or high risk category shall be a considered moderate risk and screened as a moderate risk.

(J) MMAC may request and consider additional information or documentation related to the eligibility criteria, if at any time during the application process it appears that: the enrollment application or supporting documentation is inaccurate, incomplete, or misleading; or it appears the applying person may be ineligible to become a MO HealthNet provider.

**(11) The provider shall advise MMAC, in writing, on enrollment forms specified by MMAC, of any changes affecting the provider’s enrollment records within ninety (90) days of the change, with the exception of change of ownership or control of any provider which must be reported within thirty (30) days.**

(A) The Provider Enrollment Unit within MMAC is responsible for determining whether a current MO HealthNet provider record shall be updated or a new MO HealthNet provider record is created. A new MO HealthNet provider record is not created for any changes, including, but not limited to, change of ownership, change of operator, tax identification change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations. This includes replacement facilities, whether they are at the same location or a different location, and whether the Medicare number is retained or if a new Medicare number is issued. A provider may be subject to administrative action if information is withheld at the time of application that results in a new provider number being created in error. The division shall issue payments to the entity identified in the current MO HealthNet provider enrollment application. Regardless of changes in control or ownership, MMAC shall recover from the entity identified in the current MO HealthNet

**provider enrollment application liabilities, sanctions, and penalties pertaining to the MO HealthNet program, regardless of when the services were rendered.**

**(12) MO HealthNet provider identifiers shall not be released to any non-governmental entity, except the enrolled provider, by the MO HealthNet Division or its agents.**

*[(10)](13)* The provisions of this rule are declared severable. If any provision of this rule is held invalid by a court of competent jurisdiction, the remaining provisions of this rule shall remain in full force and effect, unless otherwise determined by a court of competent jurisdiction to be invalid.

*[(11)](14)* Except to the extent inconsistent with this rule, the requirements of *[13 CSR 70-3.020 and]* 13 CSR 70-3.030 remain in force, including any provisions regarding denial of applications and termination, until those provisions are rescinded.

*AUTHORITY: sections 208.159 and 660.017, RSMo [2000] 2016. Original rule filed Dec. 12, 2013, effective July 30, 2014. Amended: Filed May 26, 2015, effective Nov. 30, 2015. Amended: Filed Aug. 20, 2021. Emergency amendment filed March 11, 2022, effective March 30, 2022, expires Sept. 26, 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.*

**U**nder 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."

**E**ntirely 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.

**A**n 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.

**I**f 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*.

**A**n 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.

**I**f 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 1—OFFICE OF ADMINISTRATION  
Division 40—Purchasing and Materials Management  
Chapter 1—Procurement**

**PROPOSED AMENDMENT**

**1 CSR 40-1.050 Procedures for Solicitation, Receipt of Bids, and Award and Administration of Contracts.** The division is amending sections (2), (3), (4), (6), (12), (14), and (22) of this rule and adding section (26) to comply with changes in the applicable statutes.

*PURPOSE: This rule is amended to reflect the changes in the statutes in Senate Substitute for House Committee Substitute for House Bill 1088 of the 100th General Assembly, which was signed into law by the Governor. This rule fulfills the statutory requirement of section 536.023(3), RSMo.*

(2) As used in this chapter unless the content clearly indicates other-

wise, the following terms are defined as:

(I) Multiple award. A purchase order or contract awarded to two (2) or more bidders in order to meet the needs of agencies, **or an award to the next lowest and best vendor where a contract is cancelled for breach or the contract award is rescinded;**

(N) Shortlisting. **The process of narrowing down and selecting, from the offerors who responded to the solicitation, those offerors that are eligible for negotiations, further negotiations, or for demonstrations or testing, based upon the criteria specified in the solicitation;**

*[(N)](O)* Solicitation. The process of notifying prospective bidders that the state wishes to receive bids or proposals to provide supplies. The term includes request for proposal (RFP), request for quotation (RFQ), invitation for bid (IFB), single feasible source (SFS), and any other appropriate procurement method;

*[(O)](P)* State. The state of Missouri;

*[(P)](Q)* Suspension. An exclusion from contracting with the state for a temporary period of time; *[and]*

(R) Vendor, bidder, offeror, or supplier. **Unless specifically defined in a solicitation, the entity or person who may, or who has, submitted a bid or proposal in response to a solicitation; and**

*[(Q)](S)* Women's business enterprise (WBE). The definition in section 37.020.1(6), RSMo, will be applied.

All other terms will follow their relevant statutory or regulatory definitions.

(3) When the procurement is estimated to be less than *[twenty-five thousand dollars (\$25,000)]* **one hundred thousand dollars (\$100,000)**, an informal method of solicitation may be utilized. Informal methods of procurement may include Request for Quotation (RFQ), telephone quotes, etc.

(4) When the procurement is estimated to be *[twenty-five thousand dollars (\$25,000)]* **one hundred thousand dollars (\$100,000)**, or more, a formal method of solicitation must be utilized. Formal competitive bidding may be accomplished by utilizing an Invitation for Bid (IFB). Pursuant to section 34.047, RSMo, information technology purchases estimated not to exceed *[seventy-five thousand dollars (\$75,000)]* **one hundred and fifty thousand dollars (\$150,000)** may be completed under an informal process provided the procurement does not exceed twelve (12) months and it is posted on the division online bidding/vendor registration system website.

(6) Submission of bids or proposals. Formal bids/proposals should be received in the division or a secured electronic database in a sealed format by the time set for the opening of the bids/proposals.

(C) Under extraordinary circumstances, the director or designee may authorize the opening of a late proposal. In such cases, the proposal must have been turned over to the physical control of an independent postal or courier service with promised delivery time prior to the time set for the opening of proposal, **or late delivery of the proposal must be attributable to an issue with the state's electronic bid system that was out of the control of the submitting vendor.** All such decisions are at the sole discretion of the director or designee. The following guidelines may be utilized to determine the criteria for an extraordinary circumstance:

1. State offices were closed due to inclement weather conditions;

2. Postal or courier services were delayed due to labor strikes or unforeseen "Acts of God"; *[or]*

3. Postal or courier service did not meet delivery time promised to the bidder/offeror. In such a case, the bidder/offeror must provide written proof from the delivery service that promised delivery time was prior to the time set for the opening of bids/proposals*[/i];*

4. Evidence that the bid/proposal was in the division's post office box or physical possession before the time of bid opening; or

5. Any other evidence relevant to the specific situation.

(12) A bid or proposal award protest must be submitted in writing to the director or designee and received by the division within ten (10) **state** business days after the date of award. *[If the tenth day falls on a Saturday, Sunday, or state holiday, the period will extend to the next state business day.]* A protest submitted after the ten (10) **state** business-day period shall not be considered. The written protest should include the following information:

(14) The division will encourage participation in the procurement process and fairness in consideration of bids/proposals submitted by Missouri Service-Disabled Veteran Business Enterprises (SDVEs). Programs/procedures designed to accomplish these objectives may include: inclusion of SDVE subcontractor goals in solicitation documents; close review of requirements for bonding; notice of procurement opportunities on the division's website; access to bid history and pricing abstracts on the division's website; access to the division's procurement staff; utilization of service-disabled personnel on evaluation committees, if available; etc.

(A) The *[division]* **Office of Administration** will compile, maintain, and make available a listing of SDVEs to all bidders/offerors and contractors on *[the division's]* **an Office of Administration** website. The listing may include the following: name; address; contact information of SDVE; the general area of commodities or services it provides; etc. The *[division]* **Office of Administration** will also maintain statistics and issue periodic reports about SDVE participation.

(D) The following standards are used by the *[division]* **Office of Administration** in determining whether an individual, business, or organization is eligible to be listed as a Service-Disabled Veteran Business Enterprise (SDVE):

1. Doing business as a Missouri firm, corporation, or individual or maintaining a Missouri office or place of business, not including an office of a registered agent;

2. Having not less than fifty-one percent (51%) of the business owned by one (1) or more service-disabled veterans (SDVs) or, in the case of any publicly-owned business, not less than fifty-one percent (51%) of the stock of which is owned by one (1) or more SDVs;

3. Having the management and daily business operations controlled by one (1) or more SDVs;

4. Having a copy of the SDV's Certificate of Release or Discharge from Active Duty (DD Form 214), and a disability rating letter issued by the Department of Veterans Affairs establishing a service connected disability rating, or a Department of Defense determination of service connected disability, unless the SDVE is listed with the *[division]* **Office of Administration** on its website as previously certified in which case said documentation is not required;

5. The SDV(s) possesses the power to make day-to-day as well as major decisions on matters of management, policy, and operation;

6. All SDVE listings and renewals are effective for a period not to exceed three (3) years, unless otherwise found inapplicable; and

7. If it has been determined that the SDVE at any time no longer meets the requirements stated above, it is removed from the listing.

(H) If a bidder/offeror is proposing SDVE vendor participation, it must provide to the division all documents specified by the solicitation including:

1. Complete information as specified by the solicitation document including a list of each proposed SDVE vendor, the committed percentage of participation for each SDVE with the corresponding dollar amount of the participation of each SDVE, and the commercially useful supplies to be provided by each listed SDVE. If the bidder/offeror is a listed SDVE vendor, then the bidder/offeror must also list itself;

2. A copy of the SDVE's certification as a SDVE unless the SDVE is listed with the *[division]* **Office of Administration** on its website as previously certified in which case said documentation is not required; and

3. Written documentation as specified in the solicitation from

each listed SDVE that it is willing to participate in the contract in the kind and amount of work provided in the bidder/offeror's response.

(22) With regard to competitive negotiation procurements, the basic steps of the evaluation should generally include the following:

(B) Unless shortlisting of proposals has been determined to be appropriate, when competitive negotiations are necessary regarding the Request for Proposal, the division will request a written best and final offer (BAFO) from each potentially acceptable offeror. Although not required, the BAFO letter should identify all proposal deficiencies that may make the proposal unacceptable. The BAFO request letter should provide the offeror the opportunity to reconsider any other aspect of its proposal, including pricing. All offerors will be given the same amount of time to respond to the BAFO request, but the issuance of a request letter does not necessarily have to be simultaneous;.

**1. Negotiations may be conducted with only a shortlist of offerors who have submitted proposals if the solicitation permits shortlisting and if the solicitation identifies the method by which the shortlist of offerors will be determined. Shortlisting may also be used to limit the number of offerors demonstrating their products or solutions, or having their products or solutions examined or tested by the agency. Even if shortlisting is permitted, negotiations may still be conducted with all potentially acceptable offerors;**

**(26) Reverse Auctions. A procurement involving a reverse auction process shall include:**

**(A) The qualifications, if any, for the prospective vendors;**

**(B) The process to be followed for the reverse auction, including that of the vendors;**

**(C) The merchandise, supplies, raw materials, or finished goods to be procured; and**

**(D) The evaluation criteria to determine the winning vendor, with price as the primary factor in evaluating bids. A reverse auction shall not be used for supplies covered by section 34.047, RSMo.**

*AUTHORITY: sections 34.050, 34.074, and 630.405.5, RSMo 2016. Original rule filed Oct. 15, 1992, effective June 7, 1993. For intervening history, please consult the Code of State Regulations. Amended: Filed March 15, 2022.*

*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 Division of Purchasing, Attn: Karen Boeger, Division of Purchasing, 301 W. High Street, Room 430, PO Box 809, Jefferson City, MO 65102-0809. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

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

**PROPOSED AMENDMENT**

**5 CSR 20-100.210 Persistently Dangerous Schools.** The Department of Elementary and Secondary Education is amending sections (1)-(4).

*PURPOSE: This amendment incorporates charter schools as required by the federal requirement set forth in the Every Student Succeeds Act of 2015, which requires certain Missouri public elementary and secondary schools, including charter schools, to be identified as “persistently dangerous.”*

(1) The following definition(s) apply to this rule:

(A) Expulsions are defined as removal from school by local board action **or by a charter board** for an indefinite period of time unless the student is reinstated by the local board of education **or charter board**./;

(B) A victim is a student who suffered a personal injury or injury to his or her property as a direct result of a violent criminal offense. The definition of victim does not include bystanders or witnesses to the act or friends or classmates of the victim unless they, too, suffered personal or property injury as a direct result of a violent criminal offense./; **and**

(C) **As used in this section, a public elementary or secondary school includes charter schools operating in the state.**

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

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

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

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

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

(3) *[A student shall be allowed to attend a safe public school within the district, if that student is enrolled in a persistently dangerous school as defined above or becomes a victim of a violent criminal offense while on school property which includes, but is not limited to, school buses or school activities.] If a student is enrolled in a persistently dangerous school as defined above, or becomes a victim of a violent criminal offense while on school property, which includes but is not limited to school buses or school activities, that student shall be allowed to attend a safe public school within the district or charter school, if more than one (1) building serving the same grade level exists.*

(4) For the purposes of determining a persistently dangerous school, an **“act of school violence” or “violent behavior,”** at a minimum, shall be any offense that would require school administrators to, as soon as reasonably practical, notify the appropriate law enforcement agency. An *[“]act of school violence[”]* or *[“]violent behavior[”]* shall **also** be reported by the school district **or charter school** to the Department of Elementary and Secondary Education *[(DESE)]* through Core Data.

*AUTHORITY: sections 160.261, 161.092, and 167.171, RSMo 2016. This rule previously filed as 5 CSR 50-355.100. Original rule filed Jan. 14, 2003, effective Aug. 30, 2003. Moved to 5 CSR 20-100.210, effective Aug. 16, 2011. Amended: Filed June 29, 2017, effective Jan. 30, 2018. Amended: Filed March 11, 2022.*

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

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

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

**Title 7—MISSOURI DEPARTMENT OF  
TRANSPORTATION  
Division 10—Missouri Highways and Transportation  
Commission  
Chapter 1—Organization; General Provisions**

**PROPOSED AMENDMENT**

**7 CSR 10-1.010 Description, Organization, and Information.** The Missouri Highways and Transportation Commission is amending section (2).

*PURPOSE: This amendment updates the department’s organizational structure consistent with the department’s current business practices as required by section 536.023, RSMo.*

(2) Organization.

(A) General Management.

1. The director is the chief executive officer and is appointed by, and serves at the discretion of, the commission. The director appoints a **deputy director/**chief engineer, *[chief financial officer, chief counsel (with the consent of the commission),]* **assistant chief engineer, chief administrative officer, chief counsel (with the consent of the commission), chief financial officer, chief safety and operations officer,** and other leaders and employees as the commission may designate and deem necessary. Under the direction of the commission, the director is responsible for the overall operations and performance of the department and prescribes the duties and authority of employees. The selection and removal of all employees is without regard to political affiliation. The duties of the **deputy director/**chief engineer, **assistant chief engineer, chief administrative officer, chief counsel,** chief financial officer, and *[chief counsel]* **chief safety and operations officer** are as follows:

A. The **deputy director/**chief engineer serves as MoDOT’s primary advisor regarding engineering issues. This position is responsible for providing general oversight of all planning, design, construction, and maintenance work for the department as determined by the director, including preparation and approval of all engineering documents, plans, and specifications. The chief engineer reports to the director and provides input on overall department decisions;

B. *[The chief financial officer is responsible for all administrative operations of MoDOT. This position provides general oversight of financial and business planning, information technology, and other administrative and financial functions as determined by the director; and]* **The assistant chief engineer provides leadership and oversight to the department’s technical engineering functions;**

**C. The chief administrative officer provides leadership and oversight to the department’s administrative business functions;**

*[C./D.]* The chief counsel advises and represents the commission and the director in all actions and proceedings to which either may be a party or in proceedings under Chapters 226 and 227, RSMo, or with respect to any law administered by the commission or any order or proceeding of the commission. The chief counsel is responsible for drafting all contracts, conveyances, agreements, or other documents affecting the commission, property held or acquired

by it, and any action taken by the commission. The chief counsel, with the director's approval, appoints assistant counsel(s) as necessary to represent the commission and the department./;];

**E. The chief financial officer provides leadership and oversight to the department's accounting, finance, fleet, facilities, procurement, and information systems functions; and**

**F. The chief safety and operations officer provides leadership and oversight to the department's safety and operations functions.**

2. The secretary to the commission is responsible for maintaining records of all proceedings of the commission and is the custodian of all records, documents, and papers filed with the commission, department, and other public governmental bodies established by the commission.

(B) Divisions. MoDOT pursues its mission through the following divisions:

1. Audits and Investigations is responsible for conducting audits of department operations, external contracts, grant agreements, motor carrier fuel tax returns, and apportioned registrations. The division also investigates/;]; fraud, waste, and abuse; employee grievances; Equal Employment Opportunity complaints; and conducts mediations/; and analyzes competitive bidding practices/;]. **The division analyzes competitive bidding practices, assesses the potential for fraud in construction contracts, and conducts reviews of construction contracts;**

2. Bridge is responsible for the structural design and detailed plans production for all state highway bridges, including cost estimates and site-specific job special provisions. Additional responsibilities include maintaining the National Bridge Inventory, recommending load posting limits for both state and non-state bridges, bridge inspection, and analyzing structures for special superload overweight permit loads traveling within the state;

3. Communications is responsible for disseminating information on the activities of the commission and MoDOT to the public and to MoDOT personnel. Communications coordinates customer comments to MoDOT through public involvement meetings, customer service representatives, and surveys. Communications helps MoDOT communicate with news media through news releases and personal contact. Communications creates strategies statewide and through MoDOT's districts that educate and inform stakeholders through the web, social media, presentations, video, publications, displays, and other mediums;

4. Construction and Materials is responsible for administering construction contracts awarded by the commission. Contracts are awarded through the competitive bid or design build selection process, and then work is assigned to project offices geographically located throughout the state. Engineers and technicians make owner/engineering decisions, verify contract compliance through testing and inspection, and complete and review documentation necessary to authorize payment. Construction and Materials is responsible for testing to ensure the materials used for maintenance and construction of our transportation system meet the quality standards and specifications;

5. Design is responsible for the location, environmental, and cultural resource studies required for initial evaluation of proposed projects; detailed route studies, ground surveys, and aerial photography; and design and plan preparation including cost estimates for the state transportation projects. Design advertises and makes all preparations for receiving bids for transportation project contracts including the development of specifications and cost estimates prior to advertising for bids. Design is also responsible for acquisition of right of way required for the construction and maintenance of all state highways in addition to properties incidental to the system of state highways in Missouri, and provides relocation assistance for all persons displaced by the commission's right of way acquisition. Design administers the disposal or lease of land considered excess to commission needs and the regulation of outdoor advertising billboards and junkyards adjacent to regulated state highways. Design adminis-

ters the Scenic Byway Program;

6. Equal Opportunity and Diversity is responsible for directing the department's Affirmative Action Program and other initiatives aimed at achieving and maintaining a diverse workforce;

7. External Civil Rights is responsible for directing the department's external affirmative action, equal opportunity, and nondiscrimination programs, which include the Disadvantaged Business Enterprise Program, On-the-Job Training Program, Equal Employment Opportunity, Title VI, Americans with Disabilities Act (ADA), and all other nondiscrimination or affirmative action programs related to federal-aid contracting activities;

8. Financial Services is responsible for providing administrative support to MoDOT in accounting, financial reporting, and policy development, building and maintaining an effective system of internal controls, and cost accounting. Financial Services is also responsible for coordinating financial resources and spending plans through forecasting, analysis, and training. Financial Services also performs financial planning and fiscal analysis, budget, federal aid management, [and] innovative finance administration, **and claims management** functions for the department;

9. General Services is responsible for supporting MoDOT activities by providing guidance and support services in the areas of facilities management, procurement, inventory management, fleet management, and equipment repair;

10. Governmental Relations is responsible for acting as MoDOT's liaison between Missouri's congressional delegation, the Missouri Legislature, and local political subdivisions. Staff members review and analyze proposed transportation-related legislation affecting MoDOT and provide either support or options for improving the legislative proposals and public policies impacting the traveling public. Governmental Relations staff also serve as a liaison between MoDOT and national transportation associations;

11. Highway Safety and Traffic is responsible for *[the safe and efficient movement of people and goods on the state highway system. This includes supporting signing, striping, traffic signals, lighting, intelligent transportation systems (ITS), roadway access, and safety management programs throughout the state. Highway Safety and Traffic is responsible for the coordination of traffic management, incident management, traveler information services, and the radio and emergency communication systems; and is also responsible for planning, directing, and coordinating the solicitation, review, award, and monitoring of federal highway safety grant contracts and concentrates their efforts in the areas of education, enforcement, and engineering to prevent deaths and injuries from motor vehicle accidents]* **leading a comprehensive approach to reduce fatalities and serious injuries on Missouri roadways by combining infrastructure improvements with efforts to change driver behavior. This includes guiding the deployment of data-driven engineering strategies and working closely with safety partners to administer federal safety grants for educational programs, traffic enforcement activities, public awareness campaigns, trainings/certifications and more. The division also provides direction and support for traffic management and operations across the state, including signing, striping, traffic signals, lighting, intelligent transportation systems (ITS), roadway access, work zones, and traveler information services;**

12. Human Resources is responsible for *[continually developing and improving human resources' processes that support MoDOT and its employees in contributing to a quality transportation system. Responsibilities include nationally recruiting college graduates for placement throughout the state and administering employee development programs, personnel policies, the department's pay system, and personnel records]* **developing and administering the department's statewide personnel program. The division conducts recruiting for civil engineering positions and manages statewide efforts related to employment; work-life support; classification, pay and**

employee training; development and assessment. Human Resources also develops personnel policy, maintains personnel records for employees, and provides support for all personnel activities within the central office location;

13. Information Systems is responsible for providing *[and improving information and communication services used by employees of MoDOT through the operation and maintenance of local and statewide data networks and telephone services. Information Systems staff provide applications programming expertise to support the engineering, financial, operational, and general information needs of MoDOT]* information technology products, services and support to the department and coordinates its information technology activities. Information Systems staff provide technical expertise in the areas of application development, collaboration tools, computing systems, data service management, network management, cyber security, and other technical support areas;

*[14. Innovative Partnerships and Alternative Funding is responsible for assisting in the assessment and implementation of technological innovations impacting the state highways and state transportation systems; and analyzing alternative funding proposals including design-build, public-private partnerships, and other initiatives where allowed under federal and state law;]*

*[15.]14.* Maintenance is responsible for assisting and supporting maintenance activities for the preservation and operation of the state highway system;

*[16.]15.* Motor Carrier Services provides information, credentials, and permits and enforces safety for businesses and individuals interested in commercial property and passenger-carrying operations on public highways in and through Missouri;

*[17.]16.* Multimodal Operations is responsible for administering state and federal programs that support and develop non-highway passenger and freight transportation, which include aviation, railroads, transit, and waterways. Major programs include capital improvements, operating support, technical assistance, safety outreach, and identifying freight efficiencies/opportunities; **and**

*[18. Risk and Benefits Management is responsible for the management and implementation of medical and life insurance plans for department employees and retirees; administration of MoDOT's self-insurance operations, including workers' compensation, fleet liability, general liability, and property damage recovery; and administration of the safety and health programs; and]*

*[19.]17.* Transportation Planning is responsible for planning and coordinating a long-range, total transportation system for MoDOT. This includes developing the long range transportation plan; developing, coordinating, and tracking the five- (5-) year Statewide Transportation Improvement Program; mapping; collecting, managing, and analyzing data to provide a single source of information to support MoDOT's decision process related to maintenance, construction, and reconstruction of the state transportation system; leading organizational performance management, including the production of MoDOT's quarterly performance management document, Tracker; and facilitating process improvement, customer satisfaction, and problem-solving teams to improve operational performance.

**(C) Units. Units have a smaller scope than the department's divisions—**

**1. Employee Health and Wellness is responsible for the management and implementation of the medical and life insurance plans for department employees and retirees, ensuring employees are fit for duty to include the management of worker's compensation claims and the fit for duty process, and administering the department's drug and alcohol testing programs, including ensuring compliance with federally mandated drug and alcohol testing programs; and**

**2. Safety and Emergency Management is responsible for**

leading, managing, developing, and organizing the department's employee safety and health, security, emergency management, traffic incident management, and safety and technical training programs; collaborating with districts and divisions to develop and implement policies and procedures to eliminate or reduce employee exposure to hazards in the department's various work environments; implementing security protocols for the protection of employees and assets; monitoring industrial hygiene; developing safety and technical training programs; and overseeing the department's emergency management preparedness, prevention, mitigation, response, and administration of federal disaster recovery programs. Safety and Emergency Management is also responsible for leading the emergency support function for transportation during state or federal emergency operations center disaster activations, and staffing the recovery support function for infrastructure following state disaster declarations.

*[(C)](D)* Districts. Missouri is geographically divided into seven (7) districts. Each district is led by a district engineer who is responsible for supervising all activities of MoDOT within that particular district. The following counties are included in the indicated districts: Northwest District includes<sup>[:]</sup> Andrew, Atchison, Buchanan, Caldwell, Carroll, Chariton, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Holt, Linn, Livingston, Mercer, Nodaway, Putnam, Sullivan, and Worth; Northeast District includes<sup>[:]</sup> Adair, Audrain, Clark, Knox, Lewis, Lincoln, Macon, Marion, Monroe, Montgomery, Pike, Ralls, Randolph, Schuyler, Scotland, Shelby, and Warren; Kansas City District includes<sup>[:]</sup> Cass, Clay, Jackson, Johnson, Lafayette, Pettis, Platte, Ray, and Saline; Central District includes<sup>[:]</sup> Boone, Callaway, Camden, Cole, Cooper, Crawford, Dent, Gasconade, Howard, Laclede, Maries, Miller, Moniteau, Morgan, Osage, Phelps, Pulaski, and Washington; St. Louis District includes<sup>[:]</sup> Franklin, Jefferson, St. Charles, St. Louis, and the City of St. Louis; Southwest District includes<sup>[:]</sup> Barry, Barton, Bates, Benton, Cedar, Christian, Dade, Dallas, Greene, Henry, Hickory, Jasper, Lawrence, McDonald, Newton, Polk, St. Clair, Stone, Taney, Vernon, and Webster; Southeast District includes<sup>[:]</sup> Bollinger, Butler, Cape Girardeau, Carter, Douglas, Dunklin, Howell, Iron, Madison, Mississippi, New Madrid, Oregon, Ozark, Pemiscot, Perry, Reynolds, Ripley, St. Francois, Ste. Genevieve, Scott, Shannon, Stoddard, Texas, Wayne, and Wright.

*[(D)](E)* Assigned Entities. Although assigned to the commission or MoDOT by law for organizational purposes, the following commissions, authorities, and districts operate independently of MoDOT: the Bi-State Metropolitan Development District; the Missouri-St. Louis Metropolitan Airport Authority; the Kansas City Area Transportation Authority District; and the Mississippi River Parkway Commission. The Mississippi River Parkway Commission was established by section 226.440, RSMo. All the other entities are authorized by section 14 of the Omnibus State Reorganization Act of 1974 and section 226.007, RSMo.

*AUTHORITY: section 536.023, RSMo 2016. Original rule filed Oct. 14, 1976, effective March 1, 1977. For intervening history, please consult the Code of State Regulations. Amended: Filed March 3, 2022.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.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 7—MISSOURI DEPARTMENT OF  
TRANSPORTATION  
Division 10—Missouri Highways and Transportation  
Commission  
Chapter 11—Procurement of Supplies**

**PROPOSED AMENDMENT**

**7 CSR 10-11.020 Procedures for Solicitation, Receipt of Bids, and Award and Administration of Contracts.** The Missouri Highways and Transportation Commission is amending sections (4), (10), subsections (1)(B), (5)(B), (5)(C), and (10)(A), and adding a new subsection (10)(B).

*PURPOSE:* This amendment will add clarity to paragraph (5)(B)2. of this rule, add the word *business* to specify days in subsection (5)(C) and section (10) of this rule, as well as align the dollar amounts to current bid limits, and to provide instruction in the event of a bid protest in subsection (10)(B) of this rule.

(1) Informal Procurement Methods. When the procurement is estimated to be less than twenty-five thousand dollars (\$25,000), an informal method of solicitation may be utilized. Informal methods of procurement may include invitation for quotation (IFQ), telephone quotes, etc.

(B) The division may proceed with the evaluation and award *[any-time]* any time after the expiration of the target date and time. Quotations received after the target date and time, but before the award of a contract, may be included in the evaluation at the discretion of the division.

(4) Indefinite Delivery Contracts (IDC). IDC *[contracts]* may be utilized for facility maintenance, construction, repair, rehabilitation, renovation, or alteration services of a recurring nature when the delivery times and quantities are indefinite with a total cost of less than twenty-five thousand dollars (\$25,000).

(5) Single Feasible Source. The division may waive the requirement of competitive bids or proposals for supplies when the division has determined in writing that there is only a single feasible source for the supplies. Immediately upon discovering that other feasible sources exist, the division shall rescind the waiver and proceed to procure the supplies through the competitive processes as described in this rule.

(B) When the *[S]*single *[F]*feasible *[S]*source procurement method is utilized, the following guidelines will be used:

1. The following guidelines may be utilized to determine if supplies can be purchased as a single feasible source due to being proprietary:

A. The parts are required to maintain validity of a warranty;  
B. Additions to a system must be compatible with original equipment;

C. Only one (1) type of computer software exists for a specific application;

D. Factory authorized maintenance must be utilized to maintain validity of a warranty;

E. The materials are copyrighted and are only available from the publisher or a single distributor; or

F. The services of a particular provider are unique, e.g., entertainers, authors, etc.;

2. *[The following guidelines may be utilized i]*If past procurement activity indicates only one (1) bid has been submitted in a particular region, a single feasible source procurement may be autho-

rized. In these situations, the division will monitor the market for developing competition; and

3. The following guidelines may be utilized to determine if supplies may be purchased as a single feasible source due to being available at a discount for a limited period of time:

A. The discounted price is compared to a price established through a reasonable market analysis; and

B. The discounted price should normally be at least ten percent (10%) less than the current contract or other comparable price. A discount of less than ten percent (10%) may be acceptable under appropriate market conditions. The discount should be compared to a price which, where feasible, is within the most recent twelve (12) months.

(C) The division shall post any proposed single feasible source purchase with an estimated expenditure of *[five]* ten thousand dollars (\$~~5~~**10**,000) or more. *[If the estimated expenditure is twenty-five thousand dollars (\$25,000) or more, the intent to make such purchase will be advertised in such places as are most likely to reach prospective bidders or offerors and may provide such information through an electronic medium available to the general public]* **The proposed purchase will be advertised through an electronic medium available to prospective bidders or offerors and the general public** at least five (5) business days before the contract is to be awarded. *[Other methods of advertisement, however, may be used by the division when such other methods are deemed more advantageous for the supplies to be purchased.]* Advertising may be waived, if not feasible, due to the supplies being available at a discount for only a limited period of time.

(10) Bid Protest. A bid or proposal award protest must be **submitted** in writing **to the director or designee** and received by the division within ten (10) *[calendar]* **business** days after the date of award. If the tenth day falls on a Saturday, Sunday, or state holiday, the period *[shall]* **will** extend to the next state business day. A protest submitted after *[expiration of]* the ten- (10-) *[calendar]* **business-day** period shall not be considered.

(A) The written protest should include the following information:

*[(A)]*1. Name, address, and phone number of the protester;

*[(B)]*2. Signature of the protester or the protester's representative;

*[(C)]*3. Solicitation number;

*[(D)]*4. Detailed statement describing the grounds for the protest; and

*[(E)]*5. Supporting exhibits, evidence, or documents to substantiate claim.

**(B) A protest which fails to contain the information listed above may be denied solely on that basis. All protests filed in a timely manner will be reviewed by the director or designee. The director or designee will only issue a determination on the issues asserted in the protest. A protest, which is untimely or fails to establish standing to protest, will be summarily denied. In other cases, the determination will contain findings of fact, an analysis of the protest, and a conclusion that the protest will either be sustained or denied. If the protest is sustained, remedies include canceling the award. If the protest is denied, no further action will be taken by the division.**

*AUTHORITY:* sections 226.020, 226.130, 227.030, and 227.210, RSMo 2016. Original rule filed April 5, 1993, effective Oct. 10, 1993. Rescinded and readopted: Filed June 5, 2009, effective Jan. 30, 2010. Amended: Filed May 4, 2018, effective Dec. 30, 2018. Amended: Filed March 3, 2022.

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



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

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Highways and Transportation Commission, Pamela J. Harlan, Secretary to the Commission, PO Box 270, Jefferson City, MO 65102 or Pamela.Harlan@modot.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 9—DEPARTMENT OF MENTAL HEALTH  
Division 10—Director, Department of Mental Health  
Chapter 5—General Program Procedures**

**PROPOSED AMENDMENT**

**9 CSR 10-5.206 Report of Events.** The department is amending the purpose, sections (1)-(4), and form MO 650-9475, deleting section (5) and form DMH-9719B, and renumbering as needed.

*PURPOSE:* This amendment updates terminology and event reporting requirements for community-based agencies providing department-funded services for individuals with intellectual disabilities, developmental disabilities, and/or behavioral health disorders.

*PURPOSE:* This rule prescribes procedures for documenting, reporting, analyzing, and addressing certain events that affect individuals who reside in a community residential [facilities,] program or are receiving day program[s] or specialized services from an agency that [are] is licensed, certified [or], accredited, in possession of deemed status, is funded by, and/or has a contractual relationship with the Department of Mental Health for the provision of services as required by sections 630.005, 630.020, 630.163, 630.165, 630.167 and 630.655, RSMo.

[(1) The following words and terms, as used in this rule, mean:

(A) Consumer, individual receiving department funded or contracted services directly from any program or facility;

(B) Corrective Action Plan, the document a provider submits to the department in response to the results of an event or events which outlines those measures that are intended to reduce the likelihood that the event(s) will recur or to remediate a deficiency. Such actions include but are not limited to: removal of an individual receiving services or staff from a provider; staff training; improvements in the physical plant; revision of operating procedures;

(C) Department, the Department of Mental Health's local regional center, district administrator, or supported community living office, depending on the division providing service;

(D) Guardian, individual who is legally responsible for the care and custody of the consumer;

(E) "On call" system, procedure of the specific regional department personnel being available to receive notification of events during nonbusiness hours. A telephone number is provided to verbally relay this information to the individual representing the specific region and division providing service;

(F) Provider—

1. A residential facility, day program or specialized service that is licensed, certified or funded by the Department of Mental Health;

2. Provider does not include facilities licensed by the Department of Health and Senior Services under Chapter

198, RSMo unless the facility is also licensed by the Department of Mental Health. In this case this rule applies only to consumers that have a primary diagnosis of mental illness and whose board and care are funded by the Department of Mental Health.

3. Duties of the provider under this rule are the responsibility of the chief administrative officer of the residential facility, day program or specialized service, or his/her designee;

(G) Reportable events, those specific incidents and medication errors identified on the applicable department report form dependent on the division providing service to the consumer; and

(H) Report form, Department of Mental Health form identifying reportable events and the timelines for reporting such events to the department. The form is used for data entry into the department Incident and Investigation Tracking System for statewide data collection. This form is identified as DMH-9719A (Divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services) or DMH-9719B (Division of Mental Retardation/Developmental Disabilities), dependent on department division of service, which is included herein.

(2) This section applies to event notification and reporting requirements for employees of providers, as defined under section 630.005, RSMo. Facilities, programs and services that are operated by the Department of Mental Health are regulated by the department's operating regulations and are not included in this definition, because this rule does not apply to Department of Mental Health operated facilities.

(A) Providers must maintain written policies requiring their employees to report events under this regulation and those events identified in 9 CSR 10-5.200. The policies must make clear that administrative or disciplinary sanctions may result from failure to report. Providers must ensure that their employees and those who support the agency are educated about the department's notification and reporting requirements.

(B) It is the responsibility of the provider to—

1. Notify the department with a written or verbal report of all events reportable under this regulation involving consumers as identified on the report form. For those events requiring immediate notification, if a verbal report, it will be followed up in writing on the report form and faxed or otherwise transmitted to arrive within one (1) business day to the appropriate department office. All other events not requiring immediate notification shall be provided in writing on the report form in the time frame specified on the report form.

2. Notify the department using the department's "on call" system after 5:00 p.m. or on weekends/holidays for those events on the report form requiring immediate department notification, and any event resulting in extensive property damage or major disruption of the program or service the consumer receives; and

3. Within twenty-four (24) hours of knowledge of an event that requires immediate department notification, verbally notify the legal guardian or parent (if consumer is a minor) of the specifics regarding the event. The provider shall also communicate that the event has been reported to the department. The only exception to this verbal notification is if the parent(s) or legal guardian is the suspected primary person involved that forms the basis for the reported event. If the provider is unable to verbally contact the guardian/parent, the provider shall document on the report form all efforts made to comply.

(3) *The provider shall ensure that patterns and trends of reportable events, specific to a consumer, are included and addressed in the consumer's personal/treatment plan upon approval by the planning team. To the extent that specific consumer issues are identified, the department staff may meet with the provider to discuss action steps to address and resolve issues, including submission of corrective action plans.*

(1) **Definitions.** The following words and terms, as used in this rule, mean:

(A) **Administrative agent**, an organization and its approved designee(s) authorized by the department as an entry and exit point into the state mental health service delivery system for a geographic service area defined by the department;

(B) **Affiliate**, an organization that is contracted with the department to provide specific community psychiatric rehabilitation (CPR) services in a designated geographic region;

(C) **Agency**, a community residential program/center, day program, group home, outpatient program, and/or specialized services licensed, certified, deemed certified, or deemed licensed by the department, and/or funded by, and/or has a contractual relationship with the department for the provision of services. This does not include entities licensed by the Department of Health and Senior Services under Chapter 198, RSMo, unless the entity is also licensed by the department to serve individuals that have a primary diagnosis of mental illness and/or developmental disability and their services and supports are funded by the department;

(D) **Customer Information Management, Outcomes, and Reporting, Event Management and Tracking (CIMOR-EMT)**, system used by the department to collect and analyze relevant data on events that have actual or potential adverse outcomes for individuals served. Data is entered into the system by agency staff or department staff in accordance with established policies and procedures;

(E) **Deemed status**, acknowledges that an agency is monitored and held accountable by a recognized national accrediting body and the department accepts the agency's verification of good standing with the accrediting body as sufficient to meet the department's standards of care;

(F) **Department**, the Department of Mental Health, executive agency of Missouri state government comprised of the Division of Behavioral Health (DBH) and Division of Developmental Disabilities (DD) and its regional and district offices;

(G) **Division of Behavioral Health (DBH)**, operating division of the department responsible for ensuring prevention, evaluation, treatment, recovery supports, and rehabilitation services are available for individuals and family members experiencing a substance use disorder and/or mental illness;

(H) **Division of Developmental Disabilities (DD)**, operating division of the department responsible for supporting the needs of individuals, family members, and caregivers who experience a developmental disability;

(I) **EMT Community Event Report**, form used by community providers for reporting events to the department in accordance with DBH and DD protocol;

(J) **Guardian**, individual who is court appointed to be legally responsible for the care and custody of the individual being served;

(K) **Individual**, a person/consumer/client receiving department-funded services directly from an agency or self-directed services;

(L) **Reportable events/categories**, events affecting individuals residing in or receiving services from an agency, as defined in subsection (1)(C) of this rule, that meet reporting requirements applicable to DBH or DD;

(M) **On-call system**, procedure in which identified staff in DD

are available to receive notification of reportable events requiring immediate notification during non-business hours, a weekend, or holiday;

(N) **Plan of Action (POA)**, documents the action to be taken by agency staff to reduce the likelihood an event will recur or to remediate an area found out of compliance. Such action may include, but is not limited to, staff training, improvements to the physical plant, and/or revision of operating procedures;

(2) **Reporting Requirements.** This rule applies to any employee of an agency as defined in subsection (1)(C) of this rule.

(A) **Agency designee(s)** shall ensure events are reported in accordance with protocol established by DD or DBH, as applicable to the individual being served.

1. Event reports involving individuals served by DD shall be submitted via the CIMOR-EMT system in accordance with established protocols.

2. Event reports involving individuals served by DBH shall be submitted to designated DBH staff via the EMT Community Event Report form MO 650-9475 in accordance with established protocols.

A. **Administrative agents/affiliates** shall be notified of events involving individuals receiving DBH-funded services. The administrative agent/affiliate shall submit event reports to the appropriate DBH regional office staff via the EMT Community Event Report form MO 650-9475 in accordance with established protocols.

(B) Any allegation or suspicion of abuse, neglect, or misuse of funds/property, as defined in 9 CSR 10-5.200, which is reported to or suspected by agency staff must be immediately reported to the applicable division in accordance with procedures described in 9 CSR 10-5.200.

(C) Events requiring immediate notification which occur after 5:00 p.m. on a weekday, weekend, or holiday shall be reported as follows:

1. To DBH staff no later than the next business day in a written report utilizing the EMT Community Event Report form MO 650-9475.

2. To DD staff verbally in accordance with the on-call protocol, followed by entry into CIMOR-EMT on the next business day.

(D) The parent(s) of a minor or the legal guardian of an individual who is involved in a report of abuse, neglect, and/or misuse of funds/property shall receive verbal notification from agency staff regarding the details of the event, except the names of any employees or other individuals shall not be revealed. This notification shall occur as soon as possible, but no later than twenty-four (24) hours following the agency's notification of the alleged event.

1. Email or text communication may be substituted for the verbal notification if the parent/guardian has indicated that is the preferred means of communication.

2. The date and time of parent/guardian notification shall be documented on the event report.

3. Agency staff shall communicate to the parent/guardian that the applicable division (DBH or DD) has been notified of the event.

4. If the parent/guardian is suspected to be involved in the event, notification to the parent/guardian shall be waived.

5. If agency staff are unable to contact the parent/guardian regarding such an event, efforts to comply must be documented and included in the agency's event report to the applicable division.

(3) **Policies and Procedures.** Agencies shall maintain and implement written policies and procedures to ensure the event notification, reporting requirements, and division-specific protocol outlined in this rule are followed.

(A) The policies and procedures shall clearly indicate the action to be taken by the agency if staff fail to report an event in accordance with the event notification, reporting requirements, and division-specific protocol outlined in this rule.

(B) The agency shall ensure all employees, contracted staff, students/interns, and volunteers receive training on the event notification and reporting requirements applicable to their agency, including the agency's internal policies and procedures.

1. This training shall be included as part of the agency's orientation process and take place within the first thirty (30) days of employment and annually thereafter.

2. Employees, contracted staff, students/interns, and volunteers who will have direct contact with individuals served must be trained on the event notification, reporting requirements, and division-specific protocol prior to interacting alone with individuals.

3. This training shall include review of the definitions included in 9 CSR 10-5.200 for abuse, neglect, and misuse of funds/property.

(4) **Plan of Action (POA) and Follow-up.** The *[department]* DBH or DD may request a *[corrective action plan be provided by the provider]* POA from an agency based on the facts surrounding the event. This *[plan]* POA is subject to approval by the *[department within a time frame specified by the department. This plan]* DBH or DD designee, must be carried out as specified, and shall be implemented by the agency in accordance with the approval criteria issued by the applicable division.

(A) Corrective measures and action steps to resolve the issue must be documented and maintained by the agency and be available for review by DBH or DD staff or other authorized representatives upon request.

*[(5) Programs licensed or certified by the Department of Mental Health must maintain internal records of similar events or information for individuals who do not receive department funded or contracted services, for purposes of quality review to assure that problems are identified and resolved. Non-identifying event records or non-identifying analysis of these events must be available for review by the department as needed for monitoring or licensure/certification activities. This section does not apply to facilities licensed under Chapter 198, RSMo.]*

*[(6)](5) Failure to follow [the above referenced] these regulations may result in administrative sanctions up to and including contract cancellation or **revocation** of licensure, [//]certification, or **deemed status** [revocation].*



STATE OF MISSOURI  
DEPARTMENT OF MENTAL HEALTH  
**EMT COMMUNITY EVENT REPORT - BEHAVIORAL HEALTH**

EVENT #
DMH USE ONLY

**\*\*PLEASE NOTE ALL SIGNATURE ARE REQUIRED TO BE ORIGINAL SIGNATURES. PLEASE COMPLETE THE FORM ELECTRONICALLY, PRINT, SIGN AND SUBMIT TO THE DEPARTMENT.\*\***

DIVISION  Alcohol and Drug Abuse (ADA)  Comprehensive Psychiatric Services (CPS)

1. EVENT DATE & TIME  AM  PM 2. DISCOVERY DATE & TIME  AM  PM

3. EVENT LOCATION AND ADDRESS (IF KNOWN) 4. ORGANIZATION INVOLVED IN EVENT

5. PROGRAM CATEGORY PERTINENT TO EVENT CHOOSE A SERVICE TYPE  
 ADA only:  Adult or  Adolescent  
 CPS only:  Adult or  Adolescent

6. REPORTABLE EVENT: All events identified below shall be recorded on this form and faxed to DBH within one (1) business day.

Death (All deaths, including those of consumers within 15 days post-discharge from services.) **If checked, complete suspected manner (13)**

Injury resulting in medical inpatient hospitalization, while providing services or for consumers living in DBH funded or contracted residential facilities or DBH treatment programs. **If checked, complete all of 9-10.**

Self-Injurious Behavior or Suicide Attempt (if resulting in death or injury as defined above)

Sexual Assault (during an open episode of care if the consumer is a perpetrator; occurring on community agency property or while providing services if the consumer is a victim)

Physical Assault (during an open episode of care if the consumer is a perpetrator; occurring on community agency property or while providing services if the consumer is a victim and requires more medical care beyond first aid)

Elopement/Unauthorized Absence - For CPS, when from a congregate living or semi-independent environment of a consumer who has a guardian or is NGR1 or who is suspected of posing an imminent risk of harm to self or others. For ADA, this applies to adolescents and both ADA and CPS criteria apply but only 1 report needed.

Medication Error (Occurring in residential programs or programs in which medication is administered or self administration is observed by the agency.)

**Severity: (SELECT ONE)**

Moderate: Treatment and/or interventions in addition to monitoring or observation

Serious: Life threatening and/or permanent adverse consequences

Fire (resulting in structural damage to DBH funded residential facilities)

Alleged or Suspected Abuse, Neglect, or Misuse of Funds/Property

Select Type: (all that apply)  Verbal Abuse  Physical Abuse  Sexual Abuse  Neglect  Misuse of Funds/Property

If Physical Abuse, Verbal Abuse, Sexual Abuse, Misuse of Consumer Funds/Property or Neglect is alleged by a consumer or suspected by staff, report this immediately by verbal or written report and follow all other procedures described in 9 CSR 10-5.200.

7. PERSONS INVOLVED (first/last name required); Please print (attach pages if necessary)	Relationship	Role	DMH State # (for consumers)	Date of last Services (for consumers)

Relationship Types: Consumer, Parent, Guardian, Staff, Visitor, Volunteer, Other (PLEASE SPECIFY)  
 Role Types: Complainant, Perpetrator, Victim, Witness, Other (PLEASE SPECIFY)

8. INJURY TYPE (SELECT ONE)

Accident  Consumer Inflicted  Other Inflicted  Self Inflicted  Staff Inflicted  Unknown

<p><b>9. INJURY DESCRIPTION (SELECT ALL THAT APPLY)</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Abrasion</td> <td><input type="checkbox"/> Puncture</td> </tr> <tr> <td><input type="checkbox"/> Bite</td> <td><input type="checkbox"/> Scratches</td> </tr> <tr> <td><input type="checkbox"/> Burn</td> <td><input type="checkbox"/> Strain/Sprain</td> </tr> <tr> <td><input type="checkbox"/> Complaint of Pain</td> <td><input type="checkbox"/> Swelling</td> </tr> <tr> <td><input type="checkbox"/> Contusion/Bruise</td> <td><input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td><input type="checkbox"/> Dislocation</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Fracture/Break</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Frostbite</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Heat Related Illness</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Laceration/Cut</td> <td></td> </tr> </table>	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Puncture	<input type="checkbox"/> Bite	<input type="checkbox"/> Scratches	<input type="checkbox"/> Burn	<input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Complaint of Pain	<input type="checkbox"/> Swelling	<input type="checkbox"/> Contusion/Bruise	<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Dislocation		<input type="checkbox"/> Fracture/Break		<input type="checkbox"/> Frostbite		<input type="checkbox"/> Heat Related Illness		<input type="checkbox"/> Laceration/Cut		<p><b>10. INJURED BODY PARTS (SELECT ALL THAT APPLY)</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Shoulder - Right</td> <td><input type="checkbox"/> Hip - Right</td> <td><input type="checkbox"/> Calf - Right</td> </tr> <tr> <td><input type="checkbox"/> Face</td> <td><input type="checkbox"/> Shoulder - Left</td> <td><input type="checkbox"/> Hip - Left</td> <td><input type="checkbox"/> Calf - Left</td> </tr> <tr> <td><input type="checkbox"/> Eye - Right</td> <td><input type="checkbox"/> Upper Arm - Right</td> <td><input type="checkbox"/> Lower Abdomen</td> <td><input type="checkbox"/> Shin - Right</td> </tr> <tr> <td><input type="checkbox"/> Eye - Left</td> <td><input type="checkbox"/> Upper Arm - Left</td> <td><input type="checkbox"/> Waist</td> <td><input type="checkbox"/> Shin - Left</td> </tr> <tr> <td><input type="checkbox"/> Ear - Right</td> <td><input type="checkbox"/> Elbow - Right</td> <td><input type="checkbox"/> Genitals</td> <td><input type="checkbox"/> Ankle - Right</td> </tr> <tr> <td><input type="checkbox"/> Ear - Left</td> <td><input type="checkbox"/> Elbow - Left</td> <td><input type="checkbox"/> Buttock - Right</td> <td><input type="checkbox"/> Ankle - Left</td> </tr> <tr> <td><input type="checkbox"/> Nose</td> <td><input type="checkbox"/> Forearm - Right</td> <td><input type="checkbox"/> Buttock - Left</td> <td><input type="checkbox"/> Foot - Right</td> </tr> <tr> <td><input type="checkbox"/> Mouth</td> <td><input type="checkbox"/> Forearm - Left</td> <td><input type="checkbox"/> Thigh - Right</td> <td><input type="checkbox"/> Foot - Left</td> </tr> <tr> <td><input type="checkbox"/> Teeth</td> <td><input type="checkbox"/> Wrist - Right</td> <td><input type="checkbox"/> Thigh - Left</td> <td><input type="checkbox"/> Other:</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Wrist - Left</td> <td><input type="checkbox"/> Knee - Right</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Upper Back</td> <td><input type="checkbox"/> Hand - Right</td> <td><input type="checkbox"/> Knee - Left</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand - Left</td> <td><input type="checkbox"/> Lower Back</td> <td></td> </tr> </table>	<input type="checkbox"/> Head	<input type="checkbox"/> Shoulder - Right	<input type="checkbox"/> Hip - Right	<input type="checkbox"/> Calf - Right	<input type="checkbox"/> Face	<input type="checkbox"/> Shoulder - Left	<input type="checkbox"/> Hip - Left	<input type="checkbox"/> Calf - Left	<input type="checkbox"/> Eye - Right	<input type="checkbox"/> Upper Arm - Right	<input type="checkbox"/> Lower Abdomen	<input type="checkbox"/> Shin - Right	<input type="checkbox"/> Eye - Left	<input type="checkbox"/> Upper Arm - Left	<input type="checkbox"/> Waist	<input type="checkbox"/> Shin - Left	<input type="checkbox"/> Ear - Right	<input type="checkbox"/> Elbow - Right	<input type="checkbox"/> Genitals	<input type="checkbox"/> Ankle - Right	<input type="checkbox"/> Ear - Left	<input type="checkbox"/> Elbow - Left	<input type="checkbox"/> Buttock - Right	<input type="checkbox"/> Ankle - Left	<input type="checkbox"/> Nose	<input type="checkbox"/> Forearm - Right	<input type="checkbox"/> Buttock - Left	<input type="checkbox"/> Foot - Right	<input type="checkbox"/> Mouth	<input type="checkbox"/> Forearm - Left	<input type="checkbox"/> Thigh - Right	<input type="checkbox"/> Foot - Left	<input type="checkbox"/> Teeth	<input type="checkbox"/> Wrist - Right	<input type="checkbox"/> Thigh - Left	<input type="checkbox"/> Other:	<input type="checkbox"/> Neck	<input type="checkbox"/> Wrist - Left	<input type="checkbox"/> Knee - Right		<input type="checkbox"/> Upper Back	<input type="checkbox"/> Hand - Right	<input type="checkbox"/> Knee - Left		<input type="checkbox"/> Chest	<input type="checkbox"/> Hand - Left	<input type="checkbox"/> Lower Back	
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<b>11. NOTIFIED:</b>	<b>Name of Person Contacted</b>	<b>Date</b>	<b>Time</b>																																																																		
<input type="checkbox"/> Family or Guardian			<input type="checkbox"/> AM <input type="checkbox"/> PM																																																																		
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<b>12. EVENT DESCRIPTION: Describe what happened and interventions used by staff.</b>																																																																					

Attach additional pages if necessary.

13. IMMEDIATE ACTION TAKEN BY AGENCY AND ACTION STEPS TO PREVENT REOCCURRENCE: (To be completed by agency management if action was required.)

If a death occurred: Suspected Manner of Death

- Accident     Homicide     Natural     Suicide     Undetermined

Is an Autopsy being performed?

- Yes     No     Unknown    If Yes, list Coroner/Medical Examiner: \_\_\_\_\_

14. REPORTER: AGENCY NAME

PRINT REPORTERS NAME

DATE/TIME REPORTER SIGNED

PHONE NUMBER (REQUIRED)

**TO BE COMPLETED BY DEPARTMENT OF MENTAL HEALTH STAFF**

15. ACTION/COMMENTS

Incident Type:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Consumer Self Harm</li> <li><input type="checkbox"/> Consumer struck by object resulting in injury</li> <li><input type="checkbox"/> Death</li> <li><input type="checkbox"/> Elopement/Unauthorized Absence</li> <li><input type="checkbox"/> Fall</li> <li><input type="checkbox"/> Fire</li> <li><input type="checkbox"/> Inappropriate language by staff toward consumer</li> <li><input type="checkbox"/> Medical emergency-Consumer</li> <li><input type="checkbox"/> Misuse of consumer funds/property</li> <li><input type="checkbox"/> Physical altercation-between consumers</li> <li><input type="checkbox"/> Physical altercation-Consumer &amp; non Staff</li> <li><input type="checkbox"/> Physical altercation-Staff &amp; Consumer</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Possession of Weapon</li> <li><input type="checkbox"/> Property loss/destruction</li> <li><input type="checkbox"/> Self-Injurious Behavior</li> <li><input type="checkbox"/> Sexual conduct-consumer/non-consensual</li> <li><input type="checkbox"/> Sexual conduct-staff &amp; consumer</li> <li><input type="checkbox"/> Substance Use</li> <li><input type="checkbox"/> Suicide attempt</li> <li><input type="checkbox"/> Theft by consumer</li> <li><input type="checkbox"/> Vehicular accident</li> <li><input type="checkbox"/> Violation of Consumer Rights</li> <li><input type="checkbox"/> Other</li> </ul> |
|--|--|

If other selected, please explain: \_\_\_\_\_

WAS THE EVENT A CRITICAL INCIDENT?

- Yes     No

DECISION:

- QA/Clinical Review     No Action Taken     Special Request Inquiry/Investigation requested

COMMENTS:

SIGNATURE OF DMH STAFF

DATE

**AUTHORITY:** sections [630.005,] 630.020 [and], 630.655, [RSMo 2000] and 630.165, **RSMo 2016**, and sections **630.005 and 630.167**, RSMo Supp. [2004] **2021**. Original rule filed March 1, 2005, effective Oct. 30, 2005. Amended: Filed Aug. 26, 2005, effective Feb. 28, 2006. Amended: Filed March 9, 2022.

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

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

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to [denise.thomas@dmh.mo.gov](mailto:denise.thomas@dmh.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 9—DEPARTMENT OF MENTAL HEALTH  
Division 10—Director, Department of Mental Health  
Chapter 5—General Program Procedures**

**PROPOSED AMENDMENT**

**9 CSR 10-5.220 Privacy Rule of the Health Insurance Portability and Accountability Act [of 1996] (HIPAA).** The department is amending the purpose and sections (1)-(3).

**PURPOSE:** This amendment updates terminology related to the HIPAA privacy rule.

**PURPOSE:** [This rule alerts providers to the possible HIPAA Privacy Rule requirements if the provider has determined that it is a covered entity as defined by HIPAA. Once that is established, this rule lists policies and procedures that the HIPAA Privacy Rule requires for each covered entity.] This rule specifies the policies and procedures required for covered entities under the HIPAA privacy rule.

(1) This rule applies to all programs that are licensed, certified [or], accredited, in possession of deemed status, funded by, and/or have a contractual relationship with the Department of Mental Health.

(2) Definitions. The following terms, as used in this rule, shall mean:

(A) HIPAA[:]/—the Health Insurance Portability and Accountability Act [of 1996] (45 CFR parts 160 and 164) as it relates to the Privacy Rule[:];

(B) Protected Health Information (PHI)[:]/—As defined by HIPAA (45 CFR section [164.501] **160.103**), PHI is individually identifiable health information that is—

1. Transmitted by electronic media;
2. Maintained in [any medium described in the definition of] electronic media; or
3. Transmitted or maintained in any other form or medium[:];

(C) Individually identifiable health information[:]/—As defined by HIPAA (45 CFR section 160.103), [individually identifiable health information is any information, including demographic information, collected from an individual that is] information that is a subset of health information, including demographic information collected from an individual, and—

1. Is [C/created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and

2. Relate[d/s] to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual[:]; and—

A. [which] That identifies the individual[:]; or

B. [w/With respect to which there is reasonable basis to believe [that] the information can be used to identify the individual[:]; and

[(D) Business associate: As defined by HIPAA (45 CFR section 160.103), a person who, on behalf of the covered entity or provider or of an organized healthcare arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:

1. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or

2. Any other function or activity regulated by this subchapter; or provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized healthcare arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.]

(D) Business associate—As defined by HIPAA (45 CFR section 160.103), with respect to a covered entity, a person who—

1. On behalf of the covered entity or of an organized healthcare arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement;

2. Creates, receives, maintains, or transmits protected health information for a function or activity regulated by this rule and 45 CFR section 160.103, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or

3. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized healthcare arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

(3) Covered Entity. All providers [who] that determine [that] they qualify as a covered [entities] entity must comply with the provisions of the [P]privacy [R]rule of the Health Insurance Portability and Accountability Act [of 1996] (HIPAA).

(A) A covered entity is defined as a healthcare provider[, who] that transmits any health information in electronic form in connection with a transaction covered by [this subchapter (]/section 160.103 of 45 CFR part 160[)], a health plan, or a healthcare clearinghouse.

(B) [The effective date of the Privacy Rule is April 14, 2003. If this] If a provider is a covered entity, [THEN] HIPAA requires the appropriate policies and procedures be in place to comply with the HIPAA Privacy Rule. HIPAA requires such policies and

procedures to include, but not be limited to, the following [topics]:

1. Notice of Privacy Practices[,];
2. Amendment of Protected Health Information (PHI)[,];
3. Client Access to PHI[,];
4. Accounting of Disclosures[,];
5. Workforce Training[,];
6. Verification[,];
7. Authorization for Disclosures of PHI[,];
8. HIPAA Complaint Process[,];
9. Marketing (if applicable)[,];
10. Research (if applicable)[,];
11. Audit and Monitoring of HIPAA compliance[,]; and
12. Business Associates Agreements with [those] companies [providing goods and services which require the disclosure of PHI, etc.] **qualifying as business associates as defined in this rule and in 45 CFR part 160.**

(C) Where existing confidentiality protections provided by 42 CFR part 2, related to the release of [alcohol and drug abuse] records **pertaining to substance use disorders**, are greater than HIPAA, then [the department anticipates that the provider will consider] any such provision of 42 CFR part 2 [as] **shall be the guiding law.**

*AUTHORITY:* section 630.050, RSMo [2000] 2016, and 45 CFR parts 160 and 164, the Health Insurance Portability and Accountability Act [of 1996]. Emergency rule filed April 1, 2003, effective April 14, 2003, expired Oct. 14, 2003. Original rule filed April 1, 2003, effective Oct. 30, 2003. Amended: Filed March 9, 2022.

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

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

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to [denise.thomas@dmh.mo.gov](mailto:denise.thomas@dmh.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 9—DEPARTMENT OF MENTAL HEALTH Division 30—Certification Standards Chapter 4—Mental Health Programs

### PROPOSED AMENDMENT

**9 CSR 30-4.005 Eligibility Criteria and Admission Criteria for Community Psychiatric Rehabilitation Programs.** The department is amending subsection (9)(A) of this rule.

*PURPOSE:* This amendment removes the requirement for a face-to-face consultation with a community support specialist.

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

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

*AUTHORITY:* sections 630.050, 630.655, and 632.050, RSMo 2016. This rule originally filed as 9 CSR 30-4.042. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the *Code of State Regulations*. Amended: Filed March 9, 2022.

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

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

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to [denise.thomas@dmh.mo.gov](mailto:denise.thomas@dmh.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 9—DEPARTMENT OF MENTAL HEALTH Division 30—Certification Standards Chapter 4—Mental Health Programs

### PROPOSED AMENDMENT

**9 CSR 30-4.035 Eligibility Determination, Assessment, and Treatment Planning in Community Psychiatric Rehabilitation Programs.** The department is amending section (2), adding new sections (3), (7), and (10), renumbering sections as necessary, and amending new sections (4)-(6) and (8)-(9).

*PURPOSE:* This amendment defines physician extender, corrects terminology, removes the face-to-face requirement for consultation, adds a requirement for completion of consent to treatment by the individual served, removes the requirement for the individual's signature on the treatment plan, and adds a requirement for professionals' signature to include the date.

(2) Eligibility Determination. Eligibility determination **may be completed to expedite the admission process and** requires confirmation of an eligible diagnosis as evidenced by a signature from a licensed diagnostician or a physician/physician extender. **Physician extender includes a licensed assistant physician, physician assistant, psychiatric resident, psychiatric pharmacist, and APRN.** The licensed diagnostician or physician/physician extender is accountable for the stated diagnosis.

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

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

[A.](B) [These] **The professions listed in paragraphs (2)(A)1. to 7.** are categorically approved as licensed diagnosticians as long as the diagnostic activities performed fall within the scopes of practice for each. Individuals possessing these credentials should practice in



the areas in which they are adequately trained and should not practice beyond their individual levels of competence.

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

1. *[A face-to-face meeting]* **Consultation** with the organization's licensed diagnostician (licensed psychologist, licensed professional counselor, LCSW) or a physician/physician extender; or

2. *[A face-to-face meeting]* **Consultation** with an unlicensed qualified mental health professional (QMHP) with sign-off by the organization's licensed diagnostician or a physician/physician extender; or

3. Written confirmation of an eligible diagnosis received from a physician for a psychiatric hospitalization within ninety (90) days of discharge.

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

*[(D)](E)* Documentation of eligibility determination must include, at a minimum:

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

**(3) Consent to Treatment. Each individual served or a parent/guardian must provide informed, written consent to treatment.**

**(A) A copy of the consent form, which must include the date of consent and signature of the individual served or a parent/guardian, shall be retained in the individual record.**

**(B) Consent to treat shall be updated annually, including the date of consent and signature of the individual served or a parent/guardian, and be maintained in the individual record.**

*[(3)](4)* Initial Comprehensive Assessment. A comprehensive assessment must be completed within thirty (30) days of eligibility determination.

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

1. Basic information (demographics, age, language spoken);
2. Presenting concerns from the perspective of the individual, including reason for referral/referral source, what occurred to cause him/her to seek services;
3. Risk assessment (suicide, safety, risk to others);
4. Trauma history (experienced and/or witnessed abuse, neglect, violence, sexual assault);
5. Mental health treatment history;
6. Mental status;
7. Substance use treatment history and current use including alcohol, tobacco, and/or other drugs; for children/youth, prenatal exposure to alcohol, tobacco, or other substances;
8. Medication information, including current medications, medication allergies/adverse reactions, efficacy of current or previously used medications;
9. Physical health summary (health screen, current primary

care, vision and dental, date of last examinations, current medical concerns, body mass index, tobacco use status, and exercise level; immunizations for children/youth, and medical concerns expressed by family members that may impact the child/youth);

10. Functional assessment using an instrument approved by the department **for individuals whose diagnosis requires a functional score to support admission, and if required by the department as part of the initial comprehensive assessment for all individuals** (challenges, problems in daily living, barriers);

11. Risk-taking behaviors including child/youth risk behavior(s);

12. Living situation, including where living and with whom, financial situation, guardianship, need for assistive technology, and parental/guardian custodial status for children/youth;

13. Family, including cultural identity, current and past family life experiences, family functioning/dynamics, relationships, current issues/concerns impacting children/youth;

14. Developmental information, including an evaluation of current areas of functioning such as motor development, sensory, speech problems, hearing and language problems, emotional, behavioral, intellectual functioning, self-care abilities;

15. Spiritual beliefs/religious orientation;

16. Sexuality, including current sexual activity, safe sex practices, and sexual orientation;

17. Need for and availability of social, community, and natural supports/resources such as friends, pets, meaningful activities, leisure/recreational interests, self-help groups, resources from other agencies, interactions with peers including child/youth and family;

18. Legal involvement history;

19. Legal status such as guardianship, representative payee, conservatorship, probation/parole;

20. Education, including intellectual functioning, literacy level, learning impairments, attendance, achievement;

21. Employment, including current work status, work history, interest in working, and work skills;

22. Status as a current or former member of the U.S. Armed Forces;

23. Clinical formulation, an interpretive summary including identification of co-occurring or co-morbid disorders, psychological/social adjustment to disabilities and/or disorders;

24. Diagnosis;

25. Individual's expression of service preferences;

26. Assessed needs/treatment recommendations such as life goals, strengths, preferences, abilities, barriers; and

27. Signature// **and date** of the staff person completing the assessment.

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

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

1. Identification of sections of the clinical assessment being updated, such as check boxes;

2. Updated narrative for each section of the previous assessment that has changed;

3. Clinical formulation (interpretive summary);

4. Diagnosis change/update;

5. Individual's expression of service preferences;

6. Assessed needs/treatment recommendations; and

7. Signature// **and date** of the staff person completing the assessment, Community Support Supervisor (unless they are completing the assessment), and a licensed diagnostician or physician/physician extender.

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

(A) The treatment plan *[is]* **shall be** developed collaboratively

with the individual or parent/guardian and a QMHP, the individual's community support supervisor, if different from the QMHP, and a physician/physician extender.

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

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

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

B. A licensed psychologist may approve (**sign and date**) the treatment plan when the person served is not currently receiving prescribed medications **to treat a mental health condition** and the clinical recommendations do not include a need for prescribed medications **to treat a mental health condition**.

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

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

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

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

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

**(7) Treatment Plan Review. If a functional assessment is not completed, the treatment plan must be reviewed with each individual every ninety (90) days to assess the continued need for services and progress achieved during the past ninety (90) days.**

**(A) The treatment plan shall reflect the individual's current strengths, needs, abilities, and preferences in the goals and objectives that have been established or continued based on the review.**

**(B) The treatment plan shall be updated to reflect the current needs and goals of the individual and must be documented in the individual's record and may be recorded in—**

1. **A progress note which specifies updates made to the treatment plan; or**
2. **A treatment plan review conducted quarterly.**

**(C) Treatment plan reviews shall be completed, signed, and dated by a QMHP, community support supervisor, or community support specialist.**

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

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

*1. A licensed psychologist may take the place of the physician/physician extender [if medications are] when the person served is not currently receiving prescribed medications to treat a mental health condition and the clinical recommendations do not include a need for prescribed medications to treat a mental health condition.*

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

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

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

*[(8)](9) Functional Assessment. A department-approved functional assessment must be completed [with each individual] for individuals whose diagnosis requires a functional score to support admission, and if required by the department as part of the initial comprehensive assessment. The functional assessment shall be updated in accordance with the timeframes established by the department to assess current level of functioning, progress toward treatment objectives, and appropriateness of continued services. The treatment plan shall be revised to incorporate the results of the initial functional assessment and subsequent updates.*

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

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

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

1. A narrative section with the treatment plan that includes the functional update content requirements;
2. A narrative section on the functional assessment with the content requirements; or

3. A progress note in the individual record documenting the content requirements.

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

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

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

**(A) Documentation for completion of the crisis prevention plan shall include, at a minimum, factors that may precipitate a crisis, a hierarchical list of self-care and self-help strategies identified by the individual to regain a sense of control to return to their level of functioning before the crisis or emergency, and a hierarchical list of staff interventions that may be used when a critical situation occurs.**

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

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

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

*AUTHORITY: section 630.655, RSMo 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the Code of State Regulations. Amended: Filed March 9, 2022.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to denise.thomas@dmh.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 9—DEPARTMENT OF MENTAL HEALTH  
Division 30—Certification Standards  
Chapter 4—Mental Health Programs**

**PROPOSED AMENDMENT**

**9 CSR 30-4.043 Service Provision, Staff Qualifications, and**

**Documentation Requirements for Community Psychiatric Rehabilitation Programs.** The department is amending sections (2) and (3) and renumbering as necessary.

*PURPOSE: This amendment clarifies the requirement for eligibility determination, updates terminology, moves Integrated Treatment for Co-occurring Disorders (ITCD) from an optional to a core service, defines individual and group co-occurring services in the optional services section, expands staff qualifications for children's day treatment, increases the age limit for family support from age seventeen (17) to twenty-five (25), and adds a provision to Peer Support Services.*

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

(A) Eligibility determination **(to expedite the admission process, if necessary)**, in accordance with 9 CSR 30-4.005;

(F) Crisis *[Intervention and Resolution]* **Prevention and Intervention**—face-to-face emergency or telephone intervention available twenty-four (24) hours a day, on an unscheduled basis, to assist individuals in resolving a crisis and providing support and assistance to promote a return to routine, adaptive functioning. Services must be provided by a qualified mental health professional (QMHP). Nonmedical staff providing crisis *[intervention and resolution]* **prevention and intervention** must have immediate, twenty-four (24) hour telephone access to consultation with a physician/physician extender. Minimum service functions shall include, but are not limited to—

1. Interacting with the identified individual and their family members/natural supports, legal guardian, or a combination of these;
2. Specifying factors that led to the individual's crisis state, when known;
3. Identifying maladaptive reactions exhibited by the individual;
4. Evaluating potential for rapid regression;
5. Attempting to resolve the crisis; and
6. Referring the individual for treatment in an alternative setting when indicated*/.*;
7. Documentation must include—
  - A. A description of the precipitating event(s)/situation when known;
  - B. A description of the individual's mental status;
  - C. The intervention(s) initiated to resolve the individual's crisis state;
  - D. The individual's response to the intervention(s);
  - E. The individual's disposition; and
  - F. Planned follow-up by staff*/.*;

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

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

1. Administering therapeutic injections of medication (subcutaneous or intramuscular);
2. Monitoring lab tests/levels including consultation with the physician(s), individual served, and community support specialist;
3. Coordinating medication needs with the individual served and his or her family members/natural supports, as appropriate, and pharmacy staff, including the use of indigent drug programs (does not include routine placing of prescription orders and refills with pharmacies);
4. Setting up medication boxes;
5. Delivering medication to the individual's home;
6. Educating the individual about medications;

7. Recording the individual's initial histories and vital signs;
8. Ensuring medication is taken as prescribed;
9. Monitoring side effects of medication including the use of standardized evaluations; and
10. Monitoring prescriber's orders for treatment modifications and educating the individual served[.];

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

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

- A. Review of the individual's presenting condition;
- B. Mental status exam;
- C. Review of symptoms and medication side effects;
- D. Review of the individual's functioning;
- E. Review of the individual's ability to self-administer medication;
- F. Education on the effects of medication and its relationship to the individual's mental illness and *[his/her]* choice of medication; and
- G. Prescription of medications when indicated.

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

- A. A description of the individual's presenting condition;
- B. Pertinent medical and psychiatric findings;
- C. Observations and conclusions;
- D. Any side effects of medication as reported by the individual;
- E. Actions and recommendations regarding the individual's ongoing medication regimen; and
- F. Pertinent information reported by family members/natural supports regarding a change in the individual's condition or an unusual or unexpected occurrence in his or her life, or both[.];

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

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

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

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

3. Documentation must reflect completion of the Metabolic Syndrome Screening and Monitoring Tool and a summary progress note[.] **which may include review of the health screen information, healthcare concerns discussed, and health and wellness goals included in the individual's treatment plan;**

**[(J)](K) Physician Consultation/Professional Consultation**—medical services provided by a physician, assistant physician, physician

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

1. An assessment of the individual's presenting condition as reported by staff;

2. Review of the treatment plan through consultation;

3. Participant-specific consultation with staff especially in situations which pose a high risk of psychiatric decompensation, hospitalization, or safety issues; and

4. Participant-specific recommendations regarding high risk issues and, when needed, to promote early intervention[.]; **and**

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

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

**(D) Co-Occurring Individual Counseling**, a structured, goal-oriented therapeutic process in which an individual interacts with a qualified provider in accordance with their treatment plan to resolve problems related to their documented mental illness and substance use disorder that interferes with functioning.

1. Services involve the use of evidence-based practices such as motivational interviewing, cognitive behavior therapy, and relapse prevention.

2. Counseling provided to the individual's family is for the direct benefit of the individual served in accordance with their needs and treatment goals, and for the purpose of assisting in the individual's recovery.

3. Services must be provided by a QMHP or QAP;

**(E) Co-Occurring Group Counseling**—goal-oriented therapeutic interaction between a counselor and two (2) or more individuals as specified in individual treatment plans to promote self-understanding, self-esteem, and resolution of personal problems related to the individual's documented mental disorders and substance use disorders through personal disclosure and interpersonal interaction among group members. This service utilizes evidence-based practices.

1. Services must be provided by a QMHP or QAP;

2. Group size shall not exceed ten (10) individuals;

**(F) Co-Occurring Group Rehabilitative Support**—informational and experiential services to assist individuals, family members, and others identified by the individual as a primary natural support, in the management of substance use and mental health disorders.

1. Services are delivered through systematic, structured, didactic methods to increase knowledge of mental illnesses and substance use disorders. This includes integrating affective and cognitive aspects in order to enable the individuals served, as well as family members/natural supports, to cope with the illness and understand the importance of their individual plan of care.

2. The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, symptoms, and precursors to crisis, crisis planning, community resources, recovery management, and medication action, interaction, and side effects.

3. The service includes use of evidence-based practices such as promotion of participation in peer self-help, brain chemistry and functioning, the latest research on illness causes and treatments, medication education and management, symptom management, behavior management, stress management, improving daily living skills, and independent living skills.

4. Group size is limited to twenty (20) individuals.

**5. Services must be provided by staff who have documented education and experience related to the topic presented and either be or be supervised by a QMHP or a QAP;**

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

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

2. Eligibility criteria includes—

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

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

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

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

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

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

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

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

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

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

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

F. Planning the individualized educational needs *[of the child]* with *[his or her]* **the individual's** school; and

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

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

A. Occupational therapists;

B. Physical therapists;

C. Assistant behavior analysts;

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

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

related field~~./~~; and

**F. Individuals meeting the qualifications of a community support specialist with at least three (3) years of population-specific experience providing community support services in accordance with the key service functions for community support services as specified in 9 CSR 30-4.047.**

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

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

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

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

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

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

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

**[(G)](J)** Family Support—provides a support system for parents/caregivers of *[a child or youth seventeen (17) years of age and younger]* **an individual twenty-five (25) years of age and younger** who has a SED. Activities are directed and authorized by the individualized treatment plan. Services must be provided by a family member of *[a child]* **an individual twenty-five (25) years of age and younger** who has or had a behavioral or emotional disorder. The family member must have a high school diploma or equivalent certificate, complete training required by the department, and be supervised by a QMHP. Key service functions shall include, but are not limited to:

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

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

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

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

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

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

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

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

9. Connecting families to community resources;

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

11. Connecting parents, caregivers, *[children/youth]* **and individuals served** to others with similar lived experiences to increase their support system~~./~~;

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

1. A professional counselor licensed or provisionally licensed under Missouri law with specialized training in mental health services;
2. A licensed clinical social worker or master social worker licensed under Missouri law with specialized training in mental health services;
3. A licensed, provisionally licensed, or temporarily licensed psychologist under Missouri law with specialized training in mental health services; or
4. A marital and family therapist licensed or provisionally licensed under Missouri law with specialized training in mental health services.

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

**[(J)](L)** Intensive CPR, in accordance with 9 CSR 30-4.045;

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

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

**1. Peer support services shall be provided in a manner that reflect the core competencies, principles, and values identified in the publication, *Core Competencies for Peer Workers in Behavioral Health Services*, December 2017, developed by and available from the Substance Abuse and Mental Health Services Administration (SAMHSA), 5600 Fishers Lane, Rockville, MD 20857, (877) 726-4727. Hereby incorporated by reference and made a part of this rule. This rule does not incorporate any subsequent amendments or additions to this publication.**

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

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

**[2.]3.** Certified Peer Specialists use the power of peers to support, encourage, and model recovery and resilience from behavioral health disorders in ways that are specific to the needs of each individual. Services may be provided on an individual or group basis and are designed to assist individuals in achieving the goals and

objectives on their individual treatment plan or recovery plan. Activities emphasize the opportunity for individuals to support each other as they move forward in their recovery. Interventions may include, but are not limited to/—/:

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

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

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

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

**[(P)](Q)** *[Intensive Home-Based Services for Children and Youth]* **Professional Parent Home-Based Services and Treatment Family Home-Based Services (ICPR for Children/Youth in Residential Settings)**, in accordance with 9 CSR 30-4.045.

*AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the Code of State Regulations. Amended: Filed March 9, 2022.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to denise.thomas@dmh.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 9—DEPARTMENT OF MENTAL HEALTH Division 30—Certification Standards Chapter 4—Mental Health Programs

### PROPOSED AMENDMENT

**9 CSR 30-4.0431 Integrated Treatment for Co-Occurring Disorders (ITCD) in Community Psychiatric Rehabilitation Programs.** The department is amending sections (5) and (6) of this rule.

*PURPOSE: This amendment updates staff qualifications for the ITCD program.*

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

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

1. A physician/physician extender (**physician extender includes licensed assistant physician, physician assistant, psychiatric resident, psychiatric pharmacist, and advanced practice registered nurse (APRN)**);

2. A registered professional nurse (**RN**);

3. A qualified mental health professional (**QMHP**);

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

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

*[A. A physician or QMHP who is licensed or provisionally licensed in Missouri; or*

*B. A person who is certified or registered as a QAP by the Missouri Credentialing Board.]*

**A. A physician or QMHP in Missouri or an individual who meets the applicable training and credentialing required by the Missouri Credentialing Board for any of the following accreditations (Qualified Addiction Professional):**

**(I) Certified Alcohol and Drug Counselor (CADC);**

**(II) Certified Reciprocal Alcohol and Drug Counselor (CRADC);**

**(III) Certified Reciprocal Advanced Alcohol and Drug Counselor (CRAADC);**

**(IV) Certified Criminal Justice Addictions Professional (CCJP);**

**(V) Registered Alcohol Drug Counselor-Provisional (RADCP);**

**(VI) Registered Alcohol Drug Counselor (RADC);**

**(VII) Co-Occurring Disorders Professional (CCDP); or**

**(VIII) Co-Occurring Disorders Professional-Diplomat (CCDP-D); and**

**B. The QMHP or QAP shall also have one (1) year of training or supervised experience in substance use disorder treatment. If they have less than one (1) year of experience in providing co-occurring disorder treatment, they shall be actively acquiring twenty-four (24) hours of training in co-occurring disorders content and receive supervision from experienced co-occurring disorders staff as approved by the department.**

(E) Only qualified staff shall provide integrated treatment for co-occurring disorder services. Qualified staff for each service are:—

1. Individual counseling, group counseling, and assessment, *[a licensed or provisionally licensed QMHP, an individual holding the Co-Occurring Disorders Professional or Co-Occurring Disorders Professional Diplomat credential, a non-licensed QMHP who meets the co-occurring counselor competency requirements established by the department; or] a QMHP, or a QAP who meets the co-occurring counselor competency requirements established by the department./.*; and

2. Group *[education]* **psychosocial rehabilitation services**, eligible providers shall have documented education and experience related to the topic presented and either be, or be supervised by, a QMHP or QAP who meets co-occurring counselor competency requirements established by the department.

(6) Treatment.

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

1. Co-occurring individual counseling. A structured goal-oriented therapeutic process in which an individual interacts *[on a face-to-face basis]* with a counselor in accordance with the individual's *[rehabilitation]* **treatment** plan in order to resolve problems related to the individual's documented mental and substance use disorders that interfere with functioning. Individual co-occurring counseling involves the use of practices such as motivational interviewing, cognitive behavioral therapy, harm reduction, and relapse prevention. Individual co-occurring counseling may include

*[face-to-face]* interaction with one (1) or more members of the individual's family or other natural supports for the purpose of assessment or supporting the individual's recovery;

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

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

4. Co-occurring assessment supplement. Individuals who present with both substance use and mental health identified service needs must receive additional assessments to document the co-occurring disorders and assess the interaction of the co-occurring disorders over time;

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

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

7. Other services as appropriate.

*AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo 2016. Original rule filed Sept. 2, 2008, effective April 30, 2009. Amended: Filed April 29, 2019, effective Nov. 30, 2019. Amended: Filed March 9, 2022.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to denise.thomas@dmh.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 9—DEPARTMENT OF MENTAL HEALTH Division 30—Certification Standards Chapter 4—Mental Health Programs

### PROPOSED AMENDMENT

**9 CSR 30-4.0432 Assertive Community Treatment (ACT) in Community Psychiatric Rehabilitation Programs.** The department is adding subsection (1)(A) and amending sections (5), (8), (9), and (12).

*PURPOSE: This amendment updates the types of ACT programs included in these regulations and staff qualifications for ACT.*

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

(A) These regulations apply to all ACT teams including specialized teams for women and children, transition-age youth, transition-age youth with behavioral health and developmental disabilities, transition-age youth with co-occurring disorders, and forensic assertive community treatment.

(5) Personnel and Staff Development. ACT shall be delivered by a transdisciplinary team (team) responsible for coordinating a comprehensive array of services. The team shall include, but is not limited to, the following disciplines:

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

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

2. A combination of a [psychiatrist, physician assistant, psychiatric resident, and an advanced practice nurse] physician/physician extender equaling sixteen (16) hours per week shall be available to no more than fifty (50) individuals (physician extender includes licensed assistant physician, physician assistant, psychiatric resident, psychiatric pharmacist, and advanced practice registered nurse (APRN)); or

3. In a service area designated as a Mental Health Professional Shortage Area, the psychiatrist, physician assistant, psychiatric pharmacist, assistant physician, or psychiatric resident shall be available ten (10) hours per week to no more than fifty (50) individuals; or an advanced practice registered nurse shall be available sixteen (16) hours per week to no more than fifty (50) individuals; **two prescribers working on the same team must include each prescriber working a minimum of eight (8) hours per week;**

(B) The ACT team prescriber shall attend at least two (2) team meetings per week either face-to-face or by teleconference;

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

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

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

2. A QAP who has less than one (1) year of experience in integrated treatment for co-occurring disorders shall be actively acquiring twenty-four (24) hours of training in that area and shall receive supervision from staff with experience in integrated treatment for co-occurring disorders;]

(E) A qualified co-occurring disorders specialist by being one (1) of the following:

1. A physician or QMHP in Missouri or an individual who meets the applicable training and credentialing required by the Missouri Credentialing Board for any of the following accreditations (QAP):

A. Certified Alcohol and Drug Counselor (CADC);

B. Certified Reciprocal Alcohol and Drug Counselor (CRADC);

C. Certified Reciprocal Advanced Alcohol and Drug Counselor (CRAADC);

D. Certified Criminal Justice Addictions Professional (CCJP);

E. Registered Alcohol Drug Counselor-Provisional (RADC-P);

F. Registered Alcohol Drug Counselor (RADC);

G. Co-Occurring Disorders Professional (CCDP); and

H. Co-Occurring Disorders Professional-Diplomat (CCDP-D); and

2. The QMHP or QAP shall also have one (1) year of training or supervised experience in substance use disorder treatment. **If they have less than one (1) year of experience in providing co-occurring disorder treatment, they shall be actively acquiring twenty-four (24) hours of training in co-occurring disorders content and receive supervision from experienced co-occurring disorders staff as approved by the department;**

(8) Admission Process.

(H) The team shall ensure the individual receiving services participates in the development of the treatment plan *[and signs the plan. The individual's parent/legal guardian also participates and signs the plan. The individual's signature is not required if signing would be detrimental to the individual's well-being. If the individual does not sign the treatment plan, the team shall insert a progress note in the case record explaining the reason the individual did not sign the treatment plan].*

(I) The team's physician/physician extender shall approve the treatment plan. A licensed psychologist, as a team member, may approve the treatment plan only *[in instances]* when the individual is currently receiving no prescribed medications **to treat a mental health condition** and the clinical recommendations do not include a need for prescribed medications **for a mental health condition**.

(9) Comprehensive Assessment and Treatment Planning.

(C) The comprehensive ACT assessment provides a guide for the team to collect information including the individual's history, including trauma history, past treatment, and to become acquainted with the individual and their family members. This assessment enables the team to individualize and tailor ACT services to ensure courteous, helpful, and respectful treatment. The comprehensive assessment includes, but is not limited to:

1. Psychiatric history, mental status, and diagnosis;
2. Physical health;
3. Use of drugs and/or alcohol;
4. Education and employment;
5. Social development and functioning;
6. Activities of daily living;
7. Family structure and relationships; and
8. Functional assessment approved by the department **for individuals whose diagnosis requires a functional score to support admission and if required by the department as part of the comprehensive assessment.**

(12) Records.

(E) The ACT team shall update the **treatment plan or** department-approved functional assessment every ninety (90) days to assess individual functioning, progress toward treatment objectives, and appropriateness of continued services. The treatment plan shall be revised and updated based on the findings from the functional assessment. Documentation in the individual record shall include, but is not limited to:

1. Barriers, issues, or problems identified by the individual, family, guardian, and/or team that identify the need for focused services;



2. A brief explanation of any change or progress in the daily living functional abilities in the prior ninety (90) days; and
3. A description of the changes for the plan of treatment based on information obtained from the functional assessment.

*AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo 2016. Original rule filed Aug. 14, 2009, effective March 30, 2010. Amended: Filed April 29, 2019, effective Nov. 30, 2019. Amended: Filed March 9, 2022.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to denise.thomas@dmh.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 9—DEPARTMENT OF MENTAL HEALTH  
Division 30—Certification Standards  
Chapter 4—Mental Health Programs**

**PROPOSED AMENDMENT**

**9 CSR 30-4.045 Intensive Community Psychiatric Rehabilitation (ICPR).** The department is amending sections (1)-(7) and (9), adding new section (10), and amending and renumbering remaining sections.

*PURPOSE: This amendment clarifies the intent of ICPR services as well as the related staffing requirements for this service.*

*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) Intensive Community Psychiatric Rehabilitation (ICPR). ICPR is separate and distinct from other community psychiatric rehabilitation (CPR) services. The individual treatment plan shall specify interventions and supports to be provided by ICPR staff that are separate from other CPR services (such as community support) to prevent duplication of services.

(A) Services are designed to help individuals who are experiencing a severe psychiatric condition, alleviating or eliminating the need to admit them into a psychiatric inpatient setting or a restrictive living setting. ICPR is a comprehensive, time-limited, community-based service for individuals who are exhibiting symptoms that interfere with individual/family life in a highly disabling manner.

(B) ICPR in all settings (children/youth and adult) must be approved by the department prior to implementation. Written proposals shall be submitted to the department in accordance with established protocol.

[(A)](C) ICPR is intended for—

1. Persons who would be hospitalized without the provision of intensive community-based intervention;

2. Persons who have extended or repeated hospitalizations;
3. Persons who have **psychiatric** crisis episodes;
4. Persons who are at risk of being removed from their home or school to a more restrictive environment; and
5. Persons who require assistance in transitioning from a highly restrictive setting to a community-based alternative, including specifically persons being discharged from inpatient psychiatric settings who **need intensive CPR services and may** require assertive outreach and engagement.

[(B)](D) Treatment teams deliver services that will maintain the individual within the family and significant support systems and assist them in meeting basic living needs and age appropriate developmental needs.

(2) Admission Criteria. To be eligible for ICPR, the individual must meet admission criteria as defined in 9 CSR 30-4.005 and at least one (1) of the following criteria:

(C) Has [had] **received services in** multiple out-of-home [placements] **residential settings** due to [his/her] **their** mental disorder; or

(D) Is at risk of being removed from [his/her] **their** home, school, or [current natural] **other community** living situation.

(3) Staff Requirements. [A treatment team coordinates a comprehensive array of services available to the individual through the CPR program.]

[(A) The treatment team is supervised by a qualified mental health professional (QMHP) and includes the following:

1. Staff required to provide specific services identified on the individualized treatment plan; and

2. The individual receiving services and family members or other natural supports if developmentally appropriate.]

Staff requirements for ICPR in residential settings are as follows:

(A) Intensive Residential Treatment Settings (IRTS) and Psychiatric Individualized Supported Living (PISL), in accordance with 9 CSR 40-1 and 9 CSR 40-4.001;

(B) Clustered apartments (CA). Staff shall be available on a full- or part-time basis in accordance with the agency's written proposal approved by the department;

1. Clustered apartment services are provided on-site. Staff providing services shall be located on site, within a five (5) mile radius of the CA, or within a ten (10) minute drive of the CA.

(C) Treatment Family Home-Based Services and Professional Parent Home-Based Services, as specified in section (7) of this rule and 9 CSR 40-6.001.

(4) Treatment for Children/Youth and Adults. All treatment teams shall be supervised by a qualified mental health professional (QMHP). The team coordinates a comprehensive array of services available to the individual through the CPR program as specified in 9 CSR 30-4.043. Other services shall be provided as clinically appropriate to meet individual needs, however, shall not duplicate services being provided on site. Each team shall include:

[(A) ICPR shall include—

1. Multiple face-to-face contacts with the individual on a weekly basis, and may require contact on a daily basis, as required for each service type;

2. Services that are available twenty-four (24) hours per day, seven (7) days per week; and

3. Crisis response services that may be coordinated with an existing crisis system.

(B) A full array of CPR services, as defined in 9 CSR 30-4.043, shall be available to each individual based upon individual need.]

(A) Staff required to provide specific services identified on the individualized treatment plan;

(B) The individual receiving services and family members or

other natural supports, if developmentally appropriate;

(C) ICPR shall include:

1. Multiple face-to-face contacts with the individual on a weekly basis, and may require contact on a daily basis, as required for each service type;

2. Services that are available twenty-four (24) hours per day, seven (7) days per week for programs that require daily services; and

3. Crisis response services that may be coordinated with an existing crisis system;

[(C)](D) The amount and frequency of services is based upon the individual's assessed acuity and need[.];

[(D)](E) A crisis prevention plan shall be developed for each individual, including clinical issues that may impact [his/her] transition to less intensive services[.];

(F) Regular treatment plan reviews shall occur to ensure individuals are receiving the appropriate level of services to meet needs and goals; and

[(E)](G) Individuals no longer need ICPR when—

1. There is a reduction of severe symptoms; and
2. They are able to function without intensive services; or
3. They choose to no longer receive intensive services.

(5) Documentation Requirements. ICPR services must be documented in accordance with 9 CSR 10-7.030(13), and as specified in this rule.

(A) For individuals currently enrolled in the CPR program, the following documentation is required upon admission to ICPR:

1. Verification they meet admission criteria;
2. Acuity level; and
3. Treatment plan update indicating the higher level of service [he/she] the individual will be receiving.

(B) For individuals newly admitted directly from the community into ICPR, a comprehensive behavioral health assessment must be completed to substantiate acuity and criteria for admission.

1. Each individual shall have a psychiatric evaluation at admission. For individuals discharged from inpatient hospitalization into ICPR, a psychiatric evaluation completed at the facility/hospital [will initially] may be initially accepted.

2. The comprehensive assessment must be completed within thirty (30) days of admission except for individuals admitted provisionally.

3. Treatment plans shall be developed upon admission and updated as necessary.

(6) ICPR for Children and Youth. Services are medically necessary to maintain a child with a Serious Emotional Disturbance (SED) in their natural home, or maintain a child with a serious mental illness or SED in a community setting who has a history of failure in multiple community settings, and/or the presence of ongoing risk of harm to self or others, which would otherwise require long-term psychiatric hospitalization. Clinical interventions are provided by a multidisciplinary treatment team on a daily basis, and the interventions must be available twenty-four (24) hours per day, seven (7) days per week for stabilization purposes. The child's family and other natural supports may receive services when they are for the direct benefit of the child in accordance with their individual treatment plan.

(A) When a child/youth is receiving this service, it is vital that the parent/guardian be actively involved in the program if the individual is to receive the full benefit of the program. Services shall be provided to the child/youth's family and other natural supports when such services are for the direct benefit of the individual, in accordance with their needs and treatment goals identified in the treatment plan, and for assisting in their recovery.

[(A)](B) Services shall include, but are not limited to[—]:

1. Medication administration/management of medication;
2. Ongoing behavioral health assessment and diagnosis;
3. Monitoring to assure individual safety;

4. Individual and group counseling; and

5. Community support.

[(B)](C) The ICPR multidisciplinary team must be supervised by a psychiatrist and shall include the following staff, based on the needs of the individual served:

1. Physician, psychiatrist, child psychiatrist, psychiatric resident, or Advanced Practice Registered Nurse (APRN);

2. QMHP;

3. RN;

4. LPN;

5. Community Support Specialist; and

6. Individuals with a high school diploma, or equivalent certificate, under the direction and supervision of a QMHP.

[(C)](D) Services are limited to ninety (90) days. Exceptions may be granted by the department and must be documented in the individual record.

(7) [Intensive Home-Based Services for Children and Youth] ICPR for Children/Youth in Residential Settings (Treatment Family Home-Based Services and Professional Parent Home-Based Services). Intensive therapeutic interventions are provided to improve the child's functioning and prevent them from being removed from their natural home and placed into a more restrictive residential treatment setting due to a SED.

(G) Placement, duration, and intensity of services is based on the specific needs of each child as specified in the MO HealthNet CPR Provider Manual, hereby incorporated reference and made a part of this rule and available from the Department of Social Services, 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500, and as specified in the department contract, September 2019. [The referenced document does not include any later revisions or updates.] This rule does not incorporate any subsequent amendments or additions to this publication.

(H) A maximum of three (3) children may receive services in a Treatment Family Home (TFH), subject to licensed capacity. One (1) child may be served in a Professional Parent Home (PPH).

(9) ICPR for Adults [and Transition-Age Youth] in Non-Residential Settings. Services are delivered by teams using one (1) of the following methods:

(F) Community support services shall not be provided while an individual is receiving ICPR non-residential services.

(10) ICPR for Transition Age Youth in Non-Residential Settings. Services are delivered by transdisciplinary specialty teams using intensive wrap-around stabilization for individuals with substantial mental health and/or co-occurring needs, with the primary diagnosis being a mental disorder.

(A) Services are for individuals who may otherwise require inpatient hospitalization. The period of engagement varies based upon individual needs as specified in the treatment plan.

(B) An initial comprehensive assessment must be completed within thirty (30) days of admission.

(C) An individual treatment plan shall be developed within forty-five (45) days of admission and shall be updated as required by the department.

[(10)](11) [Intensive Home-Based Services for Adults.] ICPR for Adults in Residential Settings (IRTS, PISL, Clustered Apartments). Medically necessary services/supports are provided to adults who have a serious mental illness and are transitioning from an inpatient psychiatric hospital to the community, or who are at risk of returning to inpatient care due to their clinical status or need for increased support. Services and supports are provided [in the individual's natural home,] on site where the individual lives under the supervision of a QMHP. [The home/program is] Residential settings are structured to meet individual needs to ensure safety and prevent the individual's return to a more restrictive setting for services.

(A) Staff providing services/supports must be at least eighteen (18) years of age and have a minimum of a high school diploma or equivalent certificate. Two (2) years of direct health care experience, or a bachelor's degree in behavioral sciences, is preferred.

(B) Staff must be systematically trained to provide intensive interventions and supports to reduce the symptoms of mental illness, and *[intervene and redirect]* **provide de-escalation and intervention techniques** to individuals in a psychiatric crisis who are exhibiting behaviors potentially dangerous to themselves or others. A training plan must be in place for each staff person identifying specific topics and frequency of refresher training on each topic, including documentation of course completion.

(C) Support and rehabilitation services related to activities of daily living and crisis prevention and intervention must be provided.

*[(D) CPR programs that provide services for adults must be approved by the department to provide intensive home-based services.]*

*[(E)](D)* Documentation must reflect delivery of direct (face-to-face) services and supports such as, daily summary progress notes, group notes, individualized progress notes documenting interventions including crisis assistance, conflict management, behavior redirection, and prompting or reminders.

*[(11)](12)* Children's Inpatient Diversion. A full array of intensive clinical services are provided to children/youth in a highly structured therapeutic setting. Services are designed to restore the child to a prior level of functioning, decrease risk of harm, and prevent transition to a more restrictive setting.

(A) Emergency medical services must be available on site or in close proximity.

(B) A psychiatrist must supervise services which are delivered by a multi-disciplinary treatment team.

(C) Licensed nursing staff must be available on a daily basis.

(D) Licensed occupational and recreational therapists must be available based on individual needs.

(E) The provision of services is limited to certified or deemed-certified CPR programs for children and youth. The service must be accredited by a national accrediting body approved by the department.

*[(12)](13)* Adult Inpatient Diversion. A full array of intensive clinical services are provided to adults in a highly supervised *[and]* **twenty-four (24) hour**, structured therapeutic setting. Services are designed to restore the individual to a prior level of functioning, decrease risk of harm, and *[prevent transition to a more restrictive setting]* **prepare for transition to a less restrictive setting.**

(A) Emergency medical services must be available on site or in close proximity.

(B) **Intensive therapeutic [S]**services must be provided in a coordinated effort under the direction of a psychiatrist. Other staff on the treatment team includes licensed nurses, licensed psychologists, social workers, counselors, psychosocial rehabilitation specialists, and other trained supportive staff.

(C) Services shall include, but are not limited to *[-]*:

1. Nursing;
2. Community support;
3. Psychosocial rehabilitation; and
4. **Treatment for [C]**co-occurring disorders *[counseling]* and other evidence-based services.

(D) The provision of services is limited to CPR programs for adults. The service must be accredited by a national accrediting body approved by the department.

**(E) The staffing ratio for daytime and evening hours shall be one staff to six individuals served (1:6), and one staff to eight individuals served (1:8) during nighttime hours.**

*AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo 2016. Emergency rule filed Dec. 28, 2001, effective Jan. 13, 2002, expired*

*July 11, 2002. Original rule filed Dec. 28, 2001, effective July 12, 2002. Emergency amendment filed June 14, 2010, effective July 1, 2010, expired Feb. 24, 2011. Amended: Filed June 14, 2010, effective Feb. 24, 2011. Amended: Filed April 29, 2019, effective Nov. 30, 2019. Amended: Filed March 9, 2022.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to [denise.thomas@dmh.mo.gov](mailto:denise.thomas@dmh.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 9—DEPARTMENT OF MENTAL HEALTH Division 30—Certification Standards Chapter 4—Mental Health Programs

### PROPOSED AMENDMENT

**9 CSR 30-4.046 Psychosocial Rehabilitation (PSR) in Community Psychiatric Rehabilitation Programs.** The department is amending sections (1) and (7).

*PURPOSE: This amendment updates terminology, adds 9 CSR 40-9 as being applicable to this regulation, and adds certified peer specialists as qualified staff.*

(1) The **Psychosocial Rehabilitation (PSR)** program must be accredited by CARF International, The Joint Commission, Council on Accreditation, or other accrediting body recognized by the department. If the *[Psychosocial Rehabilitation (PSR)]* program is not accredited, department licensure rules as specified in **9 CSR 40-1 and 9 CSR 40-9** shall apply, **as applicable.**

(7) PSR for Children and Youth. A combination of goal-oriented and rehabilitative services shall be provided in a group setting to improve or maintain the child's ability to function as independently as possible within their family and/or in the community. Services are provided according to the individual treatment plan, with an emphasis on community integration, independence, and resiliency. Hours of operation are determined by the program based on capacity, staffing availability, geography, and space requirements, but shall be no more than six (6) hours daily, per child.

(C) Other staff of the PSR team shall include the following, based on the needs of individuals served:

1. Registered nurse;
2. Occupational therapist;
3. Recreational therapist;
4. Rehabilitation therapist;
5. Community support specialist; *[and]*
6. Family *[assistance]* support worker*[-]*; and
7. **Certified peer specialist.**

*AUTHORITY: section 630.655, RSMo 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the Code of State Regulations. Amended: Filed March 9, 2022.*

*PUBLIC COST: This proposed amendment will not cost state agencies*

or political subdivisions more than five hundred dollars (\$500) in the aggregate.

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

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to [denise.thomas@dmh.mo.gov](mailto:denise.thomas@dmh.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 9—DEPARTMENT OF MENTAL HEALTH  
Division 30—Certification Standards  
Chapter 4—Mental Health Programs**

**PROPOSED AMENDMENT**

**9 CSR 30-4.190 Outpatient Mental Health Treatment Programs.**

The department is adding new section (3), renumbering as necessary, and amending new section (4).

*PURPOSE:* This amendment adds a requirement for obtaining consent to treatment from individuals served, updates terminology, and removes the requirement for obtaining the individual's signature on the treatment plan.

**(3) Consent to Treatment.** Each individual served or a parent/guardian must provide informed, written consent to treatment.

(A) A copy of the consent form, which must include the date of consent and signature of the individual served or a parent/guardian, shall be retained in the individual record.

(B) Consent to treat shall be updated annually, including the date of consent and signature of the individual served or a parent/guardian, and be maintained in the individual record.

[(3)](4) Services shall be provided under the direction of an individual treatment plan as specified in 9 CSR 10-7.030(4).

(A) An initial treatment [plan] goal shall be developed at intake to address immediate needs during the admission process to the outpatient treatment program.

(B) The admission assessment and [master] treatment plan shall be completed within the first three (3) outpatient visits.

1. Each individual shall participate in the development of [his/her] their treatment plan [and sign the plan unless signing would be detrimental to his or her well-being. Lack of the individual's signature must be explained in a progress note and included in the individual record].

2. For children and youth, the parent or guardian must participate in the development of the treatment plan and [sign the plan. Lack of parent/guardian signature must be explained in a progress note and included in the individual record] the child/youth shall participate, as appropriate.

[A. The child/youth is not required to sign the plan, however, the child/youth must participate in the development of the plan, as appropriate.]

(C) Treatment plans shall be reviewed and updated every ninety (90) days to reflect the individual's progress and changes in treatment goals and services.

(D) Treatment plans must be revised and rewritten at least annually to align with the annual assessment to reflect current needs and goals.

(E) Treatment plans shall be [developed and] approved by a licensed [mental health professional] diagnostician as defined in

**9 CSR 10-7.140.**

[(4)](5) Individual and group counseling must be delivered by a licensed mental health professional.

[(5)](6) Each agency shall maintain an organized clinical record system in accordance with 9 CSR 10-7.030(13) which ensures easily retrievable, complete, and usable records stored in a secure and confidential manner.

(A) Each agency shall implement written procedures to assure quality of individual records, including a routine review to ensure documentation requirements are being met.

*AUTHORITY:* sections 630.050 and 630.655, RSMo 2016. Original rule filed June 14, 1985, effective Dec. 1, 1985. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 29, 2019, effective Nov. 30, 2019. Amended: Filed March 9, 2022.

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

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

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to [denise.thomas@dmh.mo.gov](mailto:denise.thomas@dmh.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 13—DEPARTMENT OF SOCIAL SERVICES  
Division 65—Missouri Medicaid Audit and Compliance  
Chapter 2—Medicaid**

**PROPOSED AMENDMENT**

**13 CSR 65-2.020 Provider Enrollment and Application.** The department is amending sections (1)-(6) and (9), adding new sections (7), (11) and (12), and is renumbering accordingly.

*PURPOSE:* This amendment combines and clarifies the procedures found in this regulation and the procedure formerly found at 13 CSR 70-3.020, which is being rescinded. MO HealthNet providers will no longer have to look in two (2) locations to find Medicaid provider enrollment requirements. The amendment clarifies the circumstances under which the department may deny a provider's enrollment application or terminate the participation of an enrolled provider. Additionally, the regulation now mirrors federal Medicaid program integrity regulatory requirements that Missouri must follow as a condition of its federal Medicaid funding.

(1) Enrollment.

(C) [As required by 42 CFR Section 455.440, a]All claims for payment for items and services that were ordered, prescribed, or referred must contain the National Provider Identifier (NPI) of the provider who ordered, prescribed, or referred such items or services.

(D) All persons enrolled as MO HealthNet providers shall abide by the policies and procedures set forth in the MO HealthNet provider manual(s) applicable to the provider's provider type(s). The MO HealthNet provider manuals 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 the website [dss.mo.gov/mhd](http://dss.mo.gov/mhd), January

15, 2014] and available at <http://manuals.momed.com/manuals/>, August 20, 2021. This rule does not incorporate any subsequent amendments or additions. A MO HealthNet provider's breach of any MO HealthNet provider manual may result in imposition of sanctions, including but not limited to, termination.

(2) Applications.

(A) All applying providers shall have a valid e-mail address and shall submit an MMAC-approved application and any supplemental forms, information, and documentation required by MMAC for the appropriate provider type for which the person is applying.

(B) All information and documentation requested in the application and supplemental forms must be provided to MMAC prior to the application being considered and screening being conducted pursuant to this rule approved.

(C) Specific application instructions are modified as necessary for efficient and effective administration of the MO HealthNet Program as required by federal or state laws and regulations. Providers applying on or after the promulgation of this rule should refer to the appropriate MMAC provider bulletins and application filing instructions for specific application filing instructions and information, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Missouri Medicaid Audit and Compliance Unit, 205 Jefferson Street, Second Floor, Jefferson City, MO 65109, at its website [mmac.mo.gov](http://mmac.mo.gov), January 15, 2014] August 20, 2021. This rule does not incorporate any subsequent amendments or additions.

(D) The application shall include all information required in the mandatory disclosures pursuant to section (3) of this rule. Upon submission of any application(s), supplemental form(s), information and documentation requested in the application(s) and supplemental form(s), MMAC may, at its discretion, request additional or supplemental information and documentation from the applying provider prior to considering the application and/or conducting screening pursuant to this rule in order to clarify any information previously submitted and to verify that the provider meets all applicable requirements of state or federal laws and regulations.

(3) All providers, fiscal agents, managed care entities, and persons with an ownership or control interest in the provider are required to disclose as follows:

(A) The following disclosures are mandatory:

1. The name and address of the applying provider and any person(s) with ownership or control interest in the applying provider. The address for corporate entities must include the provider's primary business address, every business location, and each additional practice location(s), and any corresponding PO Box addresses;

2. Dates of birth and Social Security numbers (in the case of a corporeal person);

3. Other tax identification number(s) of any person with ownership or control interest in the applying provider or in any subcontractor in which the applying provider has a five percent (5%) or more interest;

4. Whether any person with ownership or control interest in the applying provider is related to another person with ownership or control interest in the applying provider as a spouse, parent, child, or sibling;

5. Whether any person with ownership or control interest in any subcontractor in which the applying provider has a five percent (5%) or more interest is related to another person with ownership or control interest in the applying provider as a spouse, parent, child, or sibling;

6. The name of any other provider(s) or applying provider in which an owner of the applying or enrolled provider has ownership or control interest; and

7. The name, address, date of birth, and Social Security number of any managing employee of the applying provider;

(B) Disclosures from any provider or applying provider are due at the following times, and must be updated within thirty-five (35) days of any changes in information required to be disclosed:

1. Upon the provider or applying provider submitting an application initial enrollment, reenrollment, or revalidation; and

2. Upon request of MMAC;

(C) Disclosures from fiscal agents are due at the following times:

1. Upon the fiscal agent submitting a proposal;

2. Upon request of MMAC;

3. Ninety (90) days prior to renewal or extension of a contract; and

4. Within thirty-five (35) days after any change in ownership of the fiscal agent;

(D) Disclosures from managed care entities (managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and health insuring organizations), except primary care case management programs, are due at the following times:

1. Upon the managed care entity submitting a proposal;

2. Upon request of MMAC; and

3. Ninety (90) days prior to renewal or extension of the contract; and

4. Within thirty (30) days after any change in ownership;

(F) All disclosures must be provided to MMAC. Disclosures not made to MMAC will be deemed non-disclosed and not in compliance with this section; and

(G) Consequences for Failure to Provide Required Disclosures. Administrative action(s) for failure to provide required disclosures.

1. Any person's failure to provide, or timely provide, disclosures pursuant to this section may result in deactivation, denial, rejection, suspension, or termination of the provider's participation in the MO HealthNet program. If the failure is inadvertent or merely technical, MMAC may choose not to impose consequences administrative actions if, after notice, the person provider promptly corrects the failure.

(4) Provider Revalidation.

(A) All enrolled MO HealthNet Program providers as of the effective date of this rule who are not on a closed-end provider agreement shall revalidate their enrollment as a MO HealthNet Program provider, on or before March 24, 2019, according to schedule as determined by MMAC, by submitting an MMAC-approved revalidation application, supplemental forms, information, and documentation requested by MMAC, along with any required application fee, hardship waiver request, or documentation showing that the provider has revalidated with Medicare or another state's Medicaid Program or CHIP within the previous twelve (12) months, if applicable.

(B)(A) All MO HealthNet Program providers shall revalidate their enrollment as with the MO HealthNet providers Division at least every five (5) calendar years from the effective date of the provider's most recently executed provider agreement, in order to remain a MO HealthNet provider. For example, a provider whose initial or revalidated provider agreement was effective on March 1, 2014] 2020, is required to revalidate his/her/its their enrollment no later than March 1, 2019] 2025. MMAC may request that the provider revalidate on an off-cycle revalidation period.

(C)(B) The MMAC-approved revalidation application, supplemental forms, information, and documentation requested by MMAC, along with the application fee and/or hardship waiver request, if applicable, shall be submitted no later than one hundred twenty (120) days prior to the expiration of the effective provider agreement.

(D)(C) Revalidating providers must comply with the requirements of this rule and will be subject to the screening process noted in this rule upon revalidation in order to have their applications

for revalidation approved.

*[(E) MMAC may request that the provider revalidate on an off-cycle revalidation period as a result of information obtained by MMAC indicating documented patterns of local health care fraud, national initiatives, complaints, or other reasons that cause MMAC to question the compliance of the provider with MO HealthNet Program.*

*(F) All MO HealthNet provider agreements with effective dates on or before the effective date of this rule shall be terminated by MMAC pursuant to the terms of the provider agreement, effective March 25, 2016, if the provider has not revalidated or begun the process of revalidation.]*

(5) Application Fee.

(A) An application fee, hardship waiver request, and/or an exemption reason **provided in this rule** must accompany every *[institutional] organizational* provider's application.

(C) Failure to submit the application fee in *[the form of a cashier's check, money order, or electronic payment acceptable to MMAC for the]* **an acceptable form and/or for the correct amount [will]** may result in the return of the fee to the provider and rejection of the application.

(D) Applying *[providers]* and *[MO HealthNet]* **revalidating** providers *[that are revalidating with the Missouri Medicaid Audit and Compliance Unit (MMAC)]* must submit an application fee, *[subject to the requirements of 13 CSR 65-2.020. The application fee is]* determined as follows:

1. As of the effective date of this rule for calendar year *[2015]* **2021**, five hundred *[fifty-three dollars (\$553)]* **ninety-nine dollars (\$599.00)**; and

2. For calendar year *[2016]* **2022** and subsequent years—

A. The amount of the application fee shall be the amount for the preceding year adjusted by the percentage change in the consumer price index for all urban consumers for the twelve- (12-) month period ending with June of the previous year as published by the Bureau of Labor Statistics of the United States Department of Labor *[If the adjustment sets the fee at an uneven dollar amount, MMAC will round the fee to the nearest whole dollar amount; and].*

*[B. The application fee will be effective from January 1 to December 31 of a calendar year.]*

*[(E) An institutional provider shall submit provider type for which the institutional provider is applying. If an application is denied and the institutional provider submits another application, an additional application fee shall be included with each, all, and every subsequent application.]*

*[(F)](E) If MMAC determines that a person [as defined herein] is [considered to be] an [institutional provider as defined herein] **organizational provider**, that person is required to pay the application fee.*

*[(G)](F) Exemptions from Application Fee. [Providers who are enrolled in, and paid the application fee required by CMS for Medicare or another state's Title XIX or Title XXI program within two (2) years of the date the application to enroll as a MO HealthNet Provider shall be exempt from paying an application fee. Providers seeking an exemption from the application fee are responsible for notifying MMAC, in writing, that they qualify for exemption and for providing proof of such qualification.] MMAC may waive the application fee under the following conditions:*

1. Providers who are enrolled in and paid the application fee required by CMS for Medicare or another state's Title XIX or Title XXI program within two (2) years of the date the application to enroll as a MO HealthNet Provider shall be exempt from paying an application fee;

2. MMAC, in consultation with other state of Missouri departments, divisions, and units, determines that imposition of the application fee would impede Missouri Medicaid partici-

pants' access to care;

3. A provider is submitting a provider application as a result of a national or state public health emergency situation as lawfully declared by a federal or state authority; and

4. The provider is owned and operated by the state of Missouri or an agency of the state of Missouri.

(G) Providers seeking an exemption from the application fee are responsible for notifying MMAC, in writing, that they qualify for exemption and for providing proof of such qualification.

(6) Hardship Waiver Request.

*[(A) Institutional providers may submit application fee hardship waiver requests when submitting their initial enrollment applications, their revalidation applications, and their applications to establish new practice locations.*

*(B) A hardship waiver request may be granted if any of the following exists:*

1. The provider demonstrates, via authenticated financial and legal records, hardship and MMAC, at its discretion, determines that imposition of the application fee would result in a hardship for the provider subject to the following requirements:

A. All records submitted in support of a hardship waiver must be authenticated by an affidavit signed under oath by the applying provider's or provider's owner(s) and chief financial officer or chief executive officer. Records not meeting this requirement shall not be considered as evidence of hardship;

B. Providers applying for hardship waivers must permit, upon request, MMAC to inspect the provider's financial records and other records MMAC deems relevant to MMAC's determination of whether hardship exists, including, but not limited to, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, and tax returns. Any provider who does not permit MMAC to inspect such records upon MMAC's request shall be denied a hardship waiver. Any provider who is denied a hardship waiver request based upon the provider's failure to permit MMAC to inspect the provider's financial records and any other records MMAC deems relevant to MMAC's determination of whether a hardship exists, shall not be eligible for a waiver under paragraph (6)(B)1. for a period of five (5) years from the date of MMAC's letter notifying the provider that its hardship waiver request was denied due to the provider's failure to permit MMAC to inspect the provider's records; and

C. A provider who is granted a hardship waiver pursuant to paragraph (6)(B)1. shall not be granted a second waiver based upon paragraph (6)(B)1. for a period of five (5) years from the date of MMAC's letter notifying the provider that its most recent paragraph (6)(B)1. waiver request was granted;

2. MMAC, in consultation with other state of Missouri departments, divisions and units, determines that imposition of the application fee would impede Missouri Medicaid participants' access to care;

3. A provider is submitting a provider application as a result of a national or state public health emergency situation as lawfully declared by a federal or state authority; and

4. The provider is owned and operated by the state of Missouri or an agency of the state of Missouri.

(C) Application fee hardship waiver requests shall be considered by MMAC on a case-by-case basis.

(D) Application fee hardship waiver requests are subject to approval by CMS.]

(A) Providers can request a hardship waiver of the application fee from the Centers for Medicare and Medicaid (CMS) when submitting their initial enrollment application or a revalidation

application, but the request must be received by MMAC before the application will be processed by MMAC. A hardship waiver request will not be considered if it is received by MMAC after MMAC approves the application or revalidation. If CMS approves the hardship waiver, MMAC will refund the application fee to the provider.

(B) A provider that requests a hardship waiver must submit a letter and supporting documentation that describes the hardship and why the hardship justifies an exception, including providing comprehensive documentation (which may include, but is not limited to, historical cost reports, recent financial statements such as balance sheets and income statements, cash flow statements, or tax returns).

(C) Factors that may suggest a hardship exception is appropriate include, but are not limited to, the following:

1. Considerable bad debt expenses;
2. Significant amount of charity care/financial assistance furnished to patients;
3. Presence of substantive partnerships with those who furnish care to a disproportionately low-income population;
4. Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments; or
5. Whether the provider is enrolling in a geographic area that is a presidentially-declared disaster area under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.

(D) Upon receipt of a hardship waiver request with an application, MMAC will send the request and all accompanying documentation to CMS. CMS will determine if the request should be approved. CMS will communicate its decision to the institutional provider and MMAC via letter.

(7) Appeal of the Denial of a Hardship Waiver Request. A provider may file a written reconsideration request with CMS within sixty (60) calendar days from the date of the notice of initial determination. The request must be signed by the individual provider, a legal representative, or any authorized official within the entity. The procedures for submitting an appeal will be provided on the denial letter from CMS.

((7))(8) MMAC shall use the application fee to offset the costs associated with the provider screening program in its entirety. This includes, but is not limited to, the following:

(A) Implementation and augmentation of MMAC's provider enrollment system; and

(B) Any other administrative costs related to the provider screening program, which include costs associated with processing fingerprints and conducting criminal background checks. The application fee does not cover the cost associated with capturing fingerprints and a provider may be charged additional costs for this purpose in addition to the application fee.

((8))(9) Refund of the Application Fee.

(A) If an institutional provider is granted a hardship exception pursuant to this rule or if the application is rejected because it was not properly signed or is missing other information required to be provided on the application itself, and an application fee was included with the application and the hardship waiver request, the application fee shall be returned to the applying provider.

(B) Once the screening process has begun, regardless whether the application goes through part or all of the screening process, the application fee is non-refundable.

((9))(10) Screening.

(A) The screening requirements contained in this section apply to all applying providers and to all persons disclosed, or required to be disclosed, in the application.

(B) MMAC shall conduct pre-enrollment screening and post-

enrollment monthly screenings. Screenings *[shall]* may include the following:

1. Screening pursuant to 42 CFR sections 455.410(a), and (b);, 42 CFR 455.412;,, 42 CFR 455.432;,, 42 CFR 455.436;,, and 42 CFR 455.452;

2. Screening to ensure that the providers meet all enrollment criteria for their provider type;

3. **Announced or [U]nannounced** pre- and post-approval site visits; and

4. For screening purposes, utilization of databases and other sources of information to prevent enrollment of *[non-existent]* fictitious providers, to ensure that spurious applications are not processed, and to prevent fraud, waste, and abuse in the MO HealthNet Program.

*[(C)] The screening procedures and requirements in this rule shall be implemented as of the effective date of this rule.*

*[(D)](C) The [new] screening procedures and requirements [will be] are applicable to all enrolled [MO HealthNet Program] or applying providers [and applying providers as of the effective date of this rule]. All [enrolled MO HealthNet] providers are required [to revalidate according to the schedule of revalidation. After being screened pursuant to this rule, MO HealthNet Program providers will be required] to revalidate their MO HealthNet enrollment(s) at least every five (5) years [from the date of their most recent revalidation].*

*[(E)] Upon the effective date of this rule, no provider shall be allowed to enroll or revalidate in the MO HealthNet Program without being screened pursuant to this rule. On or before March 25, 2016, all providers in, and applying providers to, the MO HealthNet Program shall be screened pursuant to this section. By operation of law, any provider who has not been screened pursuant to this section on or before March 25, 2016, shall have his/her/its provider number deactivated at 5:00 p.m. on March 25, 2016. Such deactivation shall remain in effect until the provider or applying provider has been screened pursuant to this rule.]*

*[(F)](D) The following screening categories are established for MO HealthNet providers, as required by federal law and regulation for Medicare and Medicaid providers under 42 CFR section 424.518 and section 1902(kk)(1) of the Social Security Act. There are three (3) levels of screening: limited, moderate, and high. Each provider type is assigned to one (1) of these screening levels. If a provider could fit within more than one (1) screening level described in this section, the highest risk category of screening is applicable.*

1. Limited Risk Category.

A. The following providers pose a limited risk of fraud, waste, and abuse to the MO HealthNet Program and are subjected to limited category screening:

(I) Physicians[, dentists,] or non-physician practitioners (except as otherwise listed in another risk category) and medical groups or clinics *[with the exception of physical therapists and physical therapy(ist) groups];*

(II) Ambulatory surgical centers (ASCs);

(III) Competitive acquisition program/Part B vendors;

(IV) End-stage renal disease (ESRD) facilities;

(V) Federally qualified health centers (FQHCs);

(VI) Histocompatibility laboratories;

**(VII) Home infusion therapy suppliers;**

*[(VII)](VIII) Hospitals, including critical access hospitals (CAHs);*

*[(VIII)](IX) Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act *[(IHS)];**

*[(IX)](X) Mammography screening centers;*

[(X)](XI) Mass immunization roster billers;  
**(XII) Opioid treatment programs (if 42 CFR 424.67(b)(3)(ii) applies);**  
 [(X1)](XIII) Organ procurement organizations (OPOs);  
 [(XII)](XIV) Pharmacies;  
 [(XIII)] *Religious nonmedical health care institutions (RNHCs);*  
 (XIV) *Rural health clinics (RHCs);*  
 (XV) Radiation therapy centers (RTCs);  
**(XVI) Religious nonmedical health care institutions (RNHCs);**  
**(XVII) Rural health clinics (RHCs); and**  
 [(XVI)] (XVIII) Skilled nursing facilities (SNFs).  
 [(XVII)] *Occupational therapists;*  
 (XVIII) *Speech language pathologists;*  
 (XIX) *Rehabilitation agencies; and*  
 (XX) *Community mental health centers (CMHCs)*

B. The providers in the limited category are subject to the following screening requirements:

(I) Verification that the applying provider, and all persons disclosed or required to be disclosed, meet all applicable federal regulations and MO HealthNet Program requirements for the provider type;

(II) Verification that the applying provider, and all persons disclosed, have a valid license, operating certificate, or certification if required for the provider type, and that there are no current limitations on such licensure, operating certificate, or certification which would preclude enrollment;

(III) Verification that the applying provider's, and that of all persons disclosed, license(s) held in any other state has/have not expired and that there is/are no current limitations on such license(s) which would preclude enrollment;

(IV) Confirmation of the identity of the applying provider and determination of the exclusion status of the applying provider and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of the following federal databases:

- (a) Social Security Administration's Death Master File;
- (b) National Plan and Provider Enumeration System;
- (c) List of Excluded Individuals/Entities;
- (d) The Excluded Parties List System;
- (e) Medicare Exclusion Database; and

[(f) *Department of the Treasury's Debt Check Database; and*

[(g) *Department of Housing and Urban Development's (DHUD) Credit Alert System or Credit Interactive Voice Response System;*

(f) Any such other databases as the Secretary of the United States Department of Health and Human Services has prescribed as of September 30, 2021, pursuant to section 455.436 of Title 42, *Code of Federal Regulations*, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 7 G Street NW, Suite A-734, Washington, DC 20401, and available at its website <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.436>. This rule does not incorporate any subsequent amendments and additions.

[(V) *Database checks of the Missouri Department of Revenue;*

[(VI)](V) Database check of the National Sex Offender Public Website;

[(VIII)](VI) The information from these databases shall be used to determine eligibility of the MO HealthNet provider and for verification of[: ] the identity of the applying person[: ], the Social Security number[: ], the National Provider Identifier (NPI)[: ], the National Practitioner Data Bank (NPDB) licensure[: ], and any exclusion by the Department of Health and Human Services, Office of Inspector General; [the taxpayer identification number; any Missouri tax delinquencies and death of the applying

provider and all other persons disclosed in the applications and supplemental forms;] and

[(VIII)](VII) MMAC may conduct preapproval site visits prior to acceptance of an applying provider's application.

2. Moderate Risk Category[: ].

A. The following providers pose a moderate risk of fraud, waste, and abuse to the MO HealthNet Program and are subject to moderate screening requirements:

[(I)] *Comprehensive outpatient rehabilitation facilities (CORFs);*

[(II)] *Hospice organizations;*

[(III)] *Independent diagnostic testing facilities (IDTFs);*

[(IV)] *Independent clinical laboratories;*

[(V)] *Ambulance service suppliers;*

[(VI)] *Physical therapists including physical therapy groups;*

[(VII)] *Portable x-ray suppliers;*

[(VIII)] *Revalidating home health agencies;*

[(IX)] *Revalidating durable medical equipment providers;*

[(X)] *Adult day care waiver providers;*

[(XI)] *Personal care providers, including providers billing under the Consumer Directed Services program;*

[(XII)] *Entities established under sections 205.968-205.973, RSMo;*

[(XIII)] *Prosthetics, orthotics, and supplies suppliers (DMEPOS) (this includes an existing pharmacy durable medical equipment supplier that seeks to add a new DMEPOS supplier store, new practice locations, and those that are owned by occupational or physical therapists); or*

[(XIV)] *Non-emergency transportation providers; and*

**(I) Adult Day Care providers (ADCs);**

**(II) Ambulance service suppliers;**

**(III) Community Mental Health Centers (CMHCs);**

**(IV) Comprehensive outpatient rehabilitation facilities (CORFs);**

**(V) Entities established under sections 205.968-205.973, RSMo;**

**(VI) Hospice organizations;**

**(VII) Independent clinical laboratories (ICLs);**

**(VIII) Independent diagnostic testing facilities (IDTFs);**

**(IX) Non-emergency transportation providers (NEMTs);**

**(X) Personal care providers, including providers billing under the Consumer Directed Services program;**

**(XI) Physical therapists including physical therapy groups;**

**(XII) Portable x-ray suppliers (PXSs);**

**(XIII) Revalidating Diabetes Prevention Program providers (DPPs);**

**(XIV) Revalidating durable medical equipment suppliers (DMEPOS);**

**(XV) Revalidating home health agencies (HHAs); and**

**(XVI) Revalidating opioid treatment programs.**

B. In addition to the screening requirements for the limited risk category in paragraph [(9)](F)](10)(D)1., the providers in the moderate risk category shall be subject to [pre-approval] site visits prior to acceptance of an applying provider's application and are additionally subject to unannounced [pre- and] post-enrollment site visits[-].

[(I)] *To determine and ensure that the provider is operational at the practice location found on the enrollment application. For these purposes, "operational" means the provider has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicaid claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider specialty, or the services or items being rendered), to furnish these items or services; and*



(II) To verify established provider standards or performance standards other than conditions of participation subject to survey and certification by MMAC, where applicable, to ensure that the provider remains in compliance with program requirements.]

3. High Risk Category.

A. The following providers pose a high risk of fraud, waste, and abuse to the MO HealthNet Program and are subject to high risk screening requirements:

(I) [Prospective (newly enrolling)] Newly enrolling or reenrolling home health agencies; [and]

(II) [Prospective (newly enrolling)] Newly enrolling or reenrolling Durable Medical Equipment, Prosthetic, Orthotic, and Supplies (DMEPOS) suppliers; [and]

(III) Newly enrolling or reenrolling DPP suppliers; and

(IV) Newly enrolling or reenrolling opioid treatment programs that have not been fully and continuously certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) since October 23, 2018.

B. In addition to the screening requirements for the limited and moderate risk [category] categories in paragraphs [(9)(F)](10)(D)1. and 2. of this rule, [and for the moderate risk category in paragraph (9)(F)2. of this rule,] the providers [in the high risk category] and their owners must submit to, or subject individuals with ownership or control interests to, a fingerprint-based criminal history report check of the Federal Bureau of Investigations (FBI) Integrated Automated Fingerprint Identification System—

(I) A revalidating provider who has already submitted fingerprints once will not be required to submit fingerprints a second time unless required by FBI protocols;

(II) Pursuant to 42 CFR section 455.434(b), the provider is responsible for the cost of [taking] supplying the fingerprints [and supplying the fingerprints,] and the state and federal government will share the cost of the processing of the fingerprints and the background check; and

(III) This fingerprint-based criminal history report check applies to all persons in this risk category applying to be a provider (whether as a billing or performing provider), or an individual with a five percent (5%) or greater direct or indirect ownership interest in such provider, or a managing employee[;].

[(G)](E) MMAC must adjust the categorical risk level from “limited” or “moderate” to “high” when any of the following occurs:

1. MMAC imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse by the provider; the provider has an existing Medicaid overpayment; or the provider has been excluded by the Department of Health and Human Services, Office of Inspector General or another state’s Medicaid program within the previous ten (10) years. The upward adjustment of the provider’s categorical risk level for a payment suspension or overpayment shall continue only so long as the payment suspension or overpayment continues; or

2. MMAC or CMS in the previous six (6) months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six (6) months from the date the moratorium was lifted.

[(H)](F) If a person has been screened by Medicare or by another state Medicaid agency and paid Medicare or another state Medicaid agency’s application fee, within two (2) years of the date of the application to MMAC, such person will not be subject to the screening requirements or application fee provided for by this rule except those screening requirements and application fee imposed pursuant to subsection [(G)](E) of this section.

[(I)](G) Any MO HealthNet Program provider not categorized by this regulation as within the limited, moderate or high risk category shall be a considered moderate risk and screened as a moderate risk.

[(J)](H) MMAC may request and consider additional information or documentation related to the eligibility criteria, if at any time dur-

ing the application process it appears that[;] the enrollment application or supporting documentation is inaccurate, incomplete, or misleading; or it appears the applying person may be ineligible to become a MO HealthNet provider.

(11) The provider shall advise MMAC, in writing, on enrollment forms specified by MMAC, of any changes affecting the provider’s enrollment records within ninety (90) days of the change, with the exception of change of ownership or control of any provider which must be reported within thirty (30) days.

(A) The Provider Enrollment Unit within MMAC is responsible for determining whether a current MO HealthNet provider record shall be updated or a new MO HealthNet provider record is created. A new MO HealthNet provider record is not created for any changes, including but not limited to change of ownership, change of operator, tax identification change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations. This includes replacement facilities, whether they are at the same location or a different location, and whether the Medicare number is retained or if a new Medicare number is issued. A provider may be subject to administrative action if information is withheld at the time of application that results in a new provider number being created in error. The division shall issue payments to the entity identified in the current MO HealthNet provider enrollment application. Regardless of changes in control or ownership, MMAC shall recover from the entity identified in the current MO HealthNet provider enrollment application liabilities, sanctions, and penalties pertaining to the MO HealthNet program, regardless of when the services were rendered.

(12) MO HealthNet provider identifiers shall not be released to any non-governmental entity, except the enrolled provider, by the MO HealthNet Division or its agents.

[(10)](13) The provisions of this rule are declared severable. If any provision of this rule is held invalid by a court of competent jurisdiction, the remaining provisions of this rule shall remain in full force and effect, unless otherwise determined by a court of competent jurisdiction to be invalid.

[(11)](14) Except to the extent inconsistent with this rule, the requirements of [13 CSR 70-3.020 and] 13 CSR 70-3.030 remain in force, including any provisions regarding denial of applications and termination, until those provisions are rescinded.

*AUTHORITY: sections 208.159 and 660.017, RSMo [2000] 2016. Original rule filed Dec. 12, 2013, effective July 30, 2014. Amended: Filed May 26, 2015, effective Nov. 30, 2015. Emergency amendment filed March 11, 2022, effective March 30, 2022, expires Sept. 26, 2022. Amended: Filed March 11, 2022.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2110—Missouri Dental Board  
Chapter 2—General Rule**

**PROPOSED AMENDMENT**

**20 CSR 2110-2.120 Dental Assistants.** The board is amending subsection (4)(A) and sections (5) and (7).

*PURPOSE: This amendment updates terminology and clarifies and increases the duties that can be delegated to an Expanded Function Dental Assistant (EFDA).*

(4) Expanded Functions Permits.

(A) Effective December 1, 2012, a currently licensed dentist may delegate, under direct supervision, functions listed in *[subsection (4)(H)] section (5)* of this rule to a dental assistant possessing a board-issued permit authorizing the dental assistant to perform expanded functions duties. To qualify for a board-issued permit to perform expanded functions duties, the dental assistant must provide the board with the following:

1. Proof of certification as a certified dental assistant from the Dental Assisting National Board and proof of competence as defined in subsection (1)(I) showing graduation from an accredited dental assisting program in which competency testing in the appropriate expanded functions category was completed; or

2. Proof of certification as a certified dental assistant from the Dental Assisting National Board and proof of competence as defined in subsection (1)(I) showing the dental assistant has completed a board-approved expanded functions training course; or

3. Proof of competence as defined in subsection (1)(I) showing that the dental assistant has passed the board's Missouri Test of Basic Dental Assisting Skills and that the dental assistant has completed a board-approved expanded functions training course; and

4. Evidence of current certification in the American Heart Association's Basic Life Support for the Healthcare Provider (BLS), or an equivalent certification approved by the Missouri Dental Board. Board-approved courses shall meet the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care (ECC) and provide written and manikin testing on the course material by an instructor who is physically present with the students. Online only courses will not be accepted to satisfy the BLS requirement.

(5) Categories.

(A) Functions delegable to a dental assistant possessing a board-issued permit to perform expanded functions are divided into five (5) categories; restorative I, restorative II, removable prosthodontics, fixed prosthodontics, and orthodontics and are listed below by category.

1. Restorative I—

A. Sizing and cementing of prefabricated crowns;

B. Placing, condensing, *[and]* carving, **and finishing** amalgam for Class I, V, and VI restorations;

C. Placing **and finishing** composite for Class I, V, and VI restorations; and

D. Minor palliative care of dental emergencies (place sedative filling).

2. Restorative II—

A. Sizing and cementing of prefabricated crowns;

B. Placing, condensing, carving, and finishing amalgam for Class I, II, III, IV, V, and VI restorations;

C. Placing and finishing composite for Class I, II, III, IV, V, and VI restorations; and

D. Minor palliative care of dental emergencies (place sedative filling).

3. Orthodontics—

A. Preliminary bending of archwire;  
B. Removal of orthodontic bands and bonds;  
C. Final cementation of any permanent **orthodontic** appliance or prosthesis;

D. Making impressions for the fabrication of any *[removable or fixed]* **orthodontic** prosthesis/appliance; and

E. Placement and cementation of orthodontic brackets and/or bands.

4. Prosthodontics—Fixed—

A. *[Place retraction cord in preparation for fixed prosthodontic impressions]* **Apply tissue retracting material prior to impression of a fixed prosthesis;**

B. Extra-oral adjustments of fixed prosthesis;

*[C. Extra-oral adjustments of removable prosthesis during and after insertion;]*

*[D.]C.* Final cementation of any permanent appliance or prosthesis; *[and]*

*[E.]D.* Making impressions for the fabrication of any removable or fixed prosthesis/appliance.; **and**

**E. Sizing and cementing of prefabricated crowns.**

5. Prosthodontics—Removable—

A. Placement of temporary soft liners in a removable prosthesis;

B. Extra-oral adjustments of removable prosthesis during and after insertion; **and**

*[C. Minor palliative care of dental emergencies (place sedative filling); and]*

*[D.]C.* Making impressions for the fabrication of any removable or fixed prosthesis/appliance.

(7) Delegated Acts.

(A) A currently licensed dentist may delegate under direct supervision to a dental assistant or certified dental assistant any functions not specifically referenced in section/s *(2)–(4)/(5)* of this rule and not considered either the practice of dentistry or the practice of dental hygiene as defined in sections 332.071 and 332.091, RSMo, and *[4 CSR 110-2.130]* **20 CSR 2110-2.130.**

*AUTHORITY: sections 332.011, 332.031.2., and 332.098, RSMo 2016. This rule originally filed as 4 CSR 110-2.120. Original rule filed Dec. 12, 1975, effective Jan. 12, 1976. For intervening history, please consult the Code of State Regulations. Amended: Filed March 8, 2022.*

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

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

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

**Title 20—DEPARTMENT OF COMMERCE AND  
INSURANCE**

**Division 2210—State Board of Optometry  
Chapter 2—General Rules**

**PROPOSED AMENDMENT**

**20 CSR 2210-2.030 License Renewal.** The board is amending subsection (10)(C).

*PURPOSE: This proposal adds additional providers to the list of board approved continuing education providers.*

(10) The following guidelines govern the attendance of educational optometric programs for license renewal:

(C) Educational programs that currently are approved, except as noted in subsection (10)(B), as meeting the minimum standards[,] include the following:

1. Educational meetings of the American Optometric Association (AOA);
2. Educational meetings of the National Optometric Association (NOA);
3. Educational meetings of the Missouri Optometric Association or any other state or regional optometric association affiliated with the American Optometric Association. This excludes local society meetings unless the courses are approved by an entity pursuant to this rule;
4. Scientific sections and continuing education courses of the American Academy of Optometry;
5. Postgraduate courses offered by any accredited college of optometry;
6. Educational meetings of the Southern Council of Optometrists;
7. Educational meetings approved by the COPE;
8. Educational meetings of the North Central States Optometric Council;
9. Educational meetings of the Heart of America Optometric Congress and the Heart of America Contact Lens Society;
10. Educational meetings of the College of Optometrists in Vision Development;
11. Educational meetings of the Optometric Extension Program; *[and]*
12. Optometric related meetings of any accredited school of medicine; **and**
- 13. Continuing education courses by the American Board of Optometry;**

*AUTHORITY: sections 336.080 and 336.160.1, RSMo Supp. [2020] 2021. This rule originally filed as 4 CSR 210-2.030. Original rule filed Dec. 19, 1975, effective Dec. 29, 1975. For intervening history, please consult the Code of State Regulations. Amended: Filed March 3, 2022.*

*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 Board of Optometry, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-8216, or via email at [optometry@pr.mo.gov](mailto:optometry@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

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

**T**he agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety-(90-) day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

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

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under sections 161.092 and 162.675, RSMo 2016, and section 162.720, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 20-100.110 Programs for Gifted Children is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2021 (46 MoReg 2242). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** The Department of Elementary and Secondary Education (department) received two (2) comments on this proposed amendment.

**COMMENT #1:** Two (2) people, Jennifer Hawkins, gifted education specialist, and Meredith Burstin Wisniewski, President of the Gifted Association of Missouri, commented in support of the amendment. **RESPONSE:** The department is appreciative of the two (2) individuals who volunteered their time to review the proposed amendment and voice their support. No change has been made to the proposed amendment because of these comments.

**Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION  
Division 20—Division of Learning Services  
Chapter 400—Office of Educator Quality**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under sections 161.092, 168.011, 168.071, and 168.081, RSMo 2016, and section 168.021, RSMo Supp. 2021, the board amends a rule as follows:

5 CSR 20-400.230 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2021 (46 MoReg 2242-2245). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** The Department of Elementary and Secondary Education (department) received a total of two (2) comments on this proposed amendment.

**COMMENT #1:** The department, in reviewing this proposed amendment, determined that clarifying language concerning its procedure for automatic revocations was necessary. The clarification includes the process by which a certificate holder is notified if his or her certificate is subject to automatic revocation, how a hearing may be obtained, and when the revocation becomes effective.

**RESPONSE AND EXPLANATION OF CHANGE:** The department has modified the amendment as proposed by adding a new section (6) and renumbering accordingly.

**COMMENT #2:** The department, in reviewing this proposed amendment, determined that clarification is necessary in paragraphs (3)(C)3. and 4. to ensure clear interpretation.

**RESPONSE AND EXPLANATION OF CHANGE:** The department has modified the amendment as proposed by updating paragraphs (3)(C)3. and 4.

**5 CSR 20-400.230 Discipline of Certificates of License to Teach**

(3) Complaints and Appeals.

(C) All complaints and appeals must—

- 1. Be in writing;
- 2. Include:

A. The full name, address, email address, and telephone number of the person or agency bringing the action (petitioner), and any attorney representing the petitioner;

B. The full name, address(es), email address(es), and telephone number(s) of the certificate holder (if known);

C. Suitable space in the caption for the board to affix a case number;

D. A written description of the specific conduct for which discipline is sought and a citation to the law and rules allegedly violated, or in the case of an appeal, the specific grounds for the appeal; and

E. As far as practical, facts in numbered paragraphs stating the relief sought and the reason for granting it; however, the failure to include facts in numbered paragraphs shall not be reason for involuntary dismissal of a complaint or appeal;

3. Be signed by petitioner or petitioner's legal counsel; and

4. Be mailed to DESE Counsel, Department of Elementary and Secondary Education, PO Box 480, Jefferson City, MO 65102-0680

or emailed to Counsel@dese.mo.gov.

(6) Mandatory Revocation.

(A) In the event a certificate holder has been found guilty of any of the offenses as described in section 168.071.6(1)-(4), RSMo, his or her certification shall be revoked, whether or not sentence is imposed.

(B) The department will notify certificate holders who are subject to mandatory revocation by certified mail, by personal delivery, or by email. The department will:

1. Include a copy of the court record showing the offense that is the basis of the revocation in its revocation notice to the certificate holder;

2. Inform the certificate holder that mandatory revocation will be effective thirty (30) days from the date of the notice of revocation in its revocation notice to the certificate holder;

3. Inform the certificate holder that they may submit written documentation, including a written statement, to the department within fifteen (15) days of the date of the notice of revocation, which challenges whether the certificate holder is the person found guilty of the qualifying offense, and/or whether the offense for which the certificate holder was found guilty is an offense described in section 168.071.6, RSMo, in its revocation notice to the certificate holder. The certificate holder shall file such documentation with the department by mail addressed to DESE Counsel, Department of Elementary and Secondary Education, PO Box 480, Jefferson City, MO 65102-0480 or to Counsel@dese.mo.gov. The department will send its decision by certified mail to the certificate holder prior to the effective date of the revocation.

4. Inform the certificate holder that they may request an in-person hearing to appeal the revocation within ninety (90) days of the effective date of the revocation. The notice shall advise certificate holders that the request for hearing must be filed by mailing the request to DESE Counsel, Department of Elementary and Secondary Education, PO Box 480, Jefferson City, MO 65102-0480 or to Counsel@dese.mo.gov in its revocation notice to the certificate holder. The appeal must contain all of the information outlined in subsection (3)(C).

(7) Hearings.

(A) Notice.

1. The board shall serve upon all parties the initial notice of the place, date, and time upon which it will hold the hearing on a complaint or on a certificate holder's appeal. The board will send the notice by certified mail, by personal delivery, or by email.

2. The board shall provide at least thirty (30) days notice to the parties that it will hold a hearing on the matters raised in the complaint or appeal.

3. The notice shall advise the parties to file all pleadings, motions, and other documents by mailing them to DESE Counsel, Department of Elementary and Secondary Education, PO Box 480, Jefferson City, MO 65102-0480 or to Counsel@dese.mo.gov.

(B) Amended Complaints.

1. Petitioner may amend the complaint without the hearing officer's leave five (5) business days before the hearing. Within five (5) business days of the hearing, petitioner shall amend the complaint only if leave is requested and granted by the hearing officer. A copy of the amended complaint shall be attached to the motion for leave.

(C) Motions.

1. Either party may file a motion to request a delay of the hearing, if the party shows good cause, which may include pending criminal charge(s) as referenced in section 168.071.4, RSMo. The hearing officer has discretion to continue the hearing date upon notice to the parties.

2. Either party may file a motion for a protective order to close records or the hearing. The motion shall include a description of what information the party will be presenting that the party believes should be closed. The motion shall cite to the legal authority under

which the board may close the record or hearing or provide a showing that the closure is in the best interest of a child. A party should file this motion at least twenty-four (24) hours before the start of the hearing; however, a party may make an oral motion at the hearing.

3. Either party may file a motion to hold a hearing by videoconference. A party should file this motion at least ten (10) business days before the start of the hearing.

4. Either party may file a motion for a witness to appear by telephone or video conference. A party should file this motion at least three (3) business days before the start of the hearing.

5. The hearing officer will entertain other motions as necessary.

(D) Videoconference Hearings.

1. The hearing officer may hold hearings via a videoconference platform. The hearing officer will contact the parties if the hearing is to be held in this manner.

(E) Burden of Proof.

1. The party bringing the action shall have the burden of proof and will present evidence first.

(F) Exhibits.

1. The parties are required to send exhibits to the hearing officer and the opposing parties at least five (5) business days in advance of the hearing. If the hearing is to be held via videoconference, each party is responsible for providing all exhibits to all parties of record and the hearing officer electronically.

(G) Certificate Holder.

1. The certificate holder shall—

A. Have a reasonable opportunity to defend him or herself at the hearing and have the right to testify in his or her own behalf; and

B. Have the right to a public hearing, unless one (1) party files a motion for protective order as outlined in paragraph (6)(C)2., above.

(8) Settlements and Surrenders.

(A) Settlements.

1. The board may informally dispose of a case through an agreed settlement.

(B) Voluntary Surrenders.

1. The board may accept a certificate holder's voluntary surrender if the certificate holder is found guilty of a crime involving moral turpitude or a felony or in any other circumstances approved by the board.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 20—Division of Learning Services  
Chapter 400—Office of Educator Quality**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under sections 161.092 and 178.430, RSMo 2016, the board rescinds a rule as follows:

**5 CSR 20-400.410 Robert C. Byrd Honors Scholarship Program  
is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2021 (46 MoReg 2245). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 20—Division of Learning Services  
Chapter 400—Office of Educator Quality**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under sections 161.092, 168.011, 168.071, 168.081, 168.400, 168.405, and 168.409, RSMo 2016, and section 168.021, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 20-400.660** Certification Requirements for Career Education (Secondary) 7-12 Certificates **is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2021 (46 MoReg 2245-2247). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 20—Division of Learning Services  
Chapter 400—Office of Educator Quality**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under sections 161.092, 168.011, 168.071, 168.081, 168.400, 168.405, and 168.409, RSMo 2016, and section 168.021, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 20-400.670** Certification Requirements for Career Education (Adult) Certificate **is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2021 (46 MoReg 2247-2249). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.221, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 25-500.010** is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2140-2141). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty

(30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education (department) received one (1) comment on the proposed amendment.

COMMENT #1: An Office of Childhood staff commented that a definition for “parent” needs to be added to 5 CSR 25-500.010.

RESPONSE AND EXPLANATION OF CHANGE: The department concurs and a definition for “parent” will be added.

**5 CSR 25-500.010 Definitions**

(18) Parent means a child’s biological parent whose parental rights have not been terminated, a step-parent, an adoptive parent, a legal guardian, a caretaker relative, or other person standing in *loco parentis* for the child.

(19) Premises is a house(s), dwelling(s), or building(s) and its adjoining land.

(20) Preschool child is any child two through five (2–5) years of age who is not in kindergarten.

(21) A religious organization is—

(A) A church, synagogue, or mosque;

(B) An entity that qualifies for federal tax exemption status as a not-for-profit religious organization under Section 501(c)(3) of the *Internal Revenue Code*; or

(C) An entity whose real estate on which the child care facility is located is exempt from taxation because it is used for religious purposes.

(22) School-age child is any child five (5) years of age or older who is in kindergarten or above.

(23) Staff/child ratio is the number of caregivers required in relation to the number of children in care.

(24) Toddler is any child twelve to twenty-four (12–24) months of age.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.211, RSMo Supp. 2021, the board rescinds a rule as follows:

**5 CSR 25-500.022** Exemption of Day Care Facilities **is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2141). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.221, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 25-500.032 Organization and Administration is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2141-2142). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and sections 210.221 and 210.1080, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 25-500.042 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2142). No changes have been made in the text of the proposed amendment, so it is not reprinted here. However, the material incorporated by reference has been changed. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education received one (1) comment on the proposed amendment.

COMMENT #1: An Office of Childhood staff commented, “The *Application to Operate a Child Care Facility* form incorporated by reference in 5 CSR 25-500.042(2) has a typo that should be corrected. In the section that says ‘please read prior to signing application,’ item G reads, ‘I/We agree to accept and provide care to children without regard to race, sex, religion, national origin, or disability.’ The word ‘proved’ in this sentence should be ‘provide.’”

RESPONSE AND EXPLANATION OF CHANGE: The *Application for License to Operate a Child Care Facility* form has been revised to fix the typo.

**5 CSR 25-500.042 Licensing Process**

The *Application for License to Operate a Child Care Facility* form that is incorporated by reference has been updated based on the comment.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and sections 210.221 and 210.252, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 25-500.052 Annual Requirements is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2143). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under sections 161.092 and 210.223, RSMo 2016, and sections 210.221 and 210.1080, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 25-500.102 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2143-2144). No changes have been made in the text of the proposed amendment, so it is not reprinted here. However, the material incorporated by reference has been changed. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education (department) received three (3) comments on the proposed amendment.

COMMENT #1: An Office of Childhood staff commented that 5 CSR 25-500.102(1)(K) needs to specify that the staff required to complete the orientation are those hired on or after August 30, 2019, the effective date of this rule.

RESPONSE: The department concurs; however, because this section was not open to comment, this change will be addressed in a future rulemaking.

COMMENT #2: An Office of Childhood staff commented that the *Center Director/Group Child Care Home Provider Certification Request* incorporated by reference in rule 5 CSR 25-500.102(2)(A)1.A. needs to be updated; specifically, the certification request form which currently references 19 CSR 30-62.102(2)(B)3.B., should now reference 5 CSR 25-500.102(2)(B)3.B.

RESPONSE AND EXPLANATION OF CHANGE: The department concurs and the *Center Director/Group Child Care Home Provider Certification Request* has been revised to update outdated rule references and terminology.

COMMENT #3: An Office of Childhood staff commented that the *Center Director/Group Child Care Home Provider Approval Request* incorporated by reference in rule 5 CSR 25-500.102(2)(A)1.B. needs to be updated. Specifically, the staff title “Child Care Facility Specialist” should be changed to the new title, “Compliance Inspector”; and references to 19 CSR 30-63 should be changed to 5 CSR 25-600.

RESPONSE AND EXPLANATION OF CHANGE: The department concurs and the *Center Director/Group Child Care Home Provider Approval Request* has been revised to update outdated rule references and terminology.

#### 5 CSR 25-500.102 Personnel

The *Center Director/Group Child Care Home Provider Approval Request* and the *Center Director/Group Child Care Home Provider Certification Request* forms that are incorporated by reference have been updated based on the comments.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.221, RSMo Supp. 2021, the board amends a rule as follows:

5 CSR 25-500.122 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2144-2145). No changes have been made in the text of the proposed amendment, so it is not reprinted here. However, the material incorporated by reference has been changed. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education received one (1) comment on the proposed amendment.

COMMENT #1: An Office of Childhood staff commented that the *Medical Examination Report for Caregivers and Staff* incorporated by reference in 5 CSR 25-500.122(1)(D) needs to be updated so that the tuberculosis (TB) clearance section will allow for the inclusion of results from either a TB Risk Assessment or a negative Tuberculin Skin Test.

RESPONSE AND EXPLANATION OF CHANGE: The department concurs and the *Medical Examination Report for Caregivers and Staff* was revised to allow for the option to submit a *TB Risk Assessment* form or a negative Tuberculin Skin Test.

#### 5 CSR 25-500.122 Medical Examination Reports

The *Medical Examination Report for Caregivers and Staff* form that is incorporated by reference has been updated based on the comment.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under

section 161.092, RSMo 2016, and section 210.221, RSMo Supp. 2021, the board rescinds a rule as follows:

#### 5 CSR 25-500.152 Hourly Care Facilities is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2145). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.221, RSMo Supp. 2021, the board amends a rule as follows:

5 CSR 25-500.162 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2145-2146). No changes have been made in the text of the proposed amendment, so it is not reprinted here. However, the material incorporated by reference has been changed. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education received one (1) comment on the proposed amendment.

COMMENT #1: An Office of Childhood staff commented that the *Child Care Facility Overlap Request* form incorporated by reference in rule 5 CSR 25-500.162(2) needs to be updated by removing mentions of Section for Child Care Regulation, and replacing outdated staff titles with updated titles.

RESPONSE AND EXPLANATION OF CHANGE: The department concurs and the *Child Care Facility Overlap Request* has been revised to update outdated terminology within the form.

#### 5 CSR 25-500.162 Overlap Care of Children

The *Child Care Facility Overlap Request* form that is incorporated by reference has been updated based on the comment.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and sections 210.221 and 210.1080, RSMo Supp. 2021, the board amends a rule as follows:



**5 CSR 25-500.222** Records and Reports is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2146). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 500—Licensing Rules for Group Child Care  
Homes and Child Care Centers**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.221, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 25-500.230** Variance Request is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2147). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 600—Child Care Comprehensive Background  
Screening**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.1080, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 25-600.010** Definitions is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2147). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education (department) received one (1) comment on the proposed amendment.

COMMENT #1: An Office of Childhood staff commented that the definition of a child care staff member in 5 CSR 25-600.010(2) does not include all components provided for by section 210.1080(2), RSMo, specifically that a child care staff member includes individuals residing in a family child care home who are under eighteen (18) years of age and have been certified as an adult for the commission of a crime.

RESPONSE: The department acknowledges the comment but section (2) was not open for comments as it was not in the proposed amendment. No changes were made as a result of this comment.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 600—Child Care Comprehensive Background  
Screening**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.1080, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 25-600.020** General Requirements is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2148). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 600—Child Care Comprehensive Background  
Screening**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.1080, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 25-600.040** Background Screening Findings is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2148). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education received one (1) comment on the proposed amendment.

COMMENT #1: An Office of Childhood staff commented that 5 CSR 25-600.010(2) identifies persons required for background screenings in reference to individuals residing in a family child care home as those who are eighteen (18) years and older. However, the proposed amendment under 5 CSR 25-600.040 addresses "household members who are under eighteen (18) years of age but have been certified as an adult for the commission of an offense." The commenter expressed concern that this requirement would be difficult to enforce. The commenter also expressed concern that the requirement places an unfair burden on a family home provider to remove their underage child from the child's home during child care hours, regardless of the child's offenses.

RESPONSE: The determination of who is required to have a criminal background check is based on section 210.1080.1(2), RSMo, and the

board does not have the authority to change this in rule; therefore, no changes were made to this amendment in response to this comment.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 25—Office of Childhood  
Chapter 600—Child Care Comprehensive Background  
Screening**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.1080, RSMo Supp. 2021, the board amends a rule as follows:

**5 CSR 25-600.050** Process for Appeal Required in Section 210.1080, RSMo is **amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2021 (46 MoReg 2148-2149). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 10—DEPARTMENT OF NATURAL RESOURCES  
Division 10—Air Conservation Commission  
Chapter 5—Air Quality Standards and Air Pollution  
Control Rules Specific to the St. Louis Metropolitan  
Area**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission amends a rule as follows:

10 CSR 10-5.381 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2021 (46 MoReg 1840-1857). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received four (4) comments from two (2) sources: the U.S. Environmental Protection Agency (EPA) and Air Pollution Control Program staff.

COMMENT #1: EPA notes that paragraph (1)(B)15. provides for the exemption of Franklin County from the requirements of the vehicle emissions inspection and maintenance (I/M) program. EPA contends that this creates confusion because subsection (1)(A), Applicability, states that vehicles registered or primarily operated in Franklin County are subject to the rule. EPA recommends removing Franklin County from the list of counties in the applicability at subsection (1)(A) rather than exempting Franklin County in paragraph (1)(B)15. If Missouri is unable to change the applicability section to remove Franklin County, EPA suggests a clarification in the exemption for Franklin County. As proposed, the exemption applies to any vehicle operated in Franklin County, rather than only vehicles registered in Franklin County. In addition, vehicles registered in Franklin County, but operated primarily in the St. Louis area should not be exempt

from I/M requirements. Conversely, EPA interprets the proposed language could allow the owner of a vehicle registered in St. Louis County, St. Louis City, St. Charles County, or Jefferson County to claim an exemption from the I/M program because the vehicle operates in Franklin County. Therefore, Missouri should clarify that the exemption would apply only to vehicles registered in Franklin County, and not those registered in Franklin County but primarily operated in the St. Louis area.

RESPONSE AND EXPLANATION OF CHANGE: The department clarified paragraph (1)(B)15. by specifying that the exemption in Franklin County applies only to vehicles registered in Franklin County and operated primarily in that county. The department is retaining the exemption in paragraph (1)(B)15. rather than removing Franklin County from subsection (1)(A) as EPA suggested because the implementation date of July 1, 2022, is tied to the exemption. As a result of this comment, the department changed the proposed amendment text in paragraph (1)(B)15.

COMMENT #2: EPA recommends Missouri remove the July 1, 2022, applicability date from the exemption in paragraph (1)(B)15. Missouri is required to implement the SIP-approved rule until the EPA approves the revision to 10 CSR 10-5.381 into Missouri's SIP. While EPA strives to take expeditious action on all state submissions, this date could cause confusion for the public in the St. Louis area and could risk the possibility of sanctions should the I/M program be decommissioned prior to full EPA approval. In the event Missouri is unable to remove the applicability date, the EPA suggests revision to the date of October 31, 2022, the end of the 2022 ozone season.

RESPONSE: The department will retain the July 1, 2022, date on which to begin the implementation as shown in paragraph (1)(B)15. Including an implementation date in the rule allows the department, contractors, and the public to plan for the program's termination in Franklin County. No change to the proposed amendment text was made as a result of this comment.

COMMENT #3: EPA recommends that Missouri retain the language in paragraphs (3)(L)2. and (3)(L)3. or replace with similar language in order to comply with the I/M program requirements of 40 CFR Part 50, Subpart S. 40 CFR 51.364 at (a)(3) requires "All findings of serious violations of rules or procedural requirements shall result in mandatory fines or retainage." 40 CFR 51.367 requires inspector training. Missouri should provide a detailed justification for the replacement and/or acceptable language elsewhere in the rule.

RESPONSE AND EXPLANATION OF CHANGE: The department proposed to delete the provisions of paragraphs (3)(L)2. and (3)(L)3. because they are either redundant, unenforceable, or unnecessary. Deleted subparagraph (3)(L)2.A. addressed inspection station business conduct. This provision is covered by the proposed language in paragraph (3)(L)2. and subsection (3)(H). Deleted subparagraph (3)(L)2.B. addressed penalties and is covered by proposed paragraph (3)(L)2. Subparagraph (3)(L)2.C. addressed financial responsibility and is neither enforceable or necessary to achieve emissions reductions and is not in the federal I/M program requirements. Deleted subparagraph (3)(L)3.A. addressed education and training and is covered by the requirements in paragraphs (3)(G)3.- 4. Deleted subparagraph (3)(L)3.B. addressed penalties and is covered by proposed paragraph (3)(L)3. Rather than deleting subparagraph (3)(L)3.C., which addresses maintaining an electronic database, the department is retaining and relocating the language to paragraph (3)(L)1. where it is more appropriate. As a result of this comment, the department changed the proposed amendment text in paragraph (3)(L)1.

COMMENT #4: Air Pollution Control Program staff commented that in paragraph (3)(K)5., the proposed amendment text adds estimate-based waivers to the list of waivers that can be investigated prior to issuing a waiver. However, in the third sentence of that same paragraph it reads that only estimate-based waivers can be issued. The third sentence should read that a waiver can be issued, and not

be specific to either cost- or estimate-based waivers.

**RESPONSE AND EXPLANATION OF CHANGE:** The department is changing the proposed amendment text in this paragraph to note that the department can issue waivers for both cost- and estimate-based repairs. The use of the word waiver is appropriate in the third sentence and does not need to be specific to cost- or estimated-based waivers. As a result of this comment, the department changed the third sentence in paragraph (3)(K)5. to read waiver instead of estimate-based waiver.

### 10 CSR 10-5.381 Onboard Diagnostics Motor Vehicle Emissions Inspection

#### (1) Applicability.

(B) The following vehicles are exempt from this rule:

1. Heavy-duty gasoline-powered and heavy-duty diesel-powered vehicles that receive a gross vehicle weight rating (GVWR) exemption described in subsection (4)(I) of this rule;

2. Light-duty gasoline-powered vehicles and trucks manufactured prior to the 1996 model year and light-duty diesel-powered vehicles and trucks manufactured prior to the 1997 model year;

3. Motorcycles and motortricycles;

4. Vehicles powered exclusively by electric or hydrogen power or by fuels other than gasoline, ethanol (E10 and E85), or diesel;

5. Motor vehicles registered in an area subject to the inspection requirements of sections 643.300–643.355, RSMo, that are domiciled and operated exclusively in an area of the state not subject to the inspection requirements of sections 643.300–643.355, RSMo, that receive an out-of-area exemption described in subsection (4)(J) of this rule;

6. New and unused motor vehicles, of model years of the current calendar year and of any calendar year within two (2) years of such calendar year, that have an odometer reading of fewer than six thousand (6,000) miles at the time of original sale by a motor vehicle manufacturer or licensed motor vehicle dealer to the first user;

7. New motor vehicles that have not been previously titled and registered for the four- (4-) year period following their model year of manufacture that have an odometer reading of fewer than forty thousand (40,000) miles. These vehicles qualify for a mileage-based exemption described in subsection (4)(H) of this rule. Otherwise, such motor vehicles shall be subject to the emissions inspection requirements of subsection (3)(B) of this rule;

8. Motor vehicles driven fewer than twelve thousand (12,000) miles biennially that receive a mileage-based exemption described in subsection (4)(H) of this rule;

9. Historic motor vehicles registered pursuant to section 301.131, RSMo;

10. School buses;

11. Tactical military vehicles;

12. Visitor, employee, or military personnel vehicles on federal installations provided appointments do not exceed sixty (60) calendar days;

13. Specially constructed vehicles;

14. Plug-in hybrid electric vehicles (PHEVs); and

15. Upon incorporation of this 2022 rule change into Missouri's federally approved State Implementation Plan or July 1, 2022, whichever is sooner, vehicles subject to subsection (1)(A) of this rule registered in Franklin County are exempt unless the vehicle is primarily operated in the area of Jefferson County, St. Charles County, St. Louis County, and the City of St. Louis. A vehicle is primarily operated in the area if at least fifty-one percent (51%) of the vehicle's annual miles are in the area.

#### (3) General Provisions.

(K) Emissions Inspection Waivers and Exemptions.

1. Cost-based waivers. Vehicle owners or purchasers shall be issued a cost-based waiver for their vehicle under the following conditions:

A. The subject vehicle has failed the initial emissions inspection, has had qualifying repairs, and has failed an emissions reinspection;

B. The vehicle has passed the following:

(I) The bulb check test described in subparagraph (5)(B)2.A. of this rule;

(II) The data link connector test described in subparagraph (5)(B)3.A. of this rule;

(III) The communications test described in subparagraph (5)(B)3.B. of this rule; and

(IV) The readiness monitor test described in paragraph (5)(B)4. of this rule; and

C. The subject vehicle has all of its emissions control components correctly installed and operating as designed by the vehicle manufacturer.

(I) To the extent practical, the department representative shall use the MSHP air pollution control device inspection method described in 11 CSR 50-2.280 to fulfill the requirement of this subparagraph.

(II) If the vehicle fails the visual inspection described in 11 CSR 50-2.280, then the vehicle will be denied a cost-based waiver;

D. The vehicle operator has submitted to the department the appropriate waiver application with all required information and necessary signatures completed, along with all itemized receipts of qualifying repairs. The qualifying repairs must meet the requirements of paragraph (3)(K)2. of this rule. The itemized receipts must meet the requirements of paragraph (3)(K)3. of this rule;

E. At the discretion of the department, the vehicle owner or operator may be required to make arrangements to bring the vehicle to the department or the department's designee for visual verification of the vehicle's repairs or estimated repairs in the case of a cost-based estimate waiver application; and

F. To the extent practical, the department representative has verified that the repairs indicated on the itemized receipts for qualifying repairs were made and that the parts were repaired/replaced as claimed.

2. The minimum amount spent on qualifying repairs for cost-based waivers shall—

A. Exceed four hundred fifty dollars (\$450) for vehicles not fully repaired solely by the owner of the failed vehicle;

B. Exceed four hundred dollars (\$400) for all vehicles repaired solely by the owner of the failed vehicle. Only qualified repairs that include the part costs for the purchase and installation of the following parts listed in 40 CFR 51.360(a)(5) will be accepted:

(I) Oxygen sensors;

(II) Catalytic converters;

(III) Exhaust gas recirculation (EGR) valves;

(IV) Evaporative canisters;

(V) Positive crankcase ventilation (PCV) valves;

(VI) Air pumps;

(VII) Distributors;

(VIII) Ignition wires;

(IX) Coils;

(X) Spark plugs; and

(XI) Any hoses, gaskets, belts, clamps, brackets, or other accessories directly associated with these parts. If the emissions failure is not related to the parts listed in this subparagraph, the cost of replacing such parts will not count towards the waiver minimum;

C. Exceed two hundred dollars (\$200) for all motorists who provide the department representative with reasonable and reliable proof that the owner is financially dependent on state and federal disability benefits and other public assistance programs. The proof shall consist of government issued documentation providing explanation of the motorist's disability and financial assistance with regard to personal income. The motorist must also submit the appropriate cost-based waiver application with their "Financial Eligibility Waiver Request";

D. Be inclusive of part costs paid by motorists performing

qualified vehicle repairs by themselves or for qualified emissions repair services performed by any repair technician. Labor costs shall only be applied toward a cost-based waiver if the qualified repair work was performed by a recognized repair technician;

E. Not include the fee for an emissions inspection or reinspection;

F. Not include the fee for a safety inspection or reinspection;

G. Not include charges for obtaining a written estimate of needed repairs;

H. Not include the charges for repairs necessary for the vehicle to pass a safety inspection;

I. Not include costs for repairs performed on the vehicle before the initial emissions inspection failure;

J. Not include expenses that are incurred for the repair of—

(I) Emissions control devices or data link connectors that have been found during either a safety or an emissions inspection to be tampered with, rendered inoperative, or removed;

(II) The MIL; or

(III) For OBD communications failures;

K. Not include the state sales tax for the following motor vehicle parts that are air pollution control devices:

(I) Air injection parts, air pumps, check valves, and smog pumps;

(II) Catalytic converters (universal converters, direct fit converters, converter kits);

(III) EGR valves;

(IV) Evaporative canisters and canister purge valves;

(V) PCV valves; and

(VI) Any vehicle parts that serve the equivalent functions of the parts listed in parts (3)(K)2.K.(I)–(3)(K)2.K.(V) of this rule;

L. Not include costs and expenses associated with aftermarket catalytic converter replacements that do not conform to the EPA's Aftermarket Catalytic Converter (AMCC) enforcement policy. The EPA's AMCC enforcement policy, which includes the following three (3) documents, is hereby incorporated by reference in this rule. This rule does not incorporate any subsequent amendments or additions to the EPA's AMCC enforcement policy:

(I) The Notice of Proposed Enforcement Policy regarding the "Sale and Use of Aftermarket Catalytic Converters," published on August 5, 1986, by 51 FR 28114 as published by the Office of the Federal Register, U.S. National Archives and Records, 700 Pennsylvania Avenue NW, Washington, DC 20408;

(II) The publication "What You Should Know About Using, Installing Or Buying Aftermarket Catalytic Converters" published in September 2000 by the U.S. Environmental Protection Agency (EPA), Office of Air and Radiation, Office of Transportation and Air Quality, 1200 Pennsylvania Avenue NW, Washington, DC 20460; and

(III) The letter "Sale and Use of Aftermarket Catalytic Converters for Vehicles Equipped with Onboard Diagnostic (OBD-II) Systems" sent on September 30, 2004, by the U.S. Environmental Protection Agency (EPA), Office of Enforcement and Compliance Assurance, 1200 Pennsylvania Avenue NW, Washington, DC 20460 to the Manufacturers of Emission Control Association;

M. Not include expenses that are incurred for the restoration of the vehicle manufacturer's emissions control system due to the installation of sensor simulators, engine control module upgrades, or other aftermarket components that disable readiness monitors or in any way bypass or compromise the vehicle manufacturer's emissions control system; and

N. Not include costs for emissions repairs or adjustments covered by a vehicle manufacturer's warranty, including the minimum federal catalytic converter warranty period of eight (8) years or eighty thousand (80,000) miles, insurance policy, or contractual maintenance agreement. The emissions repair costs covered by warranty, insurance, or maintenance agreements shall be separated from other emissions repair costs and shall not be applied toward the cost-based waiver minimum amount. The operator of a vehicle within the

statutory age and mileage coverage under subsection 207(b) of the federal Clean Air Act shall present a written denial of warranty coverage, with a complete explanation, from the manufacturer or authorized dealer in order for this provision to be waived.

3. The vehicle operator shall present all itemized repair receipts to the department representative to demonstrate compliance with paragraph (3)(K)2. of this rule. The itemized repair receipt(s) shall—

A. Include the name, physical address, and phone number of the repair facility and the model year, make, model, and VIN of the vehicle being repaired;

B. Describe the diagnostic test(s) performed to identify the reason the vehicle failed an emissions inspection;

C. Describe the emissions repair(s) that were indicated by the diagnostic test(s);

D. Document the emissions repairs performed were authorized by the vehicle owner or operator;

E. Describe the emissions repairs that were performed by the repair technician or vehicle owner;

F. For catalytic converter replacements, include, as a separate attachment, the documentation that the EPA's AMCC enforcement policy requires of the catalytic converter retail seller, vehicle owner, and/or installer. Catalytic converter replacements will only be accepted towards a cost-based waiver if they are installed on gasoline-powered vehicles that have failed the most recent OBD test with at least one (1) catalytic converter DTC (P0420–P0439) as recorded on a failing VIR described in subsection (4)(B) of this rule;

G. Describe the vehicle part(s) and the quantity or each type of part(s) that were serviced or replaced;

H. Describe the readiness monitors that were either set to ready or left unset;

I. Describe the diagnostic test(s) performed after the repairs were completed to verify that the vehicle's emissions control system is now operating as it was designed to operate by the manufacturer;

J. Clearly list the labor costs, if the vehicle was repaired by a repair technician, and the part(s) costs separately for each repair item;

K. Include the repair technician's name (printed or typed), signature and, if applicable, the unique identification number of the recognized repair technician that performed the repair work; and

L. Confirm that payment was collected or financed for the services rendered and/or parts replaced as listed on the itemized repair receipt(s).

4. Estimate-based waivers. Vehicles shall be issued an estimate-based waiver under the following conditions:

A. The subject vehicle has failed the initial emissions inspection or reinspection after repair(s) with a single DTC;

B. The vehicle has passed the following:

(I) The bulb check test described in subparagraph (5)(B)2.A. of this rule;

(II) The data link connector test described in subparagraph (5)(B)3.A. of this rule;

(III) The communications test described in subparagraph (5)(B)3.B. of this rule; and

(IV) The readiness monitor test described in paragraph (5)(B)4. of this rule;

C. The subject vehicle cannot have received either a cost-based waiver or an estimate-based waiver during a previous biennial inspection cycle for the same single DTC;

D. The vehicle owner has paid for a diagnostic test of that DTC by a recognized repair technician or a vehicle repair business that specializes in a particular make of vehicle or type of repair (e.g., transmission repairs), with the items tested and the results described on the repair estimate; and

E. The diagnostic test results and parts required for the repair of the single DTC are documented by the shop to exceed four hundred fifty dollars (\$450).

5. The department reserves the right to investigate all cost- and estimate-based waiver requests and submitted receipts. Cost-based

waiver requests with incomplete information and/or receipts that do not identify the vehicle that was repaired, do not itemize the actual cost of the parts that were serviced, do not list the labor costs separately from the part costs, indicate that state sales tax was charged on air pollution control parts exempted from state sales tax as defined in paragraph (3)(K)2. of this rule, or contain fraudulent information or part costs as determined by department representatives will not be accepted by the department. If the conditions of paragraphs (3)(K)1.–(3)(K)4. of this rule have been met, the department representative shall issue a waiver and provide the windshield sticker to be affixed to the vehicle by the vehicle owner. The windshield sticker shall meet the requirements of paragraph (4)(F)2. of this rule.

6. The contractor shall provide the means to issue cost-based waivers, VIRs, and windshield stickers from either the department's offices or from a portable solution as required by the contract. The contractor shall provide the means to issue out-of-area, reciprocity, mileage, and GVWR waivers, exemptions, and VIRs, from either the department's offices or from a portable solution as required by the contract.

7. Out-of-area exemptions. Provided the vehicle owner or driver submits a completed, signed out-of-area affidavit to the department indicating that the vehicle will be operated exclusively in an area of the state not subject to the inspection requirements of sections 643.300–643.355, RSMo, for the next twenty-four (24) months, the department shall issue an emissions inspection VIR, with an indicator to show that the vehicle has received an out-of-area exemption to the vehicle owner or driver, and a windshield sticker shall be affixed to the subject vehicle.

8. Reciprocity waivers. Provided the vehicle owner or driver presents proof, acceptable to the department, that the subject vehicle has successfully passed an OBD emissions inspection in another state within the previous sixty (60) calendar days, the department shall issue an emissions inspection VIR with an indicator to show that the vehicle has received a reciprocity waiver to the vehicle owner or driver, and a windshield sticker shall be affixed to the subject vehicle. Reciprocity waivers shall be issued if the motorist submits proof of a passing OBD emissions inspection from a state or jurisdiction participating in pass/fail OBD inspections. Should any of these states or jurisdictions discontinue the use of pass/fail OBD inspections, the reciprocity waiver shall not be granted.

9. Mileage exemptions. Provided the vehicle owner or driver submits the required information described in subsection (4)(H) of this rule, the department or the MDAS shall issue an emissions inspection VIR, with an indicator to show that the vehicle has received a mileage-based exemption to the vehicle owner or driver.

10. GVWR exemptions. Provided the emissions inspector verifies that the vehicle is over eight thousand five hundred pounds (8,500 lbs.) GVWR, the MDAS shall issue an emissions inspection VIR, with an indicator to show that the vehicle has received a GVWR exemption to the vehicle owner or driver.

(L) Quality Control Requirements.

1. Quality control for the contractor(s). The State of Missouri shall appoint a contractor to perform the outlined duties of the inspection maintenance program through vehicle emissions inspections. The contractor shall maintain for the department an electronic database of licensed emissions inspector information that, at a minimum, includes the inspector's name, unique identification number, date of license issuance, stations of employment, date of any license suspensions or revocations, and a list of inspection results by date and by model year, make, model, and VIN.

2. Quality control for emissions inspection stations. Licensed emissions stations shall conduct emissions inspections in accordance with this rule and failure to do so may result in civil, criminal, and/or monetary penalties as described in paragraphs (3)(N)2.–(3)(N)5. of this rule.

3. Quality control for emissions inspectors. Emission inspectors shall conduct vehicle emissions inspections in accordance with this rule, failure to comply may result in civil, criminal, and/or monetary

penalties as described in paragraphs (3)(N)2.–(3)(N)5. of this rule.

4. Quality control for emissions inspection records.

A. All inspection records, calibration records, and control charts shall be accurately created, recorded, maintained, and secured by the contractor.

B. The contractor shall make available all records and information requested by the department and shall fully cooperate with the department, MSHP, and other state agency representatives who are authorized to conduct audits and other quality assurance procedures.

C. The contractor shall maintain emissions inspection records, including all inspection results and repair information.

(I) These records shall be kept readily available to the department and the MSHP for at least three (3) years after the date of an initial emissions inspection.

(II) These records shall be made available to the department and the MSHP on a real time continual basis through the use of the contractor's VID as specified in the contract.

(III) These records shall also be made available immediately upon request for review by department and MSHP personnel.

5. Quality control for all emissions inspection equipment.

A. At a minimum, the practices described in this section and in the contract shall be followed.

B. Preventive maintenance on all emissions inspection equipment shall be performed on a periodic basis, as provided by the contract between the department and the contractor and consistent with the EPA's and the equipment manufacturer's requirements.

C. To assure quality control, computerized analyzers shall automatically record quality control check information, lockouts, attempted tampering, and any circumstances which require a service representative to work on the equipment.

D. To assure test accuracy, equipment shall be maintained by the contractor according to demonstrated good engineering procedures.

E. Computer control of quality assurance checks shall be used whenever possible. The emissions inspection equipment shall transmit the quality control results to the department's contractor as prescribed in the contract between the department and the contractor.