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John R. Ashcroft Secretary of State

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HOW TO CITE RULES AND RSMO

RULES

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

Title	CSR	Division	Chapter	Rule
3	*Code of*	10-	4	115
Department	*State*	Agency	General area	Specific area
	Regulations	division	regulated	regulated

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

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

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

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

Code and *Register* on the Internet

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

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

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

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

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Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
March 1, 2023	**April 3, 2023**	April 30, 2023	May 30, 2023
March 15, 2023	**April 17, 2023**	April 30, 2023	May 30, 2023
April 3, 2023	**May 1, 2023**	May 31, 2023	June 30, 2023
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August 15, 2023	**September 15, 2023**	September 30, 2023	October 30, 2023

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.

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

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

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

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

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 15 – Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA). The division is amending subsections (1)(A), (B), and (C), removing subsection (1)(D) and section (2), added new section (5), and renumbering as necessary.

PURPOSE: This emergency amendment provides for the trend factor to be applied to the inpatient and outpatient adjusted net revenues to determine the inpatient and outpatient net revenues subject to the FRA assessment for SFY 2023. It also establishes the percentage of FRA that is taxed to Missouri hospitals for SFY 2023.

*EMERGENCY STATEMENT: This emergency amendment informs Missouri hospitals what FRA rate they will be assessed starting on July 1, 2023. The Department of Social Services (DSS), MO HealthNet Division (MHD) finds that this emergency amendment is necessary to preserve a compelling governmental interest of collecting state revenue in order to provide health care to individuals eligible for the MO HealthNet program and for the uninsured. Missouri Partnership Plan (MPP) between the Centers for Medicare & Medicaid Services (CMS) and the DSS, which establishes a process whereby CMS and DSS determine the permissibility of the funding source used by Missouri to fund its share of the MO HealthNet program, is based on a state fiscal year. In order to determine the trends for State Fiscal Year (SFY) 2024, all relevant information from the necessary sources must be available to MHD. The division uses the best information available when it starts calculating the assessment so it uses the trend published in the Fourth Quarter Healthcare Cost Review publication, which is generally not available until January. The division must also analyze hospital revenue data, which is not complete until near the end of the SFY, in conjunction with the trend and hospital FRA funded payments to determine the appropriate level of assessment. Without this information, the trends cannot be determined. Therefore, due to timing of the receipt of this information and the necessary July 1, 2023 effective date, an emergency regulation is necessary. A proposed amendment, which covers the same material, will be published in this issue of the **Missouri Register**. The scope of the emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed June 15, 2023, becomes effective June 30, 2023, expires December 26, 2023.*

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

(A) Definitions.

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

2. Base year cost report – Audited Medicaid cost report from the third prior calendar year. If a hospital has more than one (1) cost report with periods ending in the third prior calendar year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base year cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of days reflected in the base year cost report, to a twelve- (12-) month period. Any changes to the base year cost report after the division issues a final decision on assessment will not be included in the calculations.

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

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

5. Department – Department of Social Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G. The trend indices, if greater than 0%, will be determined based on the Health Care Costs index as published in *Healthcare Cost Review* by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY). The trend indices listed below will be applied to the apportioned inpatient adjusted net revenue and outpatient adjusted net revenue in order to inflate or trend forward the adjusted net revenues from the FRA fiscal year cost report to the current state fiscal year to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment.

[(I) SFY 2020 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—2.9%]
*[(II)]***(I)** SFY 2021 =
(a) Inpatient Adjusted Net Revenues – 3.2%
(b) Outpatient Adjusted Net Revenues – 0%
*[(III)]***(II)** SFY 2022 =
(a) Inpatient Adjusted Net Revenues – 4.2%
(b) Outpatient Adjusted Net Revenues – 0%
*[(IV)]***(III)** SFY 2023 =
(a) Inpatient Adjusted Net Revenues – 3.8%
(b) Outpatient Adjusted Net Revenues – 0%
(IV) SFY 2024 =
(a) Inpatient Adjusted Net Revenues – 0%
(b) Outpatient Adjusted Net Revenues – 0%

(B) Each hospital engaging in the business of providing inpatient health care in Missouri shall pay an FRA. The FRA shall be calculated by the Department of Social Services.

1. The FRA shall be as described beginning with section

(2) and going forward.

[2. If a hospital does not have a third prior year base cost report, inpatient and outpatient adjusted net revenues shall be estimated as follows:

A. Hospitals required to pay the FRA, except safety net hospitals, shall be divided in quartiles based on total beds;

B. The inpatient adjusted net revenue shall be summed for each quartile and divided by the total beds in the quartile to yield an average inpatient adjusted net revenue per bed. The number of beds for the hospital without the base cost report shall be multiplied by the average inpatient adjusted net revenue per bed to determine the estimated inpatient adjusted net revenue; and

C. The outpatient adjusted net revenue shall be summed for each quartile and divided by the number of facilities in the quartile to yield an average outpatient adjusted net revenue per facility which will be the estimated outpatient adjusted net revenue for the hospital without the base cost report.]

*[3.]***2.** *[Beginning January 1, 2015, if]* **If** a hospital does not have a third prior year cost report on which to determine the hospital revenues subject to FRA assessment as set forth in paragraph (1)(A)13., inpatient and outpatient adjusted net revenues shall be based upon the projections included with its Certificate of Need (CON) application on the "Service-Specific Revenues and Expenses" form (CON projections) required in a full CON review as described in *[19 CSR 60-50.300.]* **19 CSR 60-50.470.** If the hospital did not go through a full CON review, it must submit a completed "Service-Specific Revenues and Expenses" form that has been verified by an independent auditor.

A. The hospital must provide the division with the breakdown of the inpatient and outpatient revenues that tie to the CON projections.

B. The CON projections and the breakdown of the inpatient and outpatient revenues are subject to review and validation by the division.

[C. If the facility does not provide the CON projections, the breakdown of the inpatient and outpatient revenues, or any other additional information requested by the division within thirty (30) days of the division's request, the inpatient and outpatient adjusted net revenues shall be based upon the quartile method set forth in paragraph (1)(B)2.

D. Direct Medicaid and Uninsured Add-On Payments shall be included in the estimated inpatient and outpatient adjusted net revenues.]

*[E.]***C.** Once the facility has a third prior year cost report, the assessment shall be based on the actual inpatient and outpatient adjusted net revenues from such cost report.

4. The FRA assessment for hospitals that merge operation under one (1) Medicare and MO HealthNet provider number shall be determined as follows:

A. The previously determined FRA assessment for each hospital shall be combined under the active MO HealthNet provider number for the remainder of the state fiscal year after the division receives official notification of the merger; and

B. The FRA assessment for subsequent fiscal years shall be based on the combined data for both facilities.

5. A hospital which either voluntarily or involuntarily terminates its license and which becomes relicensed will be assessed the same inpatient and outpatient assessment as the previous hospital owner/operator if the hospital becomes relicensed during the same state fiscal year. If the hospital does not become relicensed during the same state fiscal year, the inpatient and outpatient assessment will be determined based on the applicable base year data (i.e., third prior year). If the hospital does not have the applicable base year data, the inpatient and outpatient assessment will be based on the most recent cost report data available and will include annual trend factor adjustments from the year subsequent to the cost report period through the state fiscal year for which the assessments are being determined.

(C) The division shall prepare a confirmation schedule of the information from each hospital's third prior year cost report and provide each hospital with this schedule. Each hospital required to pay the FRA shall review the confirmation schedule and confirm the information is correct or provide correct information within fifteen (15) days of receiving the confirmation schedule. If the hospital fails to submit the corrected data within the fifteen (15) day time period, the hospital shall be barred from submitting corrected data later to have its FRA assessment or the *[add-on]* **additional** payments from 13 CSR 70-15.010, 13 CSR 70-15.015, *[and]* 13 CSR 70-15.220**, and 13 CSR 70-15.230** adjusted.

1. The FRA will be offset against any Missouri Medicaid payment due the hospital. The FRA Assessments shall be allocated and deducted over the applicable period.

2. A letter will be sent to the hospital indicating the FRA balance due after offset, if any, at the end of each state fiscal quarter. The FRA balance due shall be remitted by the hospital to the MO HealthNet Division as stated in the letter.

[(D) In accordance with sections 621.055 and 208.156, RSMo, hospitals may seek a hearing before the Administrative Hearing Commission from a final decision of the director of the department or division.]

[(2) Beginning July 1, 2018, the FRA assessment shall be determined at the rate of five and sixty hundredths percent (5.60%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and sixty hundredths percent (5.60%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.]

*[(3)]***(2)** Beginning July 1, 2020, the FRA assessment shall be determined at a rate of five and seventy-five hundredths percent (5.75%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

*[(4)]***(3)** Beginning July 1, 2021, the FRA assessment shall be determined at a rate of five and forty-eight hundredths percent (5.48%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

*[(5)]***(4)** Beginning July 1, 2022, the FRA assessment shall be

determined at a rate of five and four tenths percent (5.40%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(5) Beginning July 1, 2023, the FRA assessment shall be determined at a rate of four and eight tenths percent (4.80%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

AUTHORITY: sections 208.201, 208.453, 208.455, and 660.017, RSMo 2016. Emergency rule filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency rule filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Original rule filed Sept. 21, 1992, effective June 7, 1993. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed June 15, 2023, effective June 30, 2023, expires Dec. 26, 2023. A proposed amendment, covering the same material, will be published in this issue of the* ***Missouri Register****.*

PUBLIC COST: For the six (6) months of SFY 2024 that this emergency amendment is effective, this emergency amendment will result in FRA Assessment reduction to public entities of approximately $1.9 million.

PRIVATE COST: For the six (6) months of SFY 2024 that this emergency amendment is effective, this emergency amendment will result in FRA Assessment reduction to private entities of approximately $23.5 million.

FISCAL NOTE
PUBLIC COST

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

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

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) & State Hospitals - 38	Estimated reduction in FRA Assessment for 6 months of SFY 2024 - $1.9 million

III. WORKSHEET

Estimated Assessment at 4.80% for SFY 2024:

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Public Hospitals Revenues (2023)	38	$865,693,506	$934,487,226	$1,800,180,732
FRA Assessment Rate		5.40%	5.40%	5.40%
Total Assessment with Trend		$46,747,451	$50,462,310	$97,209,761
Public Hospitals Revenues (2024)		$892,603,793	$1,093,939,563	$1,986,543,356
Revenue Trend for SFY 2024		0.00%	0.00%	
Total Revenues Trended (2024)		$892,603,793	$1,093,939,563	$1,986,543,356
FRA Assessment Rate		4.80%	4.80%	4.80%
Total Assessment with Trend		$42,844,981	$52,509,099	$95,354,080
Impact of FRA Assessment Rate				($1,855,681)

IV. ASSUMPTIONS

This fiscal note reflects the total FRA Assessment of 4.80% for July 1, 2023 through June 30, 2024. The fiscal note is based on establishing the FRA Assessment rate as noted above and a trend of 0% on inpatient revenues and 0% on outpatient revenues beginning July 1, 2023. The FRA Assessment rate is levied upon Missouri hospitals' trended inpatient and outpatient net adjusted revenues in accordance with the Missouri Partnership Plan. There is a decrease in the amount of FRA that will be raised compared to SFY 2023. This is attributable to the increase in taxable revenue and decrease in the tax rate.

FISCAL NOTE
PRIVATE COST

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

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

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
97	**Hospitals**	**Estimated reduction in FRA Assessment for 6 months of SFY 2024 - $23.5 million**

III. WORKSHEET

Estimated Assessment at 4.80% for SFY 2024:

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Private Hospitals Revenues (2023)	97	$5,077,694,381	$4,882,574,169	$9,960,268,550
FRA Assessment Rate		5.40%	5.40%	5.40%
Total Assessment with Trend		$274,195,497	$263,659,006	$537,854,503
Private Hospitals Revenues (2024)		$5,323,874,453	$5,391,775,779	$10,715,650,232
Revenue Trend for SFY 2024		0.00%	0.00%	
Total Revenues Trended (2024)		$5,323,874,453	$5,391,775,779	$10,715,650,232
FRA Assessment Rate		4.80%	4.80%	4.80%
Total Assessment with Trend		$255,545,255	$258,805,239	$514,350,494
Impact of FRA Assessment Rate				($23,504,009)

IV. ASSUMPTIONS

This fiscal note reflects the total FRA Assessment of 4.80% for July 1, 2023 through June 30, 2024. The fiscal note is based on establishing the FRA Assessment rate as noted above and a trend of 0% on inpatient revenues and 0% on outpatient revenues beginning July 1, 2023. The FRA Assessment rate is levied upon Missouri hospitals' trended inpatient and outpatient net adjusted revenues in accordance with the Missouri Partnership Plan. There is a decrease in the amount of FRA that will be raised compared to SFY 2023. This is attributable to the increase in taxable revenue and decrease in the tax rate.

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 15 – Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology. The division is removing sections (1) through (4), amending section (5), and renumbering accordingly.

PURPOSE: This emergency amendment updates all documents incorporated by reference and used to create the outpatient simplified fee schedule.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency amendment is necessary to preserve a compelling governmental interest as it allows MHD to continue to pay its hospital providers under a financially sustainable payment methodology. MHD must incorporate by reference the most recent fee schedules published by the Centers for Medicare & Medicaid Services (CMS) in order to compute the Outpatient Simplified Fee Schedule (OSFS), which allows providers to be paid the correct amount for their services. Since the dates on which CMS updates its fee schedules vary throughout the year, an emergency amendment is necessary in order to maintain a correct fee schedule by July 1 of each year. This emergency amendment is necessary to incorporate the most recently published fee schedules into the methodology to comply with the regulation. Furthermore, this emergency amendment is necessary to secure a sustainable Medicaid program in Missouri, and ensure that payments for outpatient services are in line with funds appropriated for that purpose. (See Beverly Enterprises-Missouri Inc. v. Dep't of Soc. Servs., Div. of Med. Servs., 349 S.W.3d 337, 350 (Mo. Ct. App. 2008)) As a result, MHD finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, will be published in this issue of the ***Missouri Register****. This emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions****. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed June 15, 2023, becomes effective June 30, 2023, and expires December 26, 2023.*

[(1) Prospective Outpatient Hospital Services Reimbursement Percentage for Hospitals Located Within Missouri.

(A) Outpatient hospital services shall be reimbursed on a prospective outpatient payment percentage effective July 1, 2002, except for services identified in subsection (1)(C). The prospective outpatient payment percentage will be calculated using the Medicaid overall outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports regressed to the current State Fiscal Year (SFY). (If the current SFY is 2003, the fourth, fifth, and sixth prior year cost reports would be the cost report filed in calendar year 1997, 1998, and 1999.) As part of the regression analysis, a facility's outpatient payment percentage is limited to a downward adjustment of fifteen percent (15%) from the previous year with no limit on the upward swing, unless the facility chose the lower upward and downward swing option. For SFYs 2007–2010, the lower upward and downward swing option was three percent (3%) and beginning with SFY 2011 the lower upward and downward swing option is six percent (6%). Once a facility has chosen an option, it shall be fixed and applied beginning with the year it is selected. If a facility has not chosen an option, the default is the downward adjustment of fifteen percent (15%) from the previous year with no limit on the upward swing. The prospective outpatient payment percentage shall not exceed one hundred percent (100%) and shall not be less than twenty percent (20%).

(B) Outpatient cost-to-charge ratios will be as determined in the desk review of the base year cost reports. If adjustments are not made during the desk review, adjustments will be made to remove the cost and charges for services reimbursed on a fee schedule when calculating the cost-to-charge ratios used to determine the outpatient percentage rate.

1. Costs and charges for laboratory and radiology services reimbursed on a fee schedule shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates.

2. Costs and charges for outpatient surgical procedures reimbursed on a fee schedule shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates. Adjustments shall be made by the division starting with the calculation of the outpatient percentage rate for the SFY after the surgical procedures are moved to a fee schedule.

A. Exception. A hospital may request a revised calculation of the outpatient percentage rate prior to the adjustment made by the division in paragraph (1)(B)2. of this regulation. The hospital must provide the charges and cost-to-charge ratios by cost center for both Medicaid and Total (i.e., all payor types). The hospital must provide a breakdown of the amounts reimbursed on a fee schedule using a template developed by the division and available upon request. The template must be submitted to the division by April 1 of the current SFY for which the revised calculation of the outpatient percentage rate is requested. The hospital may be notified in writing of the revised outpatient percentage rate within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required. If an adjustment is not otherwise limited or prohibited, the effective date of the change in the hospital's outpatient percentage rate shall be the first day of the month following the date of the division's final determination.

3. Costs and charges for the telehealth originating site fee reimbursed on a fee schedule shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates starting with the calculation of the outpatient percentage rate for the SFY after the telehealth originating site fee is moved to a fee schedule.

4. Costs and charges for outpatient drugs reimbursed in accordance with the methodology described in 13 CSR 70-20.070 shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates beginning February 1, 2019.

(C) Outpatient Hospital Services Reimbursement Limited by Rule.

1. Certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.

2. The technical component of outpatient radiology procedures will be reimbursed from a Medicaid fee schedule.

A. Effective for dates of service beginning October 1, 2011, through December 31, 2018, the technical component of outpatient radiology procedures, will be reimbursed according to the outpatient Medicaid fee schedule. These rates are based on one hundred twenty-five percent (125%) of the

Medicare Physician fee schedule rate using Missouri Locality 01. The Medicaid outpatient radiology fee schedule for the calendar years of 2016, 2017, and 2018 is published on the MO HealthNet website. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-radiology-fee-schedule18.pdf, December 4, 2018. This rule does not incorporate any subsequent amendments or additions.

B. Effective for dates of service beginning January 1, 2019, the technical component of outpatient radiology procedures will be reimbursed according to the outpatient Medicaid fee schedule. These rates are based on ninety percent (90%) of the Medicare Physician fee schedule rate, effective January 1, 2018, using Missouri Locality 01. The Medicaid outpatient radiology fee schedule for the calendar years of 2017, 2018, and 2019 is published on the MO HealthNet website. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-radiology-fee-schedule.pdf, December 4, 2018. This rule does not incorporate any subsequent amendments or additions.

3. Effective for dates of service beginning January 1, 2019, outpatient surgical procedures are reimbursed according to the outpatient Medicaid fee schedule. These rates are based on the 2018 Medicare Hospital Prospective Payment System Addendum B. The list of outpatient surgical procedure codes are reimbursed according to the Medicaid fee schedule. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-surgical-procedure-fee-schedule.pdf, November 30, 2018. This rule does not incorporate any subsequent amendments or additions.

4. Effective for dates of service beginning January 1, 2019, telehealth originating site fee is paid at the lesser of the billed amount or the outpatient fee schedule amount.

5. Effective for service dates beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

6. Services of hospital-based physicians and certified registered nurse anesthetists are reimbursed from a Medicaid fee schedule or the billed charge, if less.

7. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed by Medicare.

8. Reimbursement of Medicare/Medicaid crossover claims (crossover claims) for Medicare Part B and Medicare Advantage/Part C outpatient hospital services, except for public hospitals operated by the Department of Mental Health (DMH), shall be determined as follows:

A. Crossover claims for Medicare Part B outpatient hospital services in which Medicare was the primary payer and the MO HealthNet Division (MHD) is the payer of last resort for cost-sharing (i.e., coinsurance, copay, and/or deductibles) must meet the following criteria to be eligible for MHD reimbursement:

(I) The crossover claim must be related to Medicare Part B outpatient hospital services that were provided to MO HealthNet participants also having Medicare Part B coverage;

(II) The crossover claim must contain approved outpatient hospital services which MHD is billed for cost-sharing; and

(III) The Other Payer paid amount field on the claim must contain the actual amount paid by Medicare. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MHD for payment regardless of how the claim is submitted. Providers submitting crossover claims for Medicare Part B outpatient hospital services to MHD must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Part B plan's remittance advice. Any amounts paid by MHD that are determined to be based on inaccurate data will be subject to recoupment;

B. Crossover claims for Medicare Advantage/Part C (Medicare Advantage) outpatient hospital services in which a Medicare Advantage plan was the primary payer and MHD is the payer of last resort for cost-sharing (i.e., coinsurance, copay, and/or deductibles) must meet the following criteria to be eligible for MHD reimbursement:

(I) The crossover claim must be related to Medicare Advantage outpatient hospital services that were provided to MO HealthNet participants who also are either a Qualified Medicare Beneficiary (QMB Only) or Qualified Medicare Beneficiary Plus (QMB Plus);

(II) The crossover claim must be submitted as a Medicare UB-04 Part C Professional Crossover claim through the MHD online billing system;

(III) The crossover claim must contain approved outpatient hospital services which MHD is billed for cost-sharing; and

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

C. MHD reimbursement for approved outpatient hospital services. MHD will reimburse seventy-five percent (75%) of the allowable cost-sharing amount; and

D. MHD will continue to reimburse one hundred percent (100%) of the allowable cost-sharing amounts for outpatient services provided by public hospitals operated by DMH as set forth above in paragraph (1)(C)4.

(2) Exempt Hospitals. Exempt hospital out-patient payment percent will be set as follows and will include:

(A) New Medicaid providers which do not have a fourth, fifth, and sixth prior year cost report.

1. Interim payment percentage. An interim outpatient payment percentage for new Medicaid hospital providers will be set at seventy-five percent (75%) for the first three (3) state fiscal years in which the hospital operates. The cost reports for these three (3) years will have a cost settlement calculated in accordance with 13 CSR 70-15.040.

2. Outpatient percentage. The outpatient payment percentage for the fourth and fifth year in which the hospital operates will be based on the overall Medicaid cost-to-charge ratio from its fourth prior year cost report.

(B) Hospitals who qualify as nominal charge providers under

42 CFR 413.13(f) or meet the definition of nominal charge provider in subsection (4)(D) shall be reimbursed on an interim basis by Medicaid at the lesser of seventy-five percent (75%) of usual and customary charges as billed by the provider for covered services or one hundred percent (100%) of the facility's Medicaid-allowable outpatient cost-to-charge ratio as determined from the most recent desk-reviewed cost report. Reimbursement at the applicable percentage shall be effective July 1 of each SFY for all providers.

(C) A hospital which had a change-in-ownership or merged its operation with another hospital between January 1, 1997, and June 30, 2002, and does not have a 1997 cost report filed by new owner, shall have the option to delay its entry into prospective outpatient payment methodology or enter the prospective outpatient payment methodology identified in subsection (1)(A) of this regulation. The hospital must notify the division of its decision by March 3, 2003. A hospital which chooses to delay its entry into the prospective outpatient payment methodology will receive an outpatient payment percentage starting July 1, 2002, and may have final settlements calculated in accordance with paragraphs (2)(C)1. and 2. The transfer to the prospective outpatient payment percentage will occur as follows:

1. A hospital which does not have a fourth prior year cost report (for SFY 2003 cost report would be 1999) filed by new owner will have its retrospective outpatient payment percentage based on the overall outpatient cost-to-charge ratio from the most current desk-reviewed cost report, either prior or current owner. All cost reports for prior and current owner ending in the SFY prior to the year the new owner receives a prospective outpatient payment percentage in accordance with paragraph (2)(C)2., will have a final settlement calculated in accordance with 13 CSR 70-15.040; and

2. A hospital which has a fourth prior year cost report filed by current owner will have its prospective outpatient payment percentage based on the overall outpatient cost-to-charge ratio from its fourth prior year cost report for the fourth and fifth SFY after the change-in-ownership or merger which occurred prior to July 1, 2002. For the sixth SFY the hospital's rate will be established in accordance with subsection (1)(A) of this regulation.

Chart for prospective rates for change in ownership or merger:

1st cost report filed calender year	Settlement calculated	SFY	SFY prospective rate granted	Cost reports used for prospective rates
1998	Yes	1998	No	
1999	Yes	1999	No	
2000	Yes	2000	No	
2001	No	2001	No	
2002	No	2002	No	
2003	No	2003	Yes	1999
N/A	No	2004	Yes	1998, 1999, & 2000
N/A	NO	2005	Yes	199, 2000, & 2001

(D) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their outpatient percentage rate calculated under the surviving hospital's (the hospital whose Medicare and MO HealthNet provider number remains active) MO HealthNet provider number. The outpatient percentage rate of the surviving entity for the remainder of the state fiscal year in which the merger occurred is determined from combining the cost report data for the applicable cost report periods for the merged facilities. The effective date of the merged rate is the date of the merger. The surviving entity's outpatient percentage rate will be calculated for subsequent state fiscal years using the combined cost report data from the appropriate cost report periods for the merged facilities.

(E) A hospital that has failed to file one (1) of the cost reports used to determine their prospective outpatient payment percentage for the year, whether it be the fourth, fifth, or sixth prior year cost report, will have their prospective outpatient payment percentage based on the two (2) cost reports that are on file with the division plus the average of those two (2) cost reports to be used in place of the missing cost report. For example, if the division does not have on file a fourth prior year cost report, but has the fifth and sixth prior year cost reports, an average of the fifth and sixth prior year cost reports would be used in place of the fourth prior year cost report. This average along with the fifth and sixth prior year cost reports would then be used to calculate the prospective outpatient payment percentage.

(3) Closed Facilities. Hospitals which closed after January 1, 1999, but before July 1, 2002, will have final settlements for cost reports ending during this time period calculated in accordance with 13 CSR 70-15.040.

(4) Definitions.

(A) Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve- (12-) month period.

(B) Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

(C) Effective date.

1. The plan effective date shall be July 1, 2002.

2. New prospective outpatient payment percentages will be effective July 1 of each SFY.

(D) Nominal charge provider. A nominal charge provider is determined from the fourth prior year desk-reviewed cost report. The hospital must meet the following criteria:

1. An acute care hospital with an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%). The unsponsored care ratio is determined as the sum of bad debts and charity care divided by total net revenue. The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or

2. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

*[(5)]***(1)** Outpatient Simplified Fee Schedule (OSFS) Payment Methodology.

(A) Definitions. The following definitions will be used in administering section (1) of this rule:

1. Ambulatory Payment Classification (APC). Medicare's ambulatory payment classification assignment groups of Current Procedural Terminology (CPT) or Healthcare Common Procedures Coding System (HCPCS) codes. APCs classify and group clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources. All services within an APC group have the same relative weight used to calculate the payment rates;

2. APC conversion factor. The unadjusted national conversion factor calculated by Medicare effective January 1 of each year, as published with the Medicare Outpatient Prospective Payment System (OPPS) Final Rule, and used to convert the APC relative weights into a dollar payment. The Medicare OPPS Final Rule is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf, November 19, 2021]* **https://www.govinfo.gov/content/pkg/FR-2022-11-23/pdf/2022-23918.pdf, November 23, 2022**. This rule does not incorporate any subsequent amendments or additions;

3. APC relative weight. The national relative weights calculated by Medicare for the Outpatient Prospective Payment System;

4. Current Procedural Terminology (CPT). A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations;

5. Dental procedure codes. The procedure codes found in the Code on Dental Procedures and Nomenclature (CDT), a national uniform coding method for dental procedures maintained by the American Dental Association;

6. Federally-Deemed Critical Access Hospital. Hospitals that meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act;

7. HCPCS. The national uniform coding method maintained by the Centers for Medicare & Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians CPT and the three (3) HCPCS unique coding levels, I, II, and III;

8. Medicare Inpatient Prospective Payment System (IPPS) wage index. The wage area index values are calculated annually by Medicare, published as part of the Medicare IPPS Final Rule;

9. Missouri conversion factor. The single, statewide conversion factor used by the MO HealthNet Division (MHD) to determine the APC-based fees, uses a formula based on Medicare OPPS. The formula consists of sixty percent (60%) of the APC conversion factor, as defined in paragraph (5)(A)2. multiplied by the St. Louis, MO Medicare IPPS wage index value, plus the remaining forty percent (40%) of the APC conversion factor, with no wage index adjustment;

10. Nominal charge provider. A nominal charge provider is determined from the third prior year audited Medicaid cost report. The hospital must meet the following criteria:

A. A public non-state governmental acute care hospital with a low-income utilization rate (LIUR) of at least forty percent (40%) and a Medicaid inpatient utilization rate (MIUR) greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%). The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or

B. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and

C. A hospital physically located in the State of Missouri;

11. Outpatient Prospective Payment System (OPPS). Medicare's hospital outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000; and

12. Payment level adjustment. The percentage applied to the Medicare fee to derive the OSFS fee.

(B) Effective for dates of service beginning July 20, 2021, outpatient hospital services shall be reimbursed on a predetermined fee-for-service basis using an OSFS based on the APC groups and fees under the Medicare Hospital OPPS. When service coverage and payment policy differences exist between Medicare OPPS and Medicaid, MHD policies and fee schedules are used. The fee schedule will be updated as follows:

1. MHD will review and adjust the OSFS annually on July 1 based on the payment method described in subsection (1)(D); and

2. The OSFS is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at *[https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm, August 10, 2022]* **https://dss.mo.gov/mhd/providers/pages/cptagree.htm, June 15, 2023**. This rule does not incorporate any subsequent amendments or additions.

(C) Payment will be the lower of the provider's charge or the payment as calculated in subsection (1)(D).

(D) Fee schedule methodology. Fees for outpatient hospital services covered by the MO HealthNet program are determined by the HCPCS procedure code at the line level and the following hierarchy:

1. The APC relative weight or payment rate assigned to the procedure in the Medicare OPPS *Addendum B* is used to calculate the fee for the service, with the exception of the hospital observation per hour fee which is calculated based on the method described in subparagraph (5)(D)1.B. Fees derived from APC weights and payment rates are established using the Medicare OPPS *Addendum B* effective as of January 1 of each year as published by the CMS for Medicare OPPS. The Medicare OPPS *Addendum B* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppsaddendum-and-addendum-b-updates/january-2022-0, January 18, 2022]* **https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/january-2023, January 20, 2023**. This rule does not incorporate any subsequent amendments or additions.

A. The fee is calculated using the APC relative weight times the Missouri conversion factor. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee.

B. The hourly fee for observation is calculated based on the relative weight for the Medicare APC (using the Medicare OPPS *Addendum A* effective as of January 1 of each year as

published by the CMS for Medicare OPPS), which corresponds with comprehensive observation services multiplied by the Missouri conversion factor divided by forty (40), the maximum payable hours by Medicare. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee. The Medicare OPPS *Addendum A* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppsaddendum-and-addendum-b-updates/january-2022, January 18, 2022]* **https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/january-2023-0, Janary 20, 2023**. This rule does not incorporate any subsequent amendments or additions.

C. For those APCs with no assigned relative weight, ninety percent (90%) of the Medicare APC payment rate is used as the fee;

2. If there is no APC relative weight or APC payment rate established for a particular service in the Medicare OPPS *Addendum B*, then the MHD approved fee will be ninety percent (90%) of the rate listed on other Medicare fee schedules, effective as of January 1 of each year: Clinical Laboratory Fee Schedule; Physician Fee Schedule; and Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule, applicable to the outpatient hospital service.

A. The Medicare *Clinical Laboratory Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.cms.gov/medicaremedicare-fee-service-paymentclinicallabfeeschedclinical-laboratory-fee-schedule-files/22clabq1, December 29, 2021]* **https://www.cms.gov/medicare/medicare-fee-service-payment/clinicallabfeesched/clinical-laboratory-fee-schedule-files/23clabq1, January 12, 2023**. This rule does not incorporate any subsequent amendments or additions.

B. The Medicare *Physician Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-carrier-specific-files/all-states-1, December 18, 2021]* **https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-carrier-specific-files/all-states-2, January 5, 2023**. This rule does not incorporate any subsequent amendments or additions.

C. The Medicare *Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule, December 15, 2021]* **https://www.cms.gov/medicaremedicare-fee-service-paymentdmeposfeescheddmepos-fee-schedule/dme23, December 19, 2022**. This rule does not incorporate any subsequent amendments or additions;

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on thirty-eight and one half percent (38.5%) of the fiftieth percentile fee for Missouri reflected in the 2022 *National Dental Advisory Service* (NDAS). The 2022 NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental at its website at *[https://wasserman-medical.com/product-category/dental/ndas/],* and available at the MO HealthNet Division, 615 Howerton Court, Jefferson, City MO 65109, *[January 31, 2022]* **https://wasserman-medical.com/product-category/dental/ndas/, January 10, 2023** . This rule does not incorporate any subsequent amendments or additions*;*

4. If there is no APC relative weight, APC payment rate, other Medicare fee schedule rate, or NDAS rate established for a covered outpatient hospital service, then a MO HealthNet fee will be determined using the MHD *Dental, Medical, Other Medical or Independent Lab–Technical Component* fee schedules.

A. The MHD *Dental Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, *[June 7, 2022]* **March 8, 2023**. This rule does not incorporate any subsequent amendments or additions.

B. The MHD *Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, *[August 8, 2022]* **March 8, 2023**. This rule does not incorporate any subsequent amendments or additions.

C. The MHD *Other Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, *[June 7, 2022]* **March 8, 2023**. This rule does not incorporate any subsequent amendments or additions.

D. The MHD *Independent Lab–Technical Component Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet *Division, 615 Howerton Court, Jefferson City, MO 65109,* and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, *[June 7, 2022]* **March 8, 2023**. This rule does not incorporate any subsequent amendments or additions*;*

5. In-state federally-deemed critical access hospitals will receive an additional forty percent (40%) of the rate as determined in paragraph (5)(B)2. for each billed procedure code; and

6. Nominal charge providers will receive an additional twenty-five percent (25%) of the rate as determined in paragraph (5)(B)2. for each billed procedure code.

(E) Packaged services. MHD adopts Medicare guidelines for procedure codes identified as "Items and Services Packaged into APC Rates" under Medicare OPPS *Addendum D1*. These procedures are designated as always packaged. Claim lines with packaged procedure codes will be considered paid but with a payment of zero (0). The Medicare OPPS *Addendum D1* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-opps-addenda.zip, November 3, 2021]* **https://www.cms.gov/license/ama?file=/files/zip/2023-nfrm-opps-addenda.zip, November 22, 2022**. This rule does not incorporate any subsequent amendments or additions.

(F) Inpatient only services. MHD adopts Medicare guidelines for procedure codes identified as "Inpatient Procedures" under Medicare OPPS *Addendum D1*. These procedures are designated

as inpatient only (referred to as the inpatient only (IPO) list). Claim lines with inpatient only procedures will not be paid under the OSFS.

(G) Drugs. Effective for dates of service beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

(H) Payment for outpatient hospital services under this rule will be final, with no cost settlement.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016[, and section 208.152, RSMo Supp. 2022]. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed June 15, 2023, effective June 30, 2023, and expires Dec. 26, 2023. A proposed amendment covering this same material will be published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment is estimated to cost state agencies or political subdivisions $8,583,529 during the time the emergency amendment is effective.

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

FISCAL NOTE
PUBLIC COST

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

Rule Number and Title:	13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) & State Hospitals enrolled in MO HealthNet - 32	**No Fiscal Impact**
Department of Social Services, MO HealthNet Division	**SFY 2024 Impact (6 Months): Total Cost is estimated at $8.6 million; State Share is estimated at $2.9 million**

III. WORKSHEET

Department of Social Services, MO HealthNet Division Savings:	
Estimated Cost for 6 Months of SFY 2024:	
Estimated Cost	$8,583,529
Times SFY 2024 Blended State Share Percentage	33.995%
Estimated State Share Cost	$2,917,971

The state estimates that there is no cost to other government (public) and state hospitals. The state anticipates an increase in payments in aggregate of $2.3 million.

IV. ASSUMPTIONS

The estimated cost to the state is due to CMS increasing the Medicare rates for the following high volume services: emergency department visits, clinic visits, and some laboratory services.

The text of proposed rules and changes will appear under this heading. A 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 explanation is set out in the PURPOSE section of each rule. A citation of the legal authority to make rules is also required, and appears following the text of the rule, after the word "Authority."

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

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

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

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

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

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

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

PROPOSED RESCISSION

5 CSR 20-100.105 Missouri School Improvement Program-5. This rule outlined the performance standards for use in Classifying school districts in the Missouri School Improvement Program-5.

PURPOSE: The Department of Elementary and Secondary Education is rescinding this rule as it is no longer needed to classify school districts. 5 CSR 20-100.125 Missouri School Improvement Program-6 is now in effect and the State Board of Education may Classify school districts under this rule.

AUTHORITY: sections 160.514, 160.526, and 167.131, RSMo 2000, and sections 160.518, 161.092, 162.081, and 168.081, RSMo Supp. 2011. Original rule filed Aug. 18, 2011, effective March 20, 2012. Rescinded: Filed June 14, 2023.

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

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

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

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

PROPOSED RULE

5 CSR 20-100.185 Show-Me Success Diploma Program

PURPOSE: This rule outlines the criteria for the Show-Me Success Diploma, an alternative pathway to graduation for high school students that may be earned at any point between the end of the student's tenth-grade year and the conclusion of the student's twelfth-grade year as outlined in section 160.560, RSMo.

(1) Definitions.

(A) Proportionate share of the state, local, and federal aid shall be defined as the sum of the following divided by total September membership and shall be paid by the school district or charter school from local or unrestricted state funds:

1. Property taxes and delinquent taxes;
2. School District Trust Fund (Prop C);
3. Merchants' and manufacturers' tax revenues;
4. Financial institutions' tax revenues;
5. City sales tax revenue, including city sales tax collected in any city not within a county;
6. Payments in lieu of taxes;
7. Revenues from state-assessed railroad and utilities tax;
8. Total state revenue; and
9. Total federal revenue.

(B) Local aid shall not be construed to include –

1. Charitable contributions, gifts, and grants made to the school district or charter school;
2. Interest earnings of school districts and student fees paid to school districts; and
3. Debt service authorized by a public vote for the purpose of making payments on a bond issuance of a school district.

(C) Intent to enroll. For purposes of section (3) of this rule, intent to enroll is demonstrated by an acceptance letter from the postsecondary institution and notification to the postsecondary institution of acceptance or payment of enrollment deposit.

(D) Qualifying postsecondary institution shall be defined as an institution that participates in a student aid program

operated by the U.S. Department of Education.

(E) Pupil attendance percentage shall be defined as the district or charter school's prior year average attendance percentage calculated by using the prior year average K-12 membership divided by the prior year regular term K-12 Average Daily Attendance (ADA).

(2) Local education agencies (LEAs) may provide a course of study for a Show-Me Success Diploma. The course of study must include all graduation requirements required by state law.

(3) For LEAs to count a Show-Me Success Diploma graduate in their attendance data for state aid purposes, the LEA must—

(A) Allow the student to remain in high school and participate in a program of study available in the LEA; or

(B) Document that the student has enrolled in or demonstrated the intent to enroll in a postsecondary program that participates in a student aid program operated by the U.S. Department of Education.

(4) LEAs who elect to offer a Show-Me Success Diploma Program must demonstrate that its program graduates have the skills and knowledge necessary to be successful in college-level courses offered by community colleges in this state that count toward a degree or certificate.

(A) Students earning a Show-Me Success Diploma must demonstrate qualifying scores in each subject on one of the following measures:

Measure	English	Mathematics	Science
Required End-of-Course (EOC)	Proficient/ Advanced English II	Proficient/ Advanced Algebra I or other required assessment	Proficient/ Advanced Biology
Course Grade	Earn a B or better in English II or higher level course	Earn a B or better in Algebra I or higher level course	Earn a B or better in Biology or higher level course

and;

(B) Students earning a Show-Me Success Diploma must demonstrate qualifying scores in each subject on one (1) of the following assessments:

Assessment	English Score	Mathematics Score
Accuplacer®	92 Sentence Skills and 85 Reading	114 Arithmetic 116 Elementary Algebra
ACT®	18	22
Asset®	41	23
SAT®	430	510

AUTHORITY: sections 161.092, RSMo 2016, and 160.560, RSMo Supp. 2022. Original rule filed June 14, 2023.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately eleven thousand five hundred dollars ($11,500) in the aggregate.

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Department of Elementary and Secondary Education, Attention: 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.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Title 5–Department of Elementary and Secondary Education
Division Title: Division 20–Division of Learning Services
Chapter Title: Chapter 100–Office of Quality Schools

Rule Number and Name:	5 CSR 20-100.185 Show-Me Success Diploma Program
Type of Rulemaking:	Notice of Proposed Rulemaking

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Elementary and Secondary Education	$11,500

III. WORKSHEET

This proposed rule will include costs to the Department of Elementary and Secondary Education (DESE) for the cost of modifying the data collection system to accurately account for students who participate in the Show-Me Diploma Program.

The estimated cost is based on the following:

MOSIS Modifications

1. Cost of adding a new exit code without rules $1,500
2. Cost of adding new field to indicate if student is participating in Show-Me Success Diploma $7,000

Core Data Modifications

3. Cost of level of effort for OAIT for the modification to DESE's Screen 14 of Core Data - estimate $3,000 until response is received.

IV. ASSUMPTIONS

Estimations include in the worksheet are based on prior modifications to the collection system and vendor feedback on estimated cost.

Modification to the Core Data System is dependent on the level of effort provide by OAIT.

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

PROPOSED RESCISSION

5 CSR 20-100.255 Missouri School Improvement Program-5 Resource and Process Standards and Indicators. This rule outlined the performance standards for use in classifying school districts in the Missouri School Improvement Program-5.

PURPOSE: The Department of Elementary and Secondary Education is rescinding this rule as it is no longer needed to classify school districts. 5 CSR 20-100.125 Missouri School Improvement Program-6 is now in effect and the State Board of Education may classify school districts under this rule.

AUTHORITY: sections 160.514, 160.526, and 167.131, RSMo 2000, and sections 160.518, 161.092, 162.081, and 168.081, RSMo Supp. 2012. Original rule filed Sept. 20, 2012, effective Jan. 22, 2015. Rescinded: Filed June 7, 2023.

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

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

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

TITLE 5–DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20–Division of Learning Services
Chapter 500–Office of Adult Learning and Rehabilitation Services

PROPOSED AMENDMENT

5 CSR 20-500.210 Services. The State Board of Education is amending the purpose statement and sections (1), (2), (3), and (4), adding subsection (2)(B) and section (5), renumbering accordingly, and adding material incorporated by reference.

PURPOSE: This amendment corrects the name of the service provider to Vocational Rehabilitation, corrects the citation, adds the office name, updates and adds language in accordance with federal regulations, and incorporates by reference applicable federal regulations.

*PURPOSE: This rule establishes the standards for vocational rehabilitation services [for the State Board of Education] through [the Division of] Vocational Rehabilitation, **Office of Adult Learning and Rehabilitation Services,** Department of Elementary and Secondary Education, for individuals with disabilities pursuant to the Rehabilitation Act of 1973 as amended and [the Code of Federal Regulations] **34 CFR section 361.48; 34 CFR section 361.53(a), (b), and (c); and 34 CFR section 361.54**.*

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) Vocational rehabilitation services as defined in the federal act and/or applicable regulations may be provided to individuals.

[(A) Financial Need.]

*[1.]***(A)** The following vocational rehabilitation services as defined in the federal act and/or applicable regulations may be provided to **eligible** individuals based upon **their** financial need **and the nature and scope of services in their individualized plan for employment (IPE)**:

*[A.]***1.** Physical and/or mental restoration, including but not limited to hospitalization, medical treatment, surgery, dentistry, and prosthesis;

*[B.]***2.** Training, including tuition, fees, books, supplies, training materials, and other services associated with training;

*[C.]***3.** Maintenance;

*[D.]***4.** Transportation;

*[E.]***5.** Placement tools, including initial stock and supplies associated with placement;

*[F.]***6.** Self-employment;

*[G.]***7.** Rehabilitation technology service, including assistive technology devices and services to assist the individual to achieve an employment outcome;

*[H.]***8.** Home modification or remodeling;

*[I.]***9.** Vehicle modification;

*[J.]***10.** Services to family members to assist the individual to achieve an employment outcome;

[K. Personal attendant services;]

[L.] **11.** Note-taking services, not involving sign language interpretation; and/or

*[M.]***12.** Other goods and services not listed above to assist the individual to achieve an employment outcome.

*[2.]***(B)** Financial need is based upon the individual's adjusted gross income level of the most recent tax records less unreimbursed disability-related expenses as approved by *[the Division of]* Vocational Rehabilitation (*[D]*VR) and compared to one hundred eighty-five percent (185%) of the U.S. Department of Health and Human Services poverty level for Missouri and the Consumer Price Index as updated on an annual basis.

*[3.]***(C)** Individuals who are *[below three hundred percent (300%)]* **above one hundred eighty-five percent (185%)** of the U.S. Department of Health and Human Services poverty level for Missouri and the Consumer Price Index as updated on an annual basis, and do not receive any services based upon financial need as listed in this subsection, may receive an annual fixed amount as determined by *[D]*VR, to be applied toward tuition costs**, books, fees,** or required *[fees]* **supplies** for training services **only**. This amount may be authorized by *[D]*VR for a twelve- (12-)*[-]*month period of time on an annual basis, beginning on the date of services listed on the *[Indivdualized Plan for Emplyoment (]*IPE*[)]*.

[(B) Nonfinancial Need.]

*[1.]***(D)** The following vocational rehabilitation services as

defined in the federal act and/or applicable regulations may be provided to individuals regardless of financial need:

*[A.]***1.** Medical diagnostic services, including medical and surgical examination; psychiatric evaluation; dental examination; inpatient hospitalization for specific identified vocational rehabilitation diagnostic and evaluation services including room, board, and other services provided by the facility; clinical laboratory tests, diagnostic x-ray procedures, and other medically recognized diagnostic services;

*[B.]***2.** Psychological diagnostic services including psychological tests and measurements, intelligence tests, achievement tests, assessment of social functioning, educational achievement, and other recognized diagnostic services;

*[C.]***3.** Social and vocational diagnostic services including evaluation of the individual's employment opportunities and objectives in light of personality factors, intelligence level, educational achievements, work experience, vocational aptitudes and interests, and personal and social adjustment;

*[D.]***4.** Maintenance when required to enable the individual to participate in **an assessment or** diagnostic evaluation*[/services]* **in order to determine eligibility and vocational rehabilitation needs**;

*[E.]***5.** Transportation when required to enable an individual to participate in **an assessment or** diagnostic evaluation*[/services]* **in order to determine eligibility and vocational rehabilitation needs**;

*[F.]***6.** Assessment for determining eligibility and vocational rehabilitation needs;

*[G.]***7. Vocational rehabilitation** *[C]***c**ounseling*[,]* **and** guidance, **including** information and *[referral]* **support** services **to assist an individual in exercising informed choice**;

*[H.]***8.** Interpreter services for deaf or non-English speaking individuals when necessary to participate in a rehabilitation plan. Note-taking services that include interpreter services are not based upon the individual's financial need; *[and/or]*

*[I.]***9. Job search and job** *[P]***p**lacement *[assistance into]* **services necessary to assist an individual in locating employment opportunities and obtaining** suitable employment *[and]* **to include job development, job retention,** follow-up **services, follow-along services,** on-the-job training fees *[required to meet a job objective, including fees for: on-the-job training fees]***, apprenticeship training fees**, **employment services, and** supported employment *[and work stations in industry.]* **services, including customized employment and individual placement with supports, to provide short- or long-term job coaching in order to assist an individual in learning job-related skills required to meet a vocational goal** (All other **need-based** services required during the training such as maintenance and transportation will be based on financial need.)**;**

10. Personal assistance services required to enable the individual to participate in the rehabilitation plan; and/or

11. Referral and other services necessary to assist in securing needed services from other agencies/programs, including other components of the state-wide workforce development system.

(2) Individuals must use and make application for all available comparable services, including but not limited to federal and state financial aid, which will be used to reduce the costs of services for *[D]*VR. Other comparable services, including Medicaid, Medicare, and insurance, will also be used by *[D]*VR to reduce the costs of services.

(A) Prior to providing any services to an individual, *[D]*VR will determine whether comparable services or benefits are available under any other program, except in the following instances:

1. When a determination would delay or interrupt the progress of the individual toward achieving the employment outcome identified in the IPE;

2. When a determination would delay or interrupt an immediate job placement; or

3. When a determination would delay or interrupt the provision of a service to any individual at extreme medical risk.

(B) The following vocational rehabilitation services are exempt from a determination of the availability of comparable services and benefits:

1. Rehabilitation technology *[service]*, including *[assistive technology devices and services]* **telecommunications, sensory, and other technological aids and devices,** to assist the individual to achieve an employment outcome;

2. Counseling*[,]***and** guidance, **including** information and *[referral]* **support** services **to assist an individual in exercising informed choice**;

3. Assessment for determining eligibility and vocational rehabilitation needs;

4. Job-related services, including job search and placement assistance, job retention services, follow-up services, and follow-along services;

5. *[When a determination would delay or interrupt the progress of the individual toward achieving the employment outcome identified in the individualized plan for employment]* **Referral and other services necessary to assist in securing needed services from other agencies/programs, including other components of the state-wide workforce development system**; **and**

6. *[When a determination would delay and interrupt job placement; and]* **Post-employment services that include services listed in paragraphs (2)(B)1.-5.**

[7. Provision of a service to any individual at extreme medical risk.]

(3) *[D]*VR funds may not be used for the purchase of the following:

(4) *[D]*VR will follow all Missouri procurement policies as specified in the *Revised Statutes of Missouri* for the purchase, retention, repossession, and discarding of items including but not limited to prosthetic appliances; home modifications; vehicle modifications; initial tools, stock**,** and equipment**;** and/or rehabilitation technology/devices.

(5) 34 CFR section 361.48; 34 CFR section 361.53(a), (b), and (c); and 34 CFR section 361.54 are hereby incorporated by reference and made part of this rule as published by the U.S. Government Publishing Office, 732 North Capitol Street NW, Washington, DC 20401-0001, in June 2023. Copies of these regulations can also be obtained from the Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Services, 205 Jefferson Street, PO Box 480, Jefferson City, MO 65102-0480 and at https://dese.mo.gov/governmental-affairs/dese-administrative-rules/incorporated-reference-materials. This rule does not incorporate any subsequent amendments or additions.

*AUTHORITY: sections 161.092, [RSMo Supp. 2003 and] 178.600, 178.610, and 178.620, RSMo [2000]**2016**. This rule previously filed*

as 5 CSR 90-5.400. Original rule filed Dec. 17, 1999, effective Aug. 30, 2000. Amended: Filed Dec. 7, 2000, effective July 30, 2001. Amended: Filed June 30, 2004, effective Jan. 30, 2005. Moved to 5 CSR 20-500.210, effective Aug. 16, 2011. Amended Filed June 9, 2023.

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions between one hundred fifty-five thousand five hundred dollars ($155,500) and four hundred seventy thousand dollars ($470,000) annually for the duration of the rule.

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Elementary and Secondary Education, Attention: Chris Clause, Ph.D., Assistant Commissioner, Office of Adult Learning and Rehabilitation Services, 3024 Dupont Circle, Jefferson City, MO 65109, or by email to info@vr.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.*

FISCAL NOTE
PUBLIC COST

I. TITLE 5–DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20–Division of Learning Services
Chapter 500–Office of Adult Learning and Rehabilitation Services

Rule Number and Name:	5 CSR 20-500.210 Services
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Elementary & Secondary Education, Vocational Rehabilitation	Estimated annual increase in costs $155,500- $470,000

III. WORKSHEET

Training Services:

The fiscal impact is based upon expected increase in training services expenditures for individuals who are over three hundred percent (300%) of the U.S. Department of Health and Senior Services poverty level for Missouri. The proposed rule change removes the requirement that an individual's income must be under 300% of the poverty level.

On average, there are one thousand (1,000) clients who participate in planned training services who are over VR's financial guidelines of one hundred eighty-five percent (185%) but under 300% of the poverty level. These individuals receive up to $2,000 in training services per year.

There is an expected increase of five percent (5%) in those planned services for individuals who are over 300% of the poverty level. This is an estimated increase of fifty (50) participants per year. The maximum expenditure is two thousand dollars ($2,000) per individual per year for training services.

Customized Employment:

Customized Employment will expand and become available statewide. This service is expected to serve an additional 15-100 participants annually. The average cost per participant for these services is three thousand seven hundred dollars ($3,700).

Potential Impact of Rule:

Training Services: 50 x $2,000 = $100,000

Customized Training: Impact is a range to account for growth each year.
15 x $3,700 = $55,500
100 x $3,700 = $370,000

Total Estimated Rule Impact: ($100,000 + $55,500 - $370,000) **= $155,500 - $470,000**

IV. ASSUMPTIONS

1. Impact of rule change for training services on VR program is dependent on number of VR clients participating in planned training services where that individual's adjusted gross income is above three hundred percent (300%) of the U.S. Department of Health and Senior Services poverty level for Missouri.
2. Impact of rule change for customized employment on VR program is dependent on number of clients participating in planned customized employment services.

TITLE 5–DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20–Division of Learning Services
Chapter 500–Office of Adult Learning and Rehabilitation Services

PROPOSED AMENDMENT

5 CSR 20-500.220 Fees. The State Board of Education is amending the purpose statement and sections (1) and (2), adding section (3), and adding material incorporated by reference.

PURPOSE: This amendment corrects the name of Vocational Rehabilitation, adds the office name, corrects the citation and the source of rates for dental fees, and incorporates by reference applicable federal regulations.

*PURPOSE: This rule establishes fees paid by [the Division of] Vocational Rehabilitation, **Office of Adult Learning and Rehabilitation Services**, Department of Elementary and Secondary Education for services for individuals with disabilities pursuant to the Rehabilitation Act of 1973 as amended and [the Code of Federal Regulations] 34 CFR section 361.50(c).*

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) Certain fees may be paid by *[the Division of]* Vocational Rehabilitation (*[D]*VR). However, if the usual and customary fee charged for the service is less than an amount listed, the usual and customary fee is the maximum that will be paid. No additional moneys can be collected from the applicant or eligible individual. The fees are as follows:

(B) Surgical and Medical Fees: Medicare formula for surgery and related services as approved by the assistant commissioner of *[D]*VR, or if the service is not covered by Medicare, then the rate will be the usual and customary fee as approved by the assistant commissioner of *[D]*VR;

(C) Psychological Diagnostic Fees: Usual and customary fees as approved by the assistant commissioner of *[D]*VR;

(D) Dental Fees: *[Missouri Medicaid]* **Medicare** rates as approved by the assistant commissioner of *[D]*VR, or if the service is not covered by *[Medicaid]* **Medicare,** then the rate will be the usual and customary fee as approved by the assistant commissioner of *[D]*VR;

(E) Community Rehabilitation and Supported Employment Programs: Evaluation of a cost analysis report for each program with the fees approved by the assistant commissioner of *[D]*VR; and/or

(F) Interpreter Services: Usual and customary fees approved by the assistant commissioner of *[D]*VR.

(2) The maximum fee which may be paid by *[D]*VR for any services or entity not listed above is the usual and customary fee for said service or entity as approved by the assistant commissioner of *[D]*VR.

(3) 34 CFR section 361.50(c) is hereby incorporated by reference and made part of this rule as published by the U.S. Government Publishing Office, 732 North Capitol Street NW, Washington, DC 20401-0001, in June 2023. Copies of this regulation can also be obtained from the Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Services, 205 Jefferson Street, PO Box 480, Jefferson City, MO 65102-0480 and at https://dese.mo.gov/governmental-affairs/dese-administrative-rules/incorporated-reference-materials. This rule does not incorporate any subsequent amendments or additions.

*AUTHORITY: sections 161.092, [RSMo Supp. 2002 and] 178.600, 178.610, and 178.620, RSMo [2000] **2016**. This rule previously filed as 5 CSR 90-5.410. Original rule filed Dec. 17, 1999, effective Aug. 30, 2000. Amended: Filed March 27, 2003, effective Oct. 30, 2003. Moved to 5 CSR 20-500.220, effective Aug. 16, 2011. Amended: Filed June 15, 2023.*

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 Elementary and Secondary Education, Attention: Chris Clause, Ph.D., Assistant Commissioner, Office of Adult Learning and Rehabilitation Services, 3024 Dupont Circle, Jefferson City, MO 65109, or by email to info@vr.dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

TITLE 5–DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20–Division of Learning Services
Chapter 500–Office of Adult Learning and Rehabilitation Services

PROPOSED AMENDMENT

5 CSR 20-500.240 Physical and Mental Restoration. The State Board of Education is amending the purpose statement and section (1), renumbering accordingly, adding section (2), and adding material incorporated by reference.

PURPOSE: This amendment corrects the name of Vocational Rehabilitation, adds the office name, updates language, corrects the citation, adds language regarding hearing aids and established rates, and incorporates by reference applicable federal regulations.

*PURPOSE: This rule establishes the standards for physical and mental restoration services provided by [the Division of] Vocational Rehabilitation, **Office of Adult Learning and Rehabilitation Services**, Department of Elementary and Secondary Education for individuals with disabilities pursuant to the Rehabilitation Act of 1973 as amended and [the Code of Federal Regulations] 34 CFR sections 361.5(c)(39) and 361.48(b)(5).*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated

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

(1) The following physical and/or mental restoration services as defined in the federal act and/or applicable regulations may be provided to applicants or eligible individuals based upon financial need:

(A) Hospital services for eligible individuals shall be provided from an instate hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or by the American Osteopathic Association and licensed by the Missouri Department of Health. Preference will be given to hospitals having fifty (50) or more beds and well developed surgical and specialty services*[;]***.**

1. Hospital services for eligible individuals from an out-of-state hospital may be paid according to *[the rates and methods approved by the vocational rehabilitation agency in the state where the hospital is located;]* **Missouri Vocational Rehabilitation (VR) established rates.**

(B) Surgical services for eligible individuals may be provided upon approval by *[the Division of Vocational Rehabilitation's (DVR) Medical Review Committee and]* **VR** when necessary to correct or substantially modify a physical or mental impairment, which is stable or slowly progressive and constitutes a substantial impediment to employment. The condition must be of such a nature that correction or modification may be reasonably expected to eliminate or substantially reduce the impediment to employment within a reasonable length of time;

(C) Hearing aids may only be provided from a Missouri licensed hearing aid dealer *[and fitter]* upon the recommendation of a Missouri physician specializing in diseases of the ear or a Missouri certified audiologist. *[The recommendation must include the recommended type of aid and specifications or prescriptions.]* **The specific make and model of hearing aids must be included in the recommendation.** All licenses or certifications must be valid, unencumbered, unrestricted, and undisciplined.

1. Prior to purchase authorization, *[D]*VR will –

A. Consult with the physician or audiologist to determine feasibility of any repair or reconditioning of an existing aid;

[B. Obtain estimates including the itemized cost of the aid, batteries, service and warranty from more than one (1) licensed dealer when practical;

C. Request agency discounts;]

[D.] **B.** Allow for the eligible individual's preference of vendor whenever possible; and

[E.] **C.** Ensure that the quality of aid, accessories, service, **basic** warranty, and cost effectiveness are evaluated; and/or

(D) Individuals with mental illness may be referred to the Missouri Department of Mental Health or other mental health providers as a comparable service. Psychotherapy services may be authorized when required for the eligible individual to begin or continue a rehabilitation plan under the following conditions:

1. The need for psychotherapy is clearly related to the expected employment outcome and recommended by a Missouri licensed psychiatrist or psychologist;

2. An Individualized Plan for Employment (IPE) must have been developed or be in the process of development to provide services leading to the attainment of the vocational goal;

3. The eligible individual meets *[D]*VR's financial need guidelines;

4. The provider must be a Missouri licensed psychiatrist, psychologist, clinical social worker, or professional counselor. The provider must possess a valid, unencumbered, unrestricted, and undisciplined Missouri license; and

5. Psychotherapy may be authorized for a period up to three (3) months. An additional three (3) months of therapy may be approved if the therapist feels that the consumer is making satisfactory progress that will lead to the attainment of the vocational goal specified on the IPE.

(2) 34 CFR sections 361.5(c)(39) and 361.48(b)(5) is hereby incorporated by reference and made part of this rule as published by the U.S. Government Publishing Office, 732 North Capitol Street NW, Washington, DC 20401-0001, in June 2023. Copies of this regulation can also be obtained from the Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Services, 205 Jefferson Street, PO Box 480, Jefferson City, MO 65102-0480 and at https://dese.mo.gov/governmental-affairs/dese-administrative-rules/incorporated-reference- materials. This rule does not incorporate any subsequent amendments or additions.

*AUTHORITY: sections 161.092, 178.600, 178.610 and 178.620, RSMo **[1994] 2016**. This rule previously filed as 5 CSR 90-5.430. Original rule filed Dec. 17, 1999, effective Aug. 30, 2000. Moved to 5 CSR 20-500.240, effective Aug. 16, 2011. Amended: Filed June 15, 2023.*

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 Elementary and Secondary Education, Attention: Chris Clause, Ph.D., Assistant Commissioner, Office of Adult Learning and Rehabilitation Services, 3024 Dupont Circle, Jefferson City, MO 65109, or by email to info@vr.dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 25 – Office of Childhood
Chapter 500 – Licensing Rules for Group Child Care Homes and Child Care Centers

PROPOSED AMENDMENT

5 CSR 25-500.010 Definitions. The State Board of Education (board) is amending sections (2) and (6).

PURPOSE: This amendment updates the definition of a caregiver to specify that sixteen- (16-) and seventeen- (17-) year olds can also be considered in this role and to specify that a child care provider is an adult person(s).

(2) Caregiver is the child care provider or other child care staff

member*[.]* **and also includes a Junior Aide for any group child care homes and child care centers. A Junior Aide is any individual sixteen (16) or seventeen (17) years of age.**

(6) Child care provider, group child care home provider, or provider is the **adult** person(s) licensed or required to be licensed under section 210.211, RSMo, in order to establish, conduct, or maintain a child care facility. This person(s) shall have the following rights and responsibilities as determined by the *[division]* **department**:

AUTHORITY: section 161.092, RSMo 2016, and section 210.221.1(3), RSMo Supp. ***[2021] 2022****. This rule previously filed as 13 CSR 40-62.010 and 19 CSR 40-62.010. Original rule filed in 1956. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed June 14, 2023.*

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 Nancy Scherer, Department of Elementary and Secondary Education, Office of Childhood, PO Box 480, Jefferson City, MO 65102, by faxing (573) 526-8000 or via email at childhoodrules@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 25 – Office of Childhood
Chapter 500 – Licensing Rules for Group Child Care Homes and Child Care Centers

PROPOSED AMENDMENT

5 CSR 25-500.102 Personnel. The State Board of Education (board) is amending subsections (1)(C) and (2)(A), and adding a new subsection (1)(U).

PURPOSE: This amendment clarifies staff who can be counted in staff/child ratios and specifies additional requirements for caregivers that are considered a Junior Aide, adds a new rule about the age of staff and volunteers in relation to the age of children specified on the license, and clarifies that a center director or group child care home provider must be an adult.

(1) General Staff Requirements.

(C) *[Individuals]***Caregivers** eighteen (18) years of age or older shall be counted in meeting the required staff/child ratios. **In addition, a Junior Aide as defined in 5 CSR 25-500.010 shall be counted in meeting the required staff/child ratios if the following requirements are met:**

1. A Junior Aide –

A. May count in staff/child ratio only if under the direct supervision of an adult caregiver within the same group of children;

B. Shall not have the direct responsibility for a group of children as the sole caregiver;

C. Shall not count towards infant/toddler staffing ratios; and

D. Shall not be the sole caregiver on the premises of a child care facility.

(U) Staff and volunteers shall not fall within the same age range as the age of children specified on the license.

(2) Center Director or Group Child Care Home Provider.

(A) General Requirements.

1. An approved certificated group child care home provider or center director shall be **an adult who is** responsible for planning, monitoring, and managing the facility's daily program.

A. A Center Director/Group Child Care Home Provider Certification Request form shall be submitted to the department. See Center Director/Group Child Care Home Provider Certification Request form, revised 2022 and incorporated by reference in this rule as published by the Missouri Department of Elementary and Secondary Education, PO Box 480, Jefferson City, MO 65102-0480 and available by the department at https://dese.mo.gov/childhood/forms. This rule does not incorporate any subsequent amendments or additions.

B. Once the center director or group child care home provider is certificated by the department, the Center Director/Group Child Care Home Provider Approval Request form shall be submitted to the department and maintained on file at the facility. See Center Director/Group Child Care Home Provider Approval Request form, revised 2021 and incorporated by reference in this rule as published by the Missouri Department of Elementary and Secondary Education, PO Box 480, Jefferson City, MO 65102-0480 and available by the department at https://dese.mo.gov/childhood/forms. This rule does not incorporate any subsequent amendments or additions.

2. Center directors and group child care home providers routinely shall be on duty during the hours of highest attendance a minimum of forty (40) hours per week. If the facility operates less than forty (40) hours per week, the center director or group child care home provider shall be on duty at least fifty percent (50%) of the operating hours.

3. The licensee is required to maintain an approved certificated group child care home provider or center director on staff.

4. The duties and responsibilities of the center director or group child care home provider shall be defined clearly in writing.

5. In the absence of the center director or group child care home provider, another responsible individual shall be designated to be in charge of the facility.

6. The center owner(s), or the board president or chairperson, shall notify the department immediately when there is a change of directors and shall have a qualifying criminal background check on file as required by 5 CSR 25-600.020 General Requirements.

AUTHORITY: section 161.092, RSMo 2016, and sections 210.221, 210.223, and 210.1080, RSMo Supp. 2022. This rule previously filed as 13 CSR 40-62.091, 13 CSR 40-62.102, and 19 CSR 40-62.102. Original rule filed March 29, 1991, effective Oct. 31, 1991. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 14, 2023.*

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 Nancy Scherer, Department of Elementary and Secondary Education, Office of Childhood, PO Box 480, Jefferson City, MO 65102, by faxing (573) 526-8000, or via email at childhoodrules@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 25 – Office of Childhood
Chapter 500 – Licensing Rules for Group Child Care Homes and Child Care Centers

PROPOSED AMENDMENT

5 CSR 25-500.112 Staff/Child Ratios. The State Board of Education (board) is amending section (1).

PURPOSE: This amendment puts ratio and group size limitations in a table format to make the rule easier to read and understand, adds group size limitations for children three (3) years of age and older, and clarifies when staff/child ratios and group sizes apply throughout the day.

(1) *[The following staff/child ratios shall be maintained on the premises at all times:*

(A) Birth Through Two (2) Years. Groups composed of mixed ages through two (2)-years shall have no less than one (1) adult to four (4) children, with no more than eight (8) children in a group;

(B) Age Two (2) Years. Groups composed solely of two (2)-year olds shall have no less than one (1) adult to eight (8) children, with no more than sixteen (16) children in a group;

(C) Ages Three Through Four (3-4) Years. Groups composed solely of three (3)- and four (4)-year olds shall have no less than one (1) adult to ten (10) children;

(D) Ages Five (5) and Up. Groups composed solely of five (5)-year olds and older shall have no less than one (1) adult to every sixteen (16) children; and

(E) Mixed Age Groups Two Years (2) and Up. Groups composed of mixed ages of children two (2) years of age and older shall have no less than one (1) adult to ten (10) children with a maximum of four (4) two (2)-year olds. When there are more than four (4) two (2)-year olds in a mixed group, the staff/child ratio shall be no less than one (1) adult to eight (8) children.] **Staff/child ratios shall be maintained at all times.**

(A) The staff/child ratio and group size shall be followed as outlined in the chart below unless it meets an exception in subsections (1)(B)-(G) below.

Ages of Children in Group	Description for the Purpose of this Rule	Minimum Staff/ Child Ratio	Maximum Group Size
Infants, toddlers, and 2-year-olds	Birth to 36 months	1:4	8
2-year-olds	Groups composed solely of children 24 to 36 months	1:8	16
3 through 4-year-olds	Groups composed solely of children 3 to 4 years old	1:10	20
5-year-olds and up	Groups composed solely of children 5 years or older	1:16	32
Mixed ages (Type 1) 2-year-olds and older, with a maximum of four (4) 2-year-olds	A mixed group of children consisting of no more than 4 children ages 24 to 36 months, and at least one child older than 36 months	1:10	20
Mixed ages (Type 2) 2-year-olds and older, with more than four (4) 2-year-olds	A mixed group of children consisting of more than 4 children ages 24 to 36 months, and at least one child older than 36 months	1:8	16

(B) For group child care homes licensed for a maximum of four (4) infants/toddlers or for child care centers licensed for a maximum of twenty (20) children, including no more than four (4) infants/toddlers, multiple groups may occupy the same physical space.

(C) During naptime, groups composed of children two (2) years old and older shall not be required to maintain staff/child ratio within the napping area, but shall not exceed group size limitations. The required staff/child ratio shall be maintained on the premises during naptime.

(D) Groups composed of children two (2) years old and older shall not be required to maintain group sizes during –

1. Outdoor play;

2. Meals;

3. Field trips; and

4. Special events including but not limited to guest speakers, assemblies, and celebrations.

(E) Group size requirements shall not apply when children are transported to or from the facility.

(F) For programs licensed exclusively for school-age children, multiple groups may occupy the same physical space.

(G) During outdoor play, staff/child ratios may be one and one-half (1 1/2) times the indoor staff/child ratios if children two (2) years of age or younger are not present in the outdoor play space. The required indoor staff/child ratios shall be maintained on the premises at all times.

AUTHORITY: section [210.221.1(3), RSMo Supp. 1993.] ***161.092, RSMo 2016, and section 210.221, RSMo Supp. 2022****. This rule previously filed as 13 CSR 40-62.100, 13 CSR 40-62.112, and 19 CSR 40-62.112. Original rule filed March 29, 1991, effective Oct. 31,*

1991. Moved to 19 CSR 40-62.112, effective Dec. 9, 1993. Changed to 19 CSR 30-62.112 July 30, 1998. Moved to 5 CSR 25-500.112 Aug. 30, 2021. Amended: Filed: June 7, 2023.

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

PRIVATE COST: This proposed amendment will cost private entities zero ($0) dollars to fifty-eight thousand eighty dollars ($58,080) for initial furniture or equipment costs.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Nancy Scherer, Department of Elementary and Secondary Education, Office of Childhood, PO Box 480, Jefferson City, MO 65102, by faxing (573) 526-8000, or via email at childhoodrules@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.*

FISCAL NOTE
PRIVATE COST

I. 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

Rule Number and Title:	5 CSR 25-500.112 Staff/Child Ratios
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
135*	Licensed Group Child Care Homes	$0
162*	Child Care Centers licensed for a maximum of 20 children	$0
375*	School-Age only programs	$0
1,097*	Child Care Centers licensed to care for 21 or more children age two (2) and older	$0 – $58,080 initial furniture or equipment cost

*All calculations are based on licensed facility data pulled April 12, 2023.

III. WORKSHEET

The Department of Elementary and Secondary Education, Office of Childhood (OOC) anticipates it will cost licensed group child care homes, child care centers licensed for a maximum of twenty (20) children, and licensed school-age only programs $0 to comply with the adoption of this rule amendment. The OOC anticipates that it will cost child care centers licensed to care for twenty-one (21) or more children age two (2) and older $0 – $58,080 to comply with the proposed rule.

Sample methodology:
2 / 33 participating stakeholders = 6% reported a fiscal impact due to proposed group size limits
1,097 X 6% = 66 (# of facilities that *may* have to rearrange or purchase furniture or equipment)
66 x 4 (estimated # of shelves) = 264 shelves x $220.00/shelf = $58,080 initial furniture or equipment costs.

IV. ASSUMPTIONS

- Federal regulation in 45 CFR 98.41(d)(1) requires the department to establish group size limits for specific age populations served in a child care setting.
- This proposed amendment adds group size limits for children three (3) years of age and older. The amendment also clarifies when staff/child ratios and group sizes apply

throughout the day. Group size limits already exist for children age two (2) and younger.

- For each age group of children, the maximum group size is double that of the staff-to-child ratio. There are no changes to staff/child ratios. To meet group size limits facilities will not be required to add additional staffing, but they may need to define space in a classroom.
- Group size is already defined in rule (5 CSR 25-500.010(12)) as the maximum number of children assigned to a specific staff member or group of staff members, occupying an individual classroom or well-defined physical space within a large room.

Licensed Group Child Care Homes & Centers Licensed for a Maximum of 20 Children

- Licensed group child care homes will not be impacted by the adoption of this rule because overall license capacity of the facility is limited to twenty (20) children and the amendment allows for multiple groups to occupy the same physical space as long as staff/child ratios are maintained. Likewise, child care centers licensed for a maximum of twenty (20) children will not be impacted by the adoption of the maximum group size for children age three (3) and up.

School-Age Only Programs

- Programs licensed exclusively for school-age children will not be impacted by this rule as the amendment specifies that multiple groups may occupy the same physical space as long as staff/child ratios are maintained to allow for supervision of children.

Child Care Centers Licensed for 21 or More Children Age Two (2) and Over

- There are 1,097 child care centers with a capacity of 21 or more children age two (2) and older.
- During stakeholder engagement sessions with groups of child care providers, many providers that would be impacted by this rule did not report any fiscal costs associated with the adoption of the proposed group sizes because they already set group size limits that do not exceed those proposed.
- The OOC recognizes that there are licensed child care centers who currently have approved room capacities larger than the proposed maximum group size limits; therefore, there are licensed child care centers that *may* be adversely impacted in one of the following ways:
    1. The provider will either decide to reduce overall capacity (revenue loss) and adhere to the maximum group size in individual classroom(s).
        - The OOC does not have data readily available to show how many individual classrooms are approved for capacities larger than the maximum group size.
    2. The provider will need to purchase or rearrange existing furniture and equipment to ensure that a larger room has well-defined space for groups to occupy.
        - For those who would need to purchase furniture or other items necessary to satisfy this requirement, staff researched options using the search term "classroom furniture shelves" on Amazon. Several acceptable options cost, on average, $220.00 per shelf.

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

PROPOSED AMENDMENT

5 CSR 25-500.182 Child Care Program. The State Board of Education (board) is amending subsections (1)(A), (2)(B), and (2)(C).

PURPOSE: This amendment is to clarify the role of an adult and a caregiver in the care and daily activities of a child.

(1) Care of the Child.
(A) General Requirements.
1. Caregivers shall not leave any child without competent ***[adult]*** supervision.
2. A caregiver personally shall admit each child upon arrival and personally shall dismiss each child upon departure. Children shall be dismissed only to the parent(s), guardian, legal custodian, or to individuals approved by the parent(s), guardian, or legal custodian.
3. Caregivers shall provide frequent, direct contact so children are not left unobserved on the premises.
4. Children under three (3) shall be supervised and assisted while in the bathroom.
5. A caregiver shall remain in the room with preschool and school-age children while they are napping or sleeping and shall be able to see and hear them if they have difficulty during napping or when they awaken.
6. Preschool children who do not sleep shall rest on cots or beds at least thirty (30) minutes, but shall not be forced to remain on cots or beds for longer than one (1) hour. They shall then be permitted to leave the napping area to engage in quiet play.
7. Caregivers shall provide special attention on an individual basis for new children having problems adjusting, distressed children, etc. Children shall be encouraged***[,]*** but not forced to participate in group activities.
8. Children shall not be subjected to child abuse/neglect as defined by section 210.110, RSMo.

(2) Daily Activities for Children.
(B) Daily activities for preschool and school-age children shall include***[:]*** **–**
1. Developmentally appropriate play experiences and activities planned to meet the interests, needs, and desires of the children;
2. Individual attention and conversation with ***[adults]*** **caregivers**;
3. Indoor and outdoor play periods which provide a balance of quiet and active play, and individual and small group activities. Activities shall provide some free choice experiences;
4. A total of at least one (1) hour of outdoor play for children in attendance a full day unless prevented by weather or special medical reasons. (Based on wind chill factor or heat index, children shall not be exposed to either extreme element.);
5. Toileting and handwashing times;
6. Regular snack and meal times;
7. A supervised nap or rest period for preschool children after the noon meal;
8. A quiet time for school-age children after the noon meal with a cot or bed available for those who wish to nap or rest; and
9. A study time for school-age children who choose to do homework, with a separate, quiet work space.
(C) Daily activities for infants and toddlers shall include***[:]*** **–**
1. Developmental and exploratory play experiences and free choices of play appropriate to the interests, needs, and desires of infants and toddlers;
2. Regular snack and meal times according to each infant's individual feeding schedule as stated by the parent(s);
3. Supervised "tummy time" for children under one (1) year of age to promote healthy development;
4. A supervised nap period that meets the child's individual needs shall meet the following requirements:
A. A child under twelve (12) months of age shall be placed on his/her back to sleep;
B. An infant's head and face shall remain uncovered during sleep;
C. Infants unable to roll from their stomachs to their backs and from their backs to their stomachs shall be placed on their backs when found face down. When infants can easily turn from their stomachs to their backs and from their backs to their stomachs, they shall be initially placed on their backs, but shall be allowed to adopt whatever positions they prefer for sleep;
D. An infant shall not be overdressed when sleeping to avoid overheating. Infants should be dressed appropriately for the environment, with no more than one (1) layer more than an adult would wear to be comfortable in that environment;
E. When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements that differ from those set forth in this rule, the provider shall have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements for such infant. The caregiver(s) shall put the infant to sleep in accordance with such written instructions;
F. Pacifiers, if used, shall not be hung around the infant's neck. Pacifier mechanisms or pacifiers that attach to infant clothing shall not be used with sleeping infants;
G. After awakening, an infant may remain in the crib as long as s/he is content, but never for periods longer than thirty (30) minutes; and
H. Toddlers shall be taken out of bed for other activities when they awaken;
5. Individual attention and play with ***[adults]*** **caregivers**, including holding, cuddling, talking, and singing;
6. Opportunities for sensory stimulation which includes visual stimulation through pictures, books, toys, nonverbal communication, games, and the like; auditory stimulation through verbal communication, music, toys, games, and the like; and tactile stimulation through surfaces, fabrics, toys, games, and the like;
7. Encouragement in the development of motor skills by providing opportunities for supervised "tummy time," reaching, grasping, pulling up, creeping, crawling, and walking; and
8. Opportunity for outdoor play when weather permits.

AUTHORITY: ***section 161.092, RSMo 2016,*** *and sections 210.221 and 210.223, RSMo Supp.* ***[2015] 2022****. This rule previously filed as 13 CSR 40-62.170, 13 CSR 40-62.182, and 19 CSR 40-62.182. Original rule filed March 29, 1991, effective Oct. 31, 1991. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed: June 7, 2023.*

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 Nancy Scherer, Department of Elementary and Secondary Education, Office of Childhood, PO Box 480, Jefferson City, MO 65102, by faxing (573) 526-8000, or via email at childhoodrules@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 9 – DEPARTMENT OF MENTAL HEALTH
Division 10 – Director, Department of Mental Health
Chapter 7 – Core Rules for Psychiatric and Substance Use Disorder Treatment Programs

PROPOSED AMENDMENT

9 CSR 10-7.035 Behavioral Health Healthcare Home. The department is amending sections (1), (2), and (3) and renumbering as necessary.

PURPOSE: This amendment updates provider qualifications, terminology, and staff requirements and adds complex trauma to the qualifying chronic conditions.

(1) Behavioral Health Healthcare Home Qualifications.

(A) Initial Provider Qualifications. In order to be recognized as a Behavioral Health Healthcare Home, a provider must, at a minimum, meet the following criteria:

1. Have a substantial percentage of individuals served enrolled in Medicaid *[, with special consideration given to those with a considerable volume of needy individuals]*. Percentage requirements will be determined by the department;

2. Have strong, engaged leadership committed to and capable of leading the organization through the transformation process to Healthcare Home service delivery practices and sustaining those practices as demonstrated through the application process and agreement to participate in learning activities, including in-person sessions and regularly scheduled phone calls as required by the department;

3. Meet the department's minimum access requirements. Prior to implementation of Behavioral Health Healthcare Home service coverage, provide assurance to the department of enhanced access to the *[C]***c**are *[T]***t**eam by individuals served, including the development of alternatives to face-to-face visits, such as telephone or email, twenty-four (24) hours per day, seven (7) days per week;

4. Actively use the department's identified health information technology tool to conduct care coordination, input metabolic syndrome screening results, track and measure care of individuals, automate care reminders, produce exception reports for care planning, and monitor *[prescriptions]* **medication adherence**;

[5. Routinely use a behavioral pharmacy management system to determine problematic prescribing patterns;]

*[6.]***5.** Conduct wellness interventions as indicated based on the individual's level of risk;

*[7.]***6.** Complete status reports to document the individual's housing, legal, employment, education, and custody status;

*[8.]***7.** Agree to convene regular, ongoing, and documented internal Healthcare Home team meetings to plan and implement goals and objectives of ongoing practice transformation;

*[9.]***8.** Agree to participate in department-approved evaluation activities;

*[10.]***9.** Agree to develop required reports describing Healthcare Home activities, efforts, and progress in implementing Healthcare Home services;

*[11.]***10.** Maintain compliance with all of the terms and conditions as a Behavioral Health Healthcare Home provider or face termination as a provider of Healthcare Home services; and

*[12.]***11.** Present a proposed Behavioral Health Healthcare Home service delivery model the department determines will have a reasonable likelihood of being cost effective. Cost effectiveness will be determined based on the size of the proposed Behavioral Health Healthcare Home, Medicaid caseload, percentage of caseload with eligible chronic conditions, and other factors to be determined by the department.

(2) Scope of Services. This section describes the activities behavioral health providers will be required to engage in, and the responsibilities they will fulfill, if recognized as a Behavioral Health Healthcare Home.

(A) Healthcare Home Services. The Healthcare Home Team shall assure the following health services are received, as necessary, by all individuals served in the Behavioral Health Healthcare Home:

1. Comprehensive Care Management. Comprehensive care management includes the following services:

A. Identification of high-risk individuals and use of information obtained during the enrollment process to determine level of participation in care management services;

B. Assessment of preliminary service needs;

C. Development of treatment plans including individual goals, preferences, and optimal clinical outcomes;

D. Assignment of *[C]***c**are *[T]***t**eam roles and responsibilities;

E. Development of treatment guidelines that establish clinical pathways for *[C]***c**are *[T]***t**eams to follow across risk levels or health conditions;

F. Monitor individual and population health status and service use to determine adherence to, or variance from, treatment guidelines; and

G. Development and dissemination of reports that indicate progress toward meeting outcomes for individual satisfaction, health status, service delivery, and costs*[.]***;**

2. Care *[c]***C**oordination. Care coordination consists of the implementation of the individualized treatment plan through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referral and linkage to long-term services and supports. Specific care coordination activities include, but are not limited to:

A. Appointment scheduling;

B. Conducting referrals and follow up monitoring;

C. Participating in hospital discharge processes; and

D. Communicating with other providers and the individual*[/]* **and their** family members/**natural supports***[.]***;**

3. Health *[p]***P**romotion *[s]***S**ervices. Services shall minimally consist of health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional

development, providing support for improving social networks, and healthy lifestyle interventions, including*[.]* but not limited to:

A. Substance use prevention;

B. Smoking prevention and cessation;

C. Nutritional counseling;

D. Obesity reduction and prevention**;** *[and]*

E. Increasing physical activity*[.]***; and**

F. Health promotion services also assist individuals in the implementation of their treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions*[.]***;**

4. Comprehensive *[t]***T**ransitional *[c]***C**are. Members of the *[C]***c**are *[T]***t**eam must provide care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. Members of the *[C]***c**are *[T]***t**eam collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing individuals' and family members' ability to manage care and live safely in the community and shift the use of reactive care and treatment to proactive health promotion and self-management*[.]***;**

5. Individual and *[f]***F**amily *[s]***S**upport *[s]***S**ervices. Services include*[,]* but are not limited to*[:]* advocating for individuals and families; **and** assisting with, obtaining, and adhering to medications and other prescribed treatments. Care *[T]***t**eam members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically*[-]*necessary services. A primary focus will be *[increasing health literacy, ability to self-manage care, and facilitate participation]* **to help individuals increase their health literacy, self-manage care, and participate** in the ongoing revision of their care/treatment plan. For individuals with developmental disabilities (DD), the *[C]***c**are *[T]***t**eam will refer to, and coordinate with, the approved DD case management entity for services more directly related to habilitation or a particular healthcare condition*[.]***; and**

6. Referral to *[c]***C**ommunity and *[s]***S**ocial *[s]***S**upport *[i]***I**ncluding *[l]***L**ong-term *[s]***S**ervices and *[s]***S**upports. This involves providing assistance for individuals to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need, and legal services, as examples. For individuals with DD, the *[C]***c**are *[T]***t**eam will refer to, and coordinate with, the approved DD case management entity for this service.

(B) Healthcare Home Staffing. Behavioral Health Healthcare Home providers will augment their current treatment teams by adding *[a]* Health**care** Home Director**(s),** *[Primary Care Physician Consultant]* **Specialized Healthcare Consultant(s)**, and Nurse Care Manager(s) to provide consultation as part of the *[C]***c**are *[T]***t**eam and assist in delivering Healthcare Home services. Care Coordinator**(**s**)** will also be funded to assist with Healthcare Home supporting functions.

(C) Learning Activities. Behavioral health providers will be supported in transforming service delivery by participating in statewide learning activities. Providers will participate in a variety of learning supports, up to and including learning collaboratives specifically designed to demonstrate how to operate as a Behavioral Health Healthcare Home and provide care using a whole person approach that integrates behavioral health, primary care, and other needed services and supports. Learning activities will be supplemented with periodic calls to reinforce the learning sessions, practice coaching, and monthly practice reporting (data and narrative) and feedback.

1. Learning activities will support Behavioral Health Healthcare Home providers in addressing the following:

A. Providing quality-driven, cost-effective, culturally-appropriate, and person- and family-centered healthcare home services;

B. Coordinating and providing access to high-quality healthcare services informed by evidence-based clinical practice guidelines;

C. Coordinating and providing access to preventive and health promotion services, including prevention of mental illness and substance use disorders;

D. Coordinating and providing access to mental health and substance use **disorder treatment** services;

E. Coordinating and providing access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of healthcare;

F. Coordinating and providing access to chronic disease management, including self-management support to individuals and their families;

G. Coordinating and providing access to individual and family supports, including referral to community, social support, and recovery services;

H. Coordinating and providing access to long-term care supports and services;

I. Developing a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical healthcare related needs and services;

J. Demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the *[C]***c**are *[T]***t**eam and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and

K. Establishing a continuous quality improvement program and collecting and reporting on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

(H) Notification of Staffing Changes. Providers are required to notify the department within five (5) working days of staff changes in *[the Behavioral Health Healthcare Home Director, Primary Care Physician Consultant, Nurse Care Manager(s), and Care Coordinators]* **any of the Healthcare Home staff positions referenced in subsection (2)(B) of this rule**.

(3) Patient Eligibility and Enrollment. This section describes eligibility and enrollment requirements for Behavioral Health Healthcare Homes.

(A) Individuals receiving Medicaid benefits must meet one (1) of the following criteria to be eligible for services from a designated Behavioral Health Healthcare Home:

1. Be diagnosed with a serious and persistent mental health condition (adults with Serious Mental Illness (SMI) and children with Severe Emotional Disturbance (SED)); or

2. Be diagnosed with a mental health condition and substance use disorder; or

3. Be diagnosed with a mental health condition and/or substance use disorder, and one (1) other chronic condition including diabetes, chronic obstructive pulmonary disease (COPD), asthma, cardiovascular disease, overweight (body mass index (BMI) > 25), tobacco use, *[and]* developmental disability**, or complex trauma**.

AUTHORITY: section 630.050, RSMo 2016. This rule originally filed as 9 CSR 10-5.240. Emergency rule filed Dec. 20, 2011, effective Jan. 1, 2012, expired June 28, 2012. Original rule filed Oct. 17, 2011, effective June 29, 2012. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 13, 2023.*

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 6 – Certified Community Behavioral Health Organization

PROPOSED AMENDMENT

9 CSR 30-6.010 Certified Community Behavioral Health Organization. The department is amending sections (1), (2), (3), and (5)-(8), adding new sections (9) and (14), and amending and renumbering subsequent sections accordingly.

PURPOSE: This amendment updates terminiology and eligibility criteria for certification as a Certified Community Behavioral Health Organization (CCBHO), adds current or former members of the U.S. Armed Forces as a population of focus, and clarifies requirements for substance use disorder treatment services, national accreditation and certification, evidence-based practices, and the fee schedule.

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) Definitions. The following definitions apply to terms used in this rule:

(A) Certified Community Behavioral Health Organization (CCBHO) – an entity certified by the department to provide CCBHO services within their designated service area(s). **The entity must be a nonprofit organization and an administrative agent or affiliate provider in Missouri**;

(2) Regulations. All CCBHOs shall comply with *[all regulations, requirements, and standards specified in]* 9 CSR 10-7**, 9 CSR 30-3,** and 9 CSR 30-4**, as applicable**.

(3) Designated Service Areas. Organizations must be certified by the department to provide CCBHO services in one (1) or more service areas as established by the department under 9 CSR 30-4.005. The required CCBHO services, as specified in this rule, must be provided in each designated service area.

(A) Each CCBHO shall develop and maintain services and supports designed to meet the needs of the populations of focus. Populations of focus shall include*[:]* –

1. Adults with serious mental illness as defined in 9 CSR 30-4.005(6);

2. Children and *[adolescents]* **youth** with serious emotional disturbances as defined in 9 CSR 30-4.005(7);

3. Children, adolescents, and adults with moderate to severe substance use disorders;

4. Children with behavioral health disorders who are in state custody; *[and]*

5. Individuals involved with law enforcement, the courts, and hospital emergency rooms who have been identified as in need of community behavioral health services*[.]***; and**

6. Current or former members of the U.S. Armed Forces.

(5) Certification and National Accreditation. CCBHOs shall maintain national accreditation and/or department certification as specified below*[:]***.**

[(A) Accreditation from the CARF International (CARF) to provide Outpatient Mental Health and Outpatient Alcohol and other Drugs/Addictions, or Outpatient Alcohol and Other Drugs/Mental Health to serve children, youth, and adults; or

(B) Accreditation from The Joint Commission (TJC) to provide Comprehensive Behavioral Health services to children, youth, and adults.

1. Provisional certification from the department to provide outpatient mental health treatment and substance use disorder treatment for children, youth, and adults is acceptable until accreditation is obtained from CARF or TJC as specified;

(C) Accreditation from CARF or TJC as a Health Home for children, youth, and adults;

(D) Accreditation from CARF for Crisis and Information Call Center for the provision of a twenty-four (24) hour crisis line for children, youth, and adults with mental health and substance use disorders. If the CCBHO contracts with a DCO to provide this service, the DCO must be accredited by CARF as specified;

(E) Accreditation from CARF for Crisis Intervention Services for the provision of a twenty-four (24) hour mobile crisis team for children, youth, and adults with mental health and substance use disorders. If the CCBHO contracts with a DCO to provide this service, the DCO must be accredited by CARF as specified.

1. The twenty-four (24) hour crisis line and twenty-four (24) hour mobile response team shall also comply with 9 CSR 30-4.195, Access Crisis Intervention (ACI) program; and

(F) Certification/deemed certification from the department in accordance with 9 CSR 30-4 as a Community Psychiatric Rehabilitation (CPR) program serving children, adolescents, and adults.]

(A) Certification/deemed certification from the department in accordance with 9 CSR 30-3 and 9 CSR 30-4 to provide –

1. American Society of Addiction Medicine (ASAM) Level 1 Outpatient and Level 1- WM Ambulatory Withdrawal Management without Extended On-Site Monitoring for adolescents and adults. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 3rd edition (2013), hereby incorporated by reference and made a part of this rule, is developed by and available from the American Society of Addiction Medicine, Inc., 11400 Rockville Pike, Suite 200, Rockville, MD 20852, (301) 656-3920. This rule does not incorporate any subsequent amendments or additions to

this publication; and

2. Community Psychiatric Rehabilitation (CPR) for children, youth, and adults;

(B) Appropriate accreditation from CARF International (CARF), The Joint Commission (TJC), Council on Accreditation (COA), or other accrediting body approved by the department for the following services:

1. Healthcare home for children, youth, and adults;

2. Outpatient mental health and substance use disorder treatment services for children, youth, and adults;

3. Crisis and information call center for the provision of a twenty-four- (24-) hour crisis line for children, youth, and adults with mental health and/or substance use disorders;

4. Crisis intervention services for the provision of a twenty-four- (24-) hour mobile crisis team for children, youth, and adults with mental health and substance use disorders –

A. If the CCBHO contracts with a DCO to provide crisis intervention services, the DCO must be accredited as specified above; and

B. The twenty-four- (24-) hour crisis line and twenty-four- (24-) hour mobile response team shall also comply with 9 CSR 30-4.195, Access Crisis Intervention (ACI) program; and

(C) Provisional certification from the department to provide outpatient mental health treatment and substance use disorder treatment for children, youth, and adults is acceptable until accreditation is obtained as specified.

(6) Required Services. CCBHOs shall provide a comprehensive array of services to create and enhance access, stabilize people in crisis, and provide the necessary treatment for individuals with the most serious, complex mental illnesses and substance use disorders.

(A) The following core CCBHO services must be directly provided by the CCBHO in each designated service area:

1. Crisis mental health services, including a twenty-four- (24-) hour crisis line and twenty-four- (24-) hour mobile crisis response team. Crisis mental health services must be available at the CCBHO during regular business hours and be provided by a Qualified Mental Health Professional (QMHP). The crisis line and mobile crisis response team services may be directly provided by the CCBHO or by contract with a department-approved DCO*[:]***.**

A. If CCBHO staff determine an in-person intervention is required based on the presentation of an individual, the intervention must occur within three (3) hours.

B. CCBHO staff shall monitor and have the capacity to report the length of time from each individual's initial crisis contact to the in-person intervention and take steps to improve performance, as necessary;

2. Screening, assessment, and diagnosis, including risk assessment;

3. *[Patient-centered]* **Individualized** treatment, including risk assessment and crisis prevention planning;

4. Outpatient mental health *[and substance use disorder treatment services, including medication services for the treatment of addictions]* **services**;

5. Substance use disorder treatment services including –

A. Individual and group counseling;

B. Group rehabilitative support;

C. Community support;

D. Peer support;

E. Family therapy;

F. Medication services to support medication assisted treatment; and

G. American Society of Addiction Medicine (ASAM) Level 1 Outpatient and Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring as referenced in paragraph (5)(A)1. of this rule;

*[5.]***6.** Outpatient clinic primary care screening and monitoring of key health indicators and health risks;

*[6.]***7.** *[Targeted case]* **Case** management;

*[7.]***8.** Psychiatric rehabilitation services;

*[8.]***9.** Peer support, counseling, and family support services, including peer and family support services for individuals receiving CPR and/or Comprehensive Substance Treatment and Rehabilitation (CSTAR) services, consistent with the array of services and supports specified in the job descriptions of **Certified** Family Support Providers and Certified Peer Specialists; and

*[9.]***10.** *[Intensive, community-based]* **Outpatient** mental health services for active members of the U.S. Armed Forces and veterans.

(7) Required Staff. CCBHOs must maintain adequate staffing to meet the needs of the populations of focus. Staff may be full- or part-time employees of the CCBHO or contracted by the CCBHO to provide services.

(A) Required staff shall include*[:]* –

1. Medical Director who is a licensed psychiatrist;

2. Licensed mental health professionals with expertise and specialized training in the treatment of trauma-related disorders;

3. Community *[Mental]* **Behavioral** Health Liaison (a cooperative agreement with a CCBHO that employs a Community *[Mental]* **Behavioral** Health Liaison is acceptable);

4. Clinical staff to complete comprehensive *[behavioral health]* assessments, annual assessments, and treatment plans;

5. Licensed mental health professionals who have completed training on evidence-based, best, and promising practices as required by the department;

6. *[Physician(s)with a waiver in accordance with the Drug Addiction Treatment Act of 2000 (DATA 2000)]* **Qualified practitioner(s)** to treat opioid use disorders with narcotic medications approved by the Food and Drug Administration (FDA)**.***[, including buprenorphine]* **Methadone must be provided by a certified opioid treatment program**;

7. Community Support Specialists who have completed department-approved wellness training;

8. Individuals who have completed department-approved smoking cessation training;

9. **Certified** Family Support Providers who *[have completed department-approved training]***are credentialed by the Missouri Credentialing Board**; and

10. Certified Peer Specialists who *[have completed department-approved training]* **are credentialed by the Missouri Credentialing Board.**

(8) Screening, Assessment, and Treatment Planning. Unless a specific tool is required by the department, CCBHO staff shall use standardized and validated screening and assessment tools, including age-appropriate functional assessments and screening tools, and**,** when appropriate, brief motivational interviewing techniques.

(A) At first contact, individuals seeking CCBHO services shall receive a preliminary screening *[and risk assessment]* to determine acuity of need. Emergency, urgent, or routine service needs shall be identified and addressed as follows:

1. Individuals who present *[in crisis]* **with emergency**

needs shall receive services immediately, including arrangements for any necessary outpatient follow-up services;

2. Individuals who present with an urgent need shall receive clinical services and an eligibility determination within one (1) business day of the time the request was made; and

3. Individuals who present with routine needs shall receive clinical services and an eligibility determination within ten (10) days of first contact.

(B) Following the preliminary screening, qualified staff shall conduct *[an initial evaluation and further screening and provide needed services as indicated by the initial evaluation. Additional screening shall include, but is not limited to:]* **a comprehensive assessment or eligibility determination. Eligibility determination may be completed to expedite the admission process. A risk assessment shall be included as part of the eligibility determination or comprehensive assessment, whichever occurs first, and shall include –**

1. Depression screening for all adolescents age thirteen (13) to eighteen (18) years of age;

2. Depression screening for all adults age nineteen (19) and older;

3. Suicide risk assessment for all adolescents and adults diagnosed with major depression;

4. Brief health screen, as specified by the department;

5. Alcohol use disorder screening; and

6. Substance use disorder screening**, including opioid use disorder**.

(C) The *[initial]* comprehensive assessment must be completed within **the first three (3) outpatient visits or within** specific treatment program timelines *[,not to exceed sixty (60) days]*.

[1. A functional assessment shall be completed utilizing an instrument approved by the department for all individuals enrolled in the CSTAR and/or CPR program, and must be updated at least every ninety (90) days.

2. For individuals not enrolled in CSTAR or CPR, a functional assessment shall be completed using a department-approved instrument, when an individual appears to be experiencing moderate or more serious impairment. If the functional assessment confirms an individual is experiencing moderate or more serious impairment, the functional assessment must be updated every ninety (90) days.

3. The comprehensive assessment must be updated in collaboration with the individual receiving services as warranted by changes in his or her health status, responses to treatment, and/or achievement of goals.

4. The comprehensive assessment must be updated at least every ninety (90) days for individuals with moderate or more serious impairment as determined by the functional assessment.]

(D) Results of the comprehensive assessment shall be utilized to develop an initial treatment plan within sixty (60) days of the individual's first contact with the CCBHO, unless a shorter time frame is required by a specific treatment program. The treatment plan shall be developed collaboratively with the individual served and/or parents/guardian, family members, and other natural supports, as appropriate.

(E) Treatment plans shall be reviewed and updated in accordance with specific program timelines, not to exceed ninety (90) days, to assess the continued need for services, changes in health status, responses to treatment, and progress achieved during the past ninety (90) days. A functional assessment may be utilized as the quarterly treatment plan review/update. The occurrence of a crisis or significant clinical event may require a further review and modification of the treatment plan.

1. The updated 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. Updates must be documented in the individual record by one (1) of the following:

A. A progress note which specifies updates made to the treatment plan; or

B. A treatment plan review conducted quarterly; or

C. An updated functional assessment score with a brief narrative.

(F) The initial treatment plan and treatment plan updates must include the dated signature(s), title(s), and credential(s) of staff completing the plan. The individual served shall also sign the plan unless there is a current signed consent to treatment included in the individual record.

1. CCBHOs shall promote collaborative treatment planning by providing the individual's *[P]***p**rimary *[C]***c**are *[P]***p**rovider (PCP) with relevant assessment, evaluation, and treatment plan information, seeking all relevant treatment and test results from the PCP, and inviting the PCP to participate in treatment planning.

*[(E)]***(G)** The following information shall be collected and be available for reporting to the department or other entities, upon request:

1. The number and percentage of new and established individuals served who were determined to need *[crisis]* **emergency**, urgent, and routine care;

2. The number and percentage of new and established individuals with urgent needs who began receiving needed clinical services within one (1) business day;

3. The number and percentage of new and established individuals with routine needs who began receiving needed clinical services within ten (10) business days; and

4. The mean number of days from first contact to completion of the *[initial]* comprehensive assessment**/ eligibility determination** and initial treatment plan for individuals served.

(9) 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.

*[(9)]***(10)** Services for *[Active Duty]* Members of the U.S. Armed Forces and Veterans. CCBHOs must determine whether all individuals seeking service are current or former members of the U.S Armed Forces.

(A) CCBHOs shall refer Active Duty *[Members or]* **and** activated Reserve Component **service** *[M]***m**embers to their Military Treatment Facility or TRICARE PRIME Remote Primary Care Manager for referral to services.

(B) *[Members of the Selected]* **Selective** Reserve*[s,]* **service members** not on active duty, who are enrolled in TRICARE Reserve Select, shall be referred to a TRICARE Reserve Select provider.

(C) If an individual is a veteran not currently enrolled in the Veterans Health Administration (VHA), CCBHO staff must offer

to assist *[him/her]* **them** in enrolling in the VHA.

*[(10)]***(11)** *[Crisis Response]* **Withdrawal Management**. CCBHOs must ensure individuals have access to *[crisis response]* **appropriate withdrawal management** services twenty-four (24) hours per day, seven (7) days per week as follows:

(A) Each CCBHO shall directly provide *[American Society of Addiction Medicine (ASAM)]* **ASAM** Level 1-Withdrawal Management (WM) services **as referenced in paragraph (5)(A)1. of this rule**;

(B) Each CCBHO **that is certified/deemed certified by the department** shall directly provide **the following services** or *[contract with a DCO]* **have a documented referral relationship with an organization that is certified/deemed certified by the department** to provide*[:]***–**

1. ASAM Level 2-WM *[services]* **with and without Extended On-Site Monitoring**;

2. ASAM Level-3.2 Clinically Managed Residential Withdrawal Management, commonly referred to as social setting detoxification services; and

3. ASAM Level 3.7*[-]*Medically Monitored Inpatient Withdrawal Management, commonly referred to as modified medical detoxification services*[:]***.**

[(C) If CCBHO staff determine that a face-to-face intervention is required based on the presentation of an individual, then that face-to-face intervention must occur within three (3) hours; and

(D) CCBHO staff shall monitor and have the capacity to report the length of time from each individual's initial crisis contact to the face-to-face intervention and take steps to improve performance, as necessary.]

*[(11)]***(12)** Care Coordination. CCBHOs shall actively pursue and promote collaborative working relationships with the broad array of community organizations and *[practitioners]* **providers** that *[provide]* **deliver** services and supports for individuals receiving services from the CCBHO.

(A) Consistent with requirements of privacy, confidentiality, and individual preference and need, CCBHO staff shall assist individuals and families of children and youth who are referred to external providers or resources in obtaining an appointment and confirming the appointment was kept.

(B) Nothing about a CCBHO's agreements for care coordination shall limit an individual's freedom of choice of provider(s) with the CCBHO or its DCOs.

(C) CCBHO policies and procedures shall promote and describe its care coordination roles and responsibilities, and whenever possible, the development of formal agreements with community organizations and *[practitioners]* **providers** that document mutual care coordination roles and responsibilities, with particular attention to emergency room, hospital, and residential treatment admissions and discharges. CCBHO policies and procedures shall ensure reasonable attempts are made and documented to –

1. Track admissions and discharges of non-Medicaid eligible individuals to and from a variety of settings, and to provide transitions to safe community settings; and

2. Follow up with individuals served within twenty-four (24) hours following hospital discharge.

(D) CCBHOs shall utilize Missouri Behavioral Health Connect (MOConnect), the designated platform to identify, unify, and track behavioral health treatment resources.

*[(D)]***(E)** For all individuals in the populations of focus, CCBHO staff shall inquire whether they have a PCP, assist individuals who do not have a PCP to acquire one, and establish policies and procedures that promote and describe the coordination of care with each individual's PCP.

*[(E)]***(F)** For all individuals in the populations of focus, CCBHO staff shall document in the individual record the name of each individual's PCP, indicate they are assisting *[him or her]* **them** in acquiring a PCP, or the individual refuses to provide the name of their PCP or accept assistance in acquiring a PCP.

*[(12)]***(13)** Evidence-Based Practices. CCBHOs shall incorporate evidence-based, best, and promising practices into its service array.

(A) CCBHOs shall have adopted, or be participating in a department-approved initiative, to promote trauma-informed care and suicide prevention.

(B) CCBHOs shall have adopted with fidelity, a model for providing integrated treatment for co-occurring disorders approved by the department.

(C) CCBHOs shall demonstrate a continued commitment to adopting *[new]* **or continuing** evidence-based, best, and promising practices **to fidelity**, such as –

1. Assertive Community Treatment (ACT);
2. Supported employment;
3. Supported housing;
4. Parent-Child Interaction Therapy;
5. Dialectical Behavior Therapy;
6. Multi-systemic Therapy; *[and]*
7. First Episode Psychosis*[.]***; and**

8. Eye Movement Desensitization and Reprocessing (EMDR).

[(13) Fee Schedule. CCBHOs shall publish a sliding fee discount schedule(s) that includes all available services. The fee schedule shall be included on the CCBHO website, posted in the waiting/reception area, and be readily accessible to individuals seeking services and their family members and other natural supports.

(A) The sliding fee discount schedule shall be communicated in languages/formats appropriate for individuals seeking services who have Limited English Proficiency (LEP) or disabilities.

(B) The fee schedule shall, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics. Absent applicable state or federal requirements, the schedule shall be based on locally prevailing rates or charges and include reasonable costs of operation.

(C) CCBHOs shall have written policies and procedures describing eligibility for services in accordance with the sliding fee discount schedule. These policies and procedures shall be applied equally to all individuals seeking services from the CCBHO.]

(14) Fee Schedule. CCBHOs shall establish a sliding fee discount program for all available services that conforms to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics. Absent applicable state or federal requirements, the sliding fee discount program shall be based on locally prevailing rates or charges and include reasonable costs of operation.

(A) Written policies and procedures shall be maintained by the CCBHO describing eligibilty for services and implementation of the sliding fee discount program which must ensure –

1. Equitable use of the sliding fee schedule for all individuals seeking services;

2. The provision of services regardless of ability to pay; and

3. Waiver or reduction of fees for those unable to pay.

(B) The CCBHO shall screen each individual seeking services to determine eligiblity for a sliding fee discount.

(C) If a CCBHO service is provided through a DCO, the DCO shall provide such services in accordance with the CCBHO fee schedule and corresponding policies and procedures.

1. The CCBHO shall provide the DCO with a copy of its policies and procedures related to the sliding fee discount program.

2. Prior to the provision of a CCBHO service, the CCBHO shall inform the DCO if an individual has been determined eligible for a fee discount. The DCO is not required to conduct its own discount eligibility screening.

(D) CCBHOs (and their DCOs, as applicable) shall provide individuals and their family members/natural supports with information regarding the sliding fee discount program.

1. The fee discount schedule shall be communicated in languages and formats appropriate for individuals seeking services who have limited English proficiency or disabilities.

2. The fee discount schedule shall be posted on the CCBHO/DCO website and in the waiting/reception area.

*[(14)]***(15)** Information Systems. CCBHOs shall maintain a health information technology (HIT) system that includes, but is not limited to, electronic health records of all individuals served. Electronic health record systems must comply with state and federal regulations.

(A) The HIT system must have the capability to capture structured information in individual records, including demographic information, diagnoses, and medication lists, provide clinical decision support, and electronically transmit prescriptions to the pharmacy.

*[(15)]***(16)** DCO Contracts. If the CCBHO enters into a contractual agreement(s) with a DCO, the contract shall include the following provisions:

(A) DCO staff having contact with individuals served, and/or their families, are subject to the same training requirements as staff of the CCBHO;

(B) The CCBHO coordinates care and services provided by the DCO in accordance with the individual's current treatment plan;

(C) The CCBHO is ultimately clinically responsible for all care provided;

(D) The individual's freedom to choose service providers is maintained;

(E) All individuals have access to the CCBHO's grievance procedures; and

(F) Services provided by the DCO shall meet the same quality standards as those provided by the CCBHO.

*[(16)]***(17)** Governing Body Representation. CCBHOs shall ensure individuals served and their parents/guardians, family members, and other natural supports have meaningful participation in the development and ongoing review of the organization's policies and procedures, service delivery practices, and service array.

(A) Meaningful participation shall be demonstrated by one (1) of the following:

1. At least fifty-one percent (51%) of the governing body consists of individuals who are receiving or have received services for a serious mental illness, serious emotional disturbance, or substance use disorder, or the parents/guardian, family members/natural supports of individuals served;

2. A substantial portion of the governing body consists of individuals who are receiving services or have received services for a serious mental illness, serious emotional disturbance, or substance use disorder, or the parents/guardian, family members/natural supports of individuals served; or

3. A transition plan is developed, with timelines appropriate to the size of the governing body and target population, to establish a governing body with at least fifty-one percent (51%) or a substantial portion of the governing body consisting of individuals who are receiving services or have received services for a serious mental illness, serious emotional disturbance, or substance use disorder, or the parents/guardian, family members and other natural supports of individuals served.

(B) If the CCBHO is a subsidiary or part of a larger corporate organization and cannot meet the requirements identified in paragraphs (16)(A)1.-3. of this rule, the CCBHO shall have or develop an advisory structure or other specifically described process to ensure individuals who are receiving services or have received services for a serious mental illness, serious emotional disturbance, or substance use disorder, or the parents/guardian, family members and other natural supports of individuals served, have meaningful input to the governing body related to its policies and procedures, service delivery practices, and service array.

(C) CCBHOs may develop and implement an alternative process, which must be approved by the department, to ensure the governing body is responsive to the needs of individuals served and their parents/guardians, family members, natural supports, and the communities it serves.

(D) CCBHOs must be able to document input from individuals served and their parents/guardian, family members, natural supports, and communities served, including the impact on its policies, processes, and services.

(E) To the extent practicable, each CCBHO's governing body and/or advisory board shall be representative of the populations served in terms of demographic factors such as*[,]* geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation.

(F) Each CCBHO's governing body members or advisory board members shall be selected for their expertise in health services, community affairs, local government, finance and banking, legal affairs, trade unions, faith communities, commercial and industrial concerns, and social services within the communities served.

(G) No more than fifty percent (50%) of the governing body members may derive more than ten percent (10%) of their annual income from the health care industry.

AUTHORITY: sections 630.050 and 630.655, RSMo 2016. Emergency rule filed March 20, 2019, effective July 1, 2019, expired Oct. 30, 2019. Original rule filed March 20, 2019, effective Oct. 30, 2019. Amended: Filed June 13, 2023.

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 15 – ELECTED OFFICIALS
Division 40 – State Auditor
Chapter 2 – Rules Applying to State Agencies

PROPOSED AMENDMENT

15 CSR 40-2.031 Control of Fixed Assets. The State Auditor is amending section (4).

PURPOSE: This amendment increases the threshold amounts of the cost of equipment and the cost of additions or betterments to equipment required to be accounted for as fixed assets by state agencies.

(4) Those items with a cost (or estimated fair value if actual cost not available)***[,]*** over the following threshold amounts are required to be accounted for as fixed assets under this rule:

(A) Land – all parcels of land (no threshold amount)***[.]*****;**

(B) Land improvements – fifteen thousand dollars ($15,000) or more***[.]*****;**

(C) Buildings – fifteen thousand dollars ($15,000) or more***[.]*****;**

(D) Equipment – ***[one thousand dollars ($1,000)]*** **five thousand dollars ($5,000)** or more***[.]*****;**

(E) Additions or betterments to buildings – fifteen thousand dollars ($15,000) or more***[.]*****; and**

(F) Additions or betterments to equipment ***[one thousand dollars ($1,000)]*** **five thousand dollars ($5,000)** or more.

AUTHORITY: section 34.125, RSMo ***[Supp. 1999] 2016****. Original rule filed Jan. 16, 1978, effective April 13, 1978. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed June 15, 2023.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment by mail to the Missouri State Auditor, PO Box 869, Jefferson City, MO 65102, or via email to Moaudit@auditor.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 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20 – Division of Community and Public Health
Chapter 70 – Community-Based Faculty Preceptor Tax Credit

PROPOSED RULE

19 CSR 20-70.010 Community-Based Faculty Preceptor Tax Credit

PURPOSE: This rule provides an income tax credit for qualified community-based faculty preceptors for physicians and physician assistants. This rule explains the Department of Health and Senior Services' Preceptor Tax Credit eligibility and how the qualifying individual may claim the credit.

(1) Definitions. The following definitions shall be used in the interpretation and enforcement of this rule:

(A) Community-based faculty preceptor or preceptor means a physician or physician assistant who is licensed in Missouri and provides preceptorships to Missouri medical students or physician assistant students without direct compensation for the work of precepting;

(B) Department means the Missouri Department of Health and Senior Services;

(C) Director means the Director of the Missouri Department of Health and Senior Services;

(D) Division means the Division of Professional Registration of the Department of Commerce and Insurance;

(E) Health Professional Shortage Area (HPSA) means a geographic area, population group, or facility designated by the United States Department of Health and Human Services' Health Resources and Services Administration (HRSA) with a shortage of primary care, dental health, or mental health providers and services;

(F) Medical student means an individual enrolled in a Missouri medical college approved and accredited as reputable by the American Medical Association or the Liaison Committee on Medical Education or enrolled in a Missouri osteopathic college approved and accredited as reputable by the Commission on Osteopathic College Accreditation;

(G) Medical student core preceptorship or physician assistant student core preceptorship means a Missouri preceptorship for a medical student or physician assistant student that provides a minimum of one hundred twenty (120) hours of community-based instruction in family medicine, internal medicine, pediatrics, psychiatry, or obstetrics and gynecology under the guidance of a community-based faculty preceptor. A community-based faculty preceptor may add together the amounts of preceptorship instruction time separately provided to multiple students in determining whether he or she has reached the minimum hours required under this subdivision, but the total preceptorship instruction time provided shall equal at least one hundred twenty (120) hours in order for such preceptor to be eligible for the tax credit authorized under this rule;

(H) Physician assistant student means an individual participating in a Missouri physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant or its successor organization;

(I) Preceptorship rotation means one hundred twenty (120) hours of community-based instruction. One hundred twenty (120) hours of community-based instruction can be comprised of one (1) or multiple students to equal the number of preceptorship hours. The total one hundred twenty (120) hours of community-based instruction equates to one (1) preceptorship rotation, two hundred forty (240) hours equates to two (2) preceptorship rotations, and three hundred sixty (360) hours equates to three (3) preceptorship rotations;

(J) Primary Care HPSA means the shortage designation in primary care physicians, as set forth by HRSA, including all the primary care specialties in which a primary care physician could be licensed, to determine the primary care HPSA score;

(K) Primary Care HPSA; score ranges from one (1) to twenty-five (25) and demonstrates the shortage level of providers providing primary care services in the HPSA; the higher the

score, the greater the need; and

(L) Taxpayer means any individual, firm, partner in a firm, corporation, or shareholder in an S corporation doing business in this state and subject to the state income tax imposed under Chapter 143, RSMo, excluding withholding tax imposed under sections 143.191 to 143.265, RSMo.

(2) Eligibility.

(A) In order to be eligible, the community-based faculty preceptor must –

1. Be a community-based faculty preceptor providing the preceptorship;

2. Hold a current and active license issued by the division;

3. Provide a medical or physician assistant student core preceptorship to one (1) or more medical student(s) or one (1) or more physician assistant student(s);

4. Complete a minimum of one (1) preceptorship rotation and up to three (3) preceptorship rotations during the tax year and not receive any direct compensation for the preceptorships; and

5. Provide a minimum of one hundred twenty (120) hours of community-based instruction in family medicine, internal medicine, pediatrics, psychiatry, or obstetrics and gynecology in the tax year for which the preceptorship is claimed.

(3) Application process.

(A) A preceptor shall complete at least one hundred twenty (120) hours in at least one (1) type of instruction outlined in paragraph (2)(A)5. A community-based faculty preceptor may add together the amounts of preceptorship instruction time separately provided to multiple students in determining whether he or she has reached this minimum.

(B) A preceptor shall provide documentation of the following:

1. The name and address of the students' college or university and the name of the department head or the program director;

2. Preceptor's name;

3. Preceptor's phone number;

4. Preceptor's email address;

5. Preceptor's mailing address;

6. Preceptor's discipline and specialty, if applicable;

7. A statement that the preceptor agrees they did not and will not accept payment in any form for the preceptorship;

8. Total number of hours of instruction;

9. A signed statement on letterhead from preceptor's employer and/or students' university that verifies that the number of hours of instruction are correct;

10. The amount of tax credit claimed; and

11. The following information on each student:

A. First and last name;

B. Phone number;

C. Email address;

D. Type of rotation completed;

E. Beginning and completed dates of the rotation; and

F. Number of hours of completed rotation.

(C) Applications will be accepted during the entire calendar year and a preceptor shall submit documentation no later than January 31 for preceptorships completed the previous tax year. Applications completed in accordance with this section will be accepted by electronic submission through the Preceptor Tax Credit webpage at https://health.mo.gov/living/families/primarycare/precept/index.php, or by mail at ORHPC – Preceptor Tax Credit, PO Box 570, Jefferson City, MO 65102-0570.

(4) Selection Process.

(A) All applications will be processed on a first-come, first-served basis as received by the department. The applications will be stamped with the date received by the department if the application is sent via regular mail or by UPS, USPS, FedEx, DHL, or other carrier. Applications received electronically will be considered received based on the date stamp on the electronic submission. It is the responsibility of the applicant to verify that an application has been received in a timely manner. Each application received by the department will be reviewed for completeness. Tax credits will be issued based on applicants' qualifications and are subject to the availability of funds. Verification processing times may be delayed if a particular application requires follow-up. For the purposes of this regulation, an electronic submission is considered an original copy of the application.

1. No more than two hundred (200) preceptorship tax credits can be authorized nor can credits exceed two hundred thousand dollars ($200,000) for any one (1) calendar year. Tax credits are subject to the availability of funds.

2. Applications will be prioritized in the following manner:

A. First-come, first-served basis;

B. Applications received on the same day will be prioritized by highest HPSA score of the location of the preceptor's employer;

C. Applications will be selected by the most underserved area as indicated by the highest HPSA score of the location of the preceptorship; and

D. In the event that there are fewer remaining tax credits than qualified applicants, or a tie for the last remaining credit, and with all of those applicants having equal status in priority, the remaining tax credits will be selected by lottery.

(5) Tax Credit Issuance.

(A) Upon each determination, the department will issue, to the preceptors awarded, a certification affirming the taxpayer's eligibility for the tax credits by March 1 of the year following the preceptorship. To receive the credit allowed by this rule, the certification provided to the taxpayer by the department shall be filed by the taxpayer with their income tax return for the year in which he or she completes the preceptorship rotations.

(B) Subject to the availability of funds, preceptors shall be allowed a credit against the tax otherwise due under Chapter 143, RSMo, excluding withholding tax imposed under sections 143.191 to 143.265, RSMo, in an amount equal to one thousand dollars ($1,000) for each completed preceptorship rotation, up to a maximum of three thousand dollars ($3,000) per preceptor per tax year.

(C) The taxpayer shall not receive a preceptorship tax credit from the department of revenue, under this rule, that exceeds their tax liability for the tax year for which such credit is claimed. Nor shall a taxpayer be allowed a tax credit against his or her tax liability for any prior or succeeding tax year. This may result in a credit of less than one thousand dollars ($1,000).

(D) No amount of any tax credit allowed under this rule shall be refundable. No tax credit allowed under this rule shall be transferred, sold, or assigned. No taxpayer shall be eligible to receive the tax credit authorized under this rule if such taxpayer employs persons who are not authorized to work in the United States under federal law.

(E) The Department of Revenue shall be responsible for verifying that the tax credit does not result in exceeding the taxpayer's income tax liability and shall only authorize the portion of the tax credit that does not result in a refund.

AUTHORITY: section 135.690, RSMo Supp. 2022, Original rule filed June 8, 2023.

PUBLIC COST: This proposed rule is estimated to cost state agencies or political subdivisions at least two hundred sixteen thousand one hundred twenty-five dollars ($216,125) in the first year period and two hundred twenty-seven thousand eight hundred eighty-two dollars ($227,882) to two hundred twenty-eight thousand one hundred twenty-four dollars ($228,124) annually thereafter.

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with Sara Davenport, Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102, or via email at ORHPCInfo@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: 19 CSR 20-70.010

Rule Number and Title:	**19 CSR 20-70.010** Community-Based Faculty Preceptor Tax Credit
Type of Rulemaking:	Proposed

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Health & Senior Services'	**$216,125 for the first year period and between $227,882 and $228,124 annually thereafter**

II. WORKSHEET

.30 Total FTE:

.15 FTE Public Health Program Specialist (Full salary $50,000)

$50,000 (salary) x .15 =$7,500 x 7/12 (7 months) = $4,375 + $2,690 (fringe benefits) = $7,065 for the first year period.

$50,500 (salary with 1% COLA increase) x .15 = $7,575 + $4,639 (fringe benefits) = $12,214 year 2.

$51,005 (salary with 1% COLA increase from year 2) x .15 = $7,651 + $4,667 (fringe benefits) = $12,318 year 3.

.10 FTE Senior Public Health Program Specialist (Full salary $62,400)

$62,400 (salary) x .10 =$6,240 x 7/12 (7 months) = $3,640 + $2,056 (fringe benefits) = $5,696 for the first year period.

$63,024 (salary with 1% COLA increase) x .10 = $6,302 + $3,548 (fringe benefits) = $9,850 year 2.

$63,348 (salary with 1% COLA increase from year 2) x .10 = $6,365 + $3,571 (fringe benefits) = $9,936 year 3.

.05 FTE Public Health Program Specialist (Full salary $75,370)

$75,370 (salary) x .05 =$3,768 x 7/12 (7 months) = $2.198 + $1,166 (fringe benefits) = $3,364 for the first year period.

$76,124 (salary with 1% COLA increase) x .05 = $3,806 + $2,012 (fringe benefits) = $5,818 year 2.

$76,877 (salary with 1% COLA increase from year 2) x .05 = $3,844 + $2,026 (fringe benefits) = $5,870 year 3.

Community-Based Faculty Preceptor Tax Credit Program Tax Credit Amount

Estimated maximum annual cost of $200,000 for preceptor tax credits.

IV. ASSUMPTIONS

In order to process the applications, application review, and issuance of tax credit letters as described in this proposed rule, the department will need .15 of a Public Health Program Specialist, .10 of a Senior Public Health Program Specialist, and .05 of a Public Health Program Manager.

TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2231 – Division of Professional Registration
Chapter 3 – Modified Application and Renewal Procedures of the Division

PROPOSED RULE

20 CSR 2231-3.030 Community-Based Faculty Preceptor Tax Credit

PURPOSE: This rule provides an income tax credit for qualified community-based faculty preceptors for physicians and physician assistants. This rule explains the Department of Health and Senior Services' Preceptor Tax Credit eligibility and how the qualifying individual may claim the credit.

(1) Definitions. The following definitions shall be used in the interpretation and enforcement of this rule:

(A) Community-based faculty preceptor or preceptor means a physician or physician assistant who is licensed in Missouri and provides preceptorships to Missouri medical students or physician assistant students without direct compensation for the work of precepting;

(B) Department means the Missouri Department of Health and Senior Services;

(C) Director means the Director of the Missouri Department of Health and Senior Services;

(D) Division means the Division of Professional Registration of the Department of Commerce and Insurance;

(E) Health Professional Shortage Area (HPSA) means a geographic area, population group, or facility designated by the United States Department of Health and Human Services' Health Resources and Services Administration (HRSA) with a shortage of primary care, dental health, or mental health providers and services;

(F) Medical student means an individual enrolled in a Missouri medical college approved and accredited as reputable by the American Medical Association or the Liaison Committee on Medical Education or enrolled in a Missouri osteopathic college approved and accredited as reputable by the Commission on Osteopathic College Accreditation;

(G) Medical student core preceptorship or physician assistant student core preceptorship means a Missouri preceptorship for a medical student or physician assistant student that provides a minimum of one hundred twenty (120) hours of community-based instruction in family medicine, internal medicine, pediatrics, psychiatry, or obstetrics and gynecology under the guidance of a community-based faculty preceptor. A community-based faculty preceptor may add together the amounts of preceptorship instruction time separately provided to multiple students in determining whether he or she has reached the minimum hours required under this subdivision, but the total preceptorship instruction time provided shall equal at least one hundred twenty (120) hours in order for such preceptor to be eligible for the tax credit authorized under this rule;

(H) Physician assistant student means an individual participating in a Missouri physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant or its successor organization;

(I) Preceptorship rotation means one hundred twenty (120) hours of community-based instruction. One hundred twenty (120) hours of community-based instruction can be comprised of one (1) or multiple students to equal the number of preceptorship hours. The total one hundred twenty (120) hours of community-based instruction equates to one (1) preceptorship rotation, two hundred forty (240) hours equates to two (2) preceptorship rotations, and three hundred sixty (360) hours equates to three (3) preceptorship rotations;

(J) Primary Care HPSA means the shortage designation in primary care physicians, as set forth by HRSA, including all the primary care specialties in which a primary care physician could be licensed, to determine the primary care HPSA score;

(K) Primary Care HPSA score ranges from one (1) to twenty-five (25) and demonstrates the shortage level of providers providing primary care services in the HPSA; the higher the score, the greater the need; and

(L) Taxpayer means any individual, firm, partner in a firm, corporation, or shareholder in an S corporation doing business in this state and subject to the state income tax imposed under Chapter 143, RSMo, excluding withholding tax imposed under sections 143.191 to 143.265, RSMo.

(2) Eligibility.

(A) In order to be eligible, the community-based faculty preceptor must –

1. Be a community-based faculty preceptor providing the preceptorship;

2. Hold a current and active license issued by the division;

3. Provide a medical or physician assistant student core preceptorship to one (1) or more medical student(s) or one (1) or more physician assistant student(s);

4. Complete a minimum of one (1) preceptorship rotation and up to three (3) preceptorship rotations during the tax year and not receive any direct compensation for the preceptorships; and

5. Provide a minimum of one hundred twenty (120) hours of community-based instruction in family medicine, internal medicine, pediatrics, psychiatry, or obstetrics and gynecology in the tax year for which the preceptorship is claimed.

(3) Application process.

(A) A preceptor shall complete at least one hundred twenty (120) hours in at least one (1) type of instruction outlined in paragraph (2)(A)5. A community-based faculty preceptor may add together the amounts of preceptorship instruction time separately provided to multiple students in determining whether he or she has reached this minimum.

(B) A preceptor shall provide documentation of the following:

1. The name and address of the students' college or university and the name of the department head or the program director;

2. Preceptor's name;

3. Preceptor's phone number;

4. Preceptor's email address;

5. Preceptor's mailing address;

6. Preceptor's discipline and specialty, if applicable;

7. A statement that the preceptor agrees they did not and will not accept payment in any form for the preceptorship;

8. Total number of hours of instruction;

9. A signed statement on letterhead from preceptor's employer and/or students' university that verifies that the number of hours of instruction are correct;

10. The amount of tax credit claimed; and

11. The following information on each student:

A. First and last name;

B. Phone number;

C. Email address;

D. Type of rotation completed;

E. Beginning and completed dates of the rotation; and

F. Number of hours of completed rotation.

(C) Applications will be accepted during the entire calendar year and a preceptor shall submit documentation no later than January 31 for preceptorships completed the previous tax year. Applications completed in accordance with this section will be accepted by electronic submission through the Preceptor Tax Credit webpage at https://health.mo.gov/living/families/primarycare/precept/index.php, or by mail at ORHPC – Preceptor Tax Credit, PO Box 570, Jefferson City, MO 65102-0570.

(4) Selection Process.

(A) All applications will be processed on a first-come, first-served basis as received by the department. The applications will be stamped with the date received by the department if the application is sent via regular mail or by UPS, USPS, FedEx, DHL, or other carrier. Applications received electronically will be considered received based on the date stamp on the electronic submission. It is the responsibility of the applicant to verify that an application has been received in a timely manner. Each application received by the department will be reviewed for completeness. Tax credits will be issued based on applicants' qualifications and are subject to the availability of funds. Verification processing times may be delayed if a particular application requires follow-up. For the purposes of this regulation, an electronic submission is considered an original copy of the application.

1. No more than two hundred (200) preceptorship tax credits can be authorized nor can credits exceed two hundred thousand dollars ($200,000) for any one (1) calendar year. Tax credits are subject to the availability of funds.

2. Applications will be prioritized in the following manner:

A. First-come, first-served basis;

B. Applications received on the same day will be prioritized by highest HPSA score of the location of the preceptor's employer;

C. Applications will be selected by the most underserved area as indicated by the highest HPSA score of the location of the preceptorship; and

D. In the event that there are fewer remaining tax credits than qualified applicants, or a tie for the last remaining credit, and with all of those applicants having equal status in priority, the remaining tax credits will be selected by lottery.

(5) Tax Credit Issuance.

(A) Upon each determination, the department will issue, to the preceptors awarded, a certification affirming the taxpayer's eligibility for the tax credits by March 1 of the year following the preceptorship. To receive the credit allowed by this rule, the certification provided to the taxpayer by the department shall be filed by the taxpayer with their income tax return for the year in which he or she completes the preceptorship rotations.

(B) Subject to the availability of funds, preceptors shall be allowed a credit against the tax otherwise due under Chapter 143, RSMo, excluding withholding tax imposed under sections 143.191 to 143.265, RSMo, in an amount equal to one thousand dollars ($1,000) for each completed preceptorship rotation, up to a maximum of three thousand dollars ($3,000) per preceptor per tax year.

(C) The taxpayer shall not receive a preceptorship tax credit from the department of revenue, under this rule, that exceeds their tax liability for the tax year for which such credit is claimed. Nor shall a taxpayer be allowed a tax credit against his or her tax liability for any prior or succeeding tax year. This may result in a credit of less than one thousand dollars ($1,000).

(D) No amount of any tax credit allowed under this rule shall be refundable. No tax credit allowed under this rule shall be transferred, sold, or assigned. No taxpayer shall be eligible to receive the tax credit authorized under this rule if such taxpayer employs persons who are not authorized to work in the United States under federal law.

(E) The Department of Revenue shall be responsible for verifying that the tax credit does not result in exceeding the taxpayer's income tax liability and shall only authorize the portion of the tax credit that does not result in a refund.

AUTHORITY: section 135.690, RSMo Supp. 2022. Original rule filed June 15, 2023.

PUBLIC COST: This proposed rule is estimated to cost state agencies or political subdivisions at least two hundred sixteen thousand, one hundred twenty-five dollars ($216,125) in the first year period and two hundred twenty-seven thousand eight hundred eighty-two dollars ($227,882) to two hundred twenty-eight thousand one hundred twenty-four dollars ($228,124) annually thereafter.

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Division of Professional Registration, Sarah E. Ledgerwood, Deputy Division Director, PO Box 1335, Jefferson City, MO 65102, or via email at profreg@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.*

FISCAL NOTE
PUBLIC COST

I. Department: Title 20: Department of Commerce and Insurance
Division Title: Division of Professional Registration
Chapter Title: 20 CSR 2231-3.030

Rule Number and Title:	**20 CSR 2231-3.030 Community-Based Faculty Preceptor Tax Credit**
Type of Rulemaking:	Proposed

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Health & Senior Services'	**$216,125 for the first year period and between $227,882 and $228,124 annually thereafter**

II. WORKSHEET

.30 Total FTE:

.15 FTE Public Health Program Specialist (Full salary $50,000)

$50,000 (salary) x .15 =$7,500 x 7/12 (7 months) = $4,375 + $2,690 (fringe benefits) = $7,065 for the first year period.

$50,500 (salary with 1% COLA increase) x .15 = $7,575 + $4,639 (fringe benefits) = $12,214 year 2.

$51,005 (salary with 1% COLA increase from year 2) x .15 = $7,651 + $4,667 (fringe benefits) = $12,318 year 3.

.10 FTE Senior Public Health Program Specialist (Full salary $62,400)

$62,400 (salary) x .10 =$6,240 x 7/12 (7 months) = $3,640 + $2,056 (fringe benefits) = $5,696 for the first year period.

$63,024 (salary with 1% COLA increase) x .10 = $6,302 + $3,548 (fringe benefits) = $9,850 year 2.

$63,348 (salary with 1% COLA increase from year 2) x .10 = $6,365 + $3,571 (fringe benefits) = $9,936 year 3.

.05 FTE Public Health Program Specialist (Full salary $75,370)

$75,370 (salary) x .05 =$3,768 x 7/12 (7 months) = $2.198 + $1,166 (fringe benefits) = $3,364 for the first year period.

$76,124 (salary with 1% COLA increase) x .05 = $3,806 + $2,012 (fringe benefits) = $5,818 year 2.

$76,877 (salary with 1% COLA increase from year 2) x .05 = $3,844 + $2,026 (fringe benefits) = $5,870 year 3.

Community-Based Faculty Preceptor Tax Credit Program Tax Credit Amount

Estimated maximum annual cost of $200,000 for preceptor tax credits.

IV. ASSUMPTIONS

In order to process the applications, application review, and issuance of tax credit letters as described in this proposed rule, the department will need .15 of a Public Health Program Specialist, .10 of a Senior Public Health Program Specialist, and .05 of a Public Health Program Manager.

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order 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 that has been changed from the text contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments that 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 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 91 – Personal Care Program

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, MO HealthNet Division, under section 208.152, RSMo Supp. 2022, and sections 208.153 and 208.159, RSMo 2016, the division amends a rule as follows:

13 CSR 70-91.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2023 (48 MoReg 601-608). 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 MO HealthNet Division received one (1) comment on the proposed amendment.

COMMENT #1: Carol Hudspeth, Executive Director of the Missouri Alliance for Home Care, requests consideration of removing the word "failure" and rewording of the sentence. HCBS services are structured around person-centered care. Many times, a participant, for example, may be in the hospital or simply refused care on a certain day due to various reasons. "Failure" tends to have a negative connotation and implies that the provider failed or did not attempt to provide services. We suggest using the following instead: Documentation, including the reason, must be kept on authorized services/units not delivered.

RESPONSE AND EXPLANATION OF CHANGE: DSS will make the change, as the revision proposed in Missouri Alliance for Home Care's comment does not change what is being required of the provider.

The last sentence in paragraph (3)(H)2. currently reads, "Documentation must be kept on undelivered services, including the reason for this failure to deliver authorized units;" and it should be revised to read, "Documentation, including the reason, must be kept on authorized services/units not delivered;"

13 CSR 70-91.010 Personal Care Program

(3) Criteria for Providers of Personal Care Services.

(H) The supervisor's responsibilities shall include, at a minimum, the following:

1. Establish, implement, and enforce a policy governing communicable diseases that prohibits provider staff contact with participants when the employee has a communicable condition, including colds or flu. Assure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by the Missouri Department of Health and Senior Services (19 CSR 20-20.020), are carried out;

2. Monitor the provision of services by the personal care worker to assure that services are being delivered in accordance with the personal care plan. This shall be primarily in the form of an at least monthly review and comparison of the worker's records of provided services with the personal care plan. The monitoring reports shall be available for review by the Departments of Social Services and Health and Senior Services upon request. Documentation, including the reason, must be kept on authorized services/units not delivered;

3. Make an on-site visit at least annually to evaluate each personal care worker's performance and the adequacy of the service plan, including review of the plan of care with the participant. The personal care worker may or may not be present for this evaluation. A written record of the evaluation shall be maintained in the personnel file of the personal care worker. This record must contain, at a minimum, the participant's name and address, the date and time of the visit, personal care worker's name, observations related to the participant's receipt of care plan delivery, the participant's satisfaction of the personal care worker's performance, and the adequacy of the service plan. In addition, the evaluation shall be signed and dated by the supervisor who prepared it and by the personal care worker. If the required evaluation is not performed or not documented, the personal care worker's qualifications to provide the services may be presumed inadequate and all payments made for services by that personal care worker may be recouped;

4. Approve, in advance, all changes to the plan of care based on supervisory on-site visits, information from the personal care worker, or observation by the RN, or a combination of these. Approval of changes shall be noted and dated in the participant's file;

5. Make appropriate recommendations to the Department of Health and Senior Services or its designee including proposed increase, reduction, or termination of services; or need for increased Department of Health and Senior Services involvement based on supervisory on-site visits, review of reports, information from the personal care worker, observation by the RN; or a combination of these;

6. Be available for regular case conferences with the Department of Health and Senior Services or its designee; and

7. Assist in orientation and personal care training for personal care workers.

TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 15 – Division of Senior and Disability Services
Chapter 7 – Service Standards

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

19 CSR 15-7.005 Definitions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2023 (48 MoReg 608-609). No changes have been made to 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 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 15 – Division of Senior and Disability Services
Chapter 7 – Service Standards

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

19 CSR 15-7.010 General Requirements for All Service Providers **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2023 (48 MoReg 609-611). No changes have been made to 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 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 15 – Division of Senior and Disability Services
Chapter 7 – Service Standards

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Health and Senior Services under section 192.2000, RSMo 2016, the department amends a rule as follows:

19 CSR 15-7.021 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2023 (48 MoReg 611-618). 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 Health and Senior Services received one (1) comment on the proposed amendment.

COMMENT #1: The Missouri Alliance for Home Care inquired if the proposed language in subsection (21)(A) regarding administrative supervisor's responsibilities could be changed/amended from "Documentation must be kept on undelivered services, including the reason for this failure to deliver authorized units" to "Documentation, including the reason, must be kept on authorized services/unit not delivered."
RESPONSE AND EXPLANATION OF CHANGE: The department took into consideration the comment and requirements for administrative supervisor's responsibilities, and the language in subsection (21)(A) will be changed to "Documentation, including the reason, must be kept on authorized services/unit not delivered."

19 CSR 15-7.021 In-Home Service Standards

(21) The administrative supervisor's responsibilities shall include, at a minimum, the following functions:

(A) Monitoring the provision of services by the in-home services worker to assure that services are being delivered in accordance with the care plan. This shall be primarily in the form of an at least monthly review and comparison of the worker's record of provided services with the care plan. Documentation, including the reason, must be kept on authorized services/units not delivered;

TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2110 – Missouri Dental Board
Chapter 2 – General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under section 332.031, RSMo 2016, the board rescinds a rule as follows:

20 CSR 2110-2.030 Licensure by Credentials – Dentists **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on April 3, 2023 (48 MoReg 702). No changes have been made to 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 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2110 – Missouri Dental Board
Chapter 2 – General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under section 332.031, RSMo 2016, the board rescinds a rule as follows:

20 CSR 2110-2.070 Licensure by Credentials – Dental Hygienists **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on April 3, 2023 (48 MoReg 702). No changes have been made to 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 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2110 – Missouri Dental Board
Chapter 2 – General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under section 332.031, RSMo 2016, the board rescinds a rule as follows:

20 CSR 2110-2.075 Nonresident Military Spouse Licensure by Credentials **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on April 3, 2023 (48 MoReg 702). No changes have been made to 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 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2230 – State Board of Podiatric Medicine
Chapter 2 – General Rules

ORDER OF RULEMAKING

By the authority vested in the State Board of Podiatric Medicine under section 330.140, RSMo 2016, the board rescinds a rule as follows:

20 CSR 2230-2.050 Licensure by Reciprocity **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on April 3, 2023 (48 MoReg 702-703). No changes have been made to 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 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2230 – State Board of Podiatric Medicine
Chapter 2 – General Rules

ORDER OF RULEMAKING

By the authority vested in the State Board of Podiatric Medicine under section 330.140, RSMo 2016, the board rescinds a rule as follows:

20 CSR 2230-2.055 Issuance of Temporary Courtesy License to Nonresident Military Spouse **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on April 3, 2023 (48 MoReg 703). No changes have been made to 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.

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

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

NOTIFICATION OF REVIEW:
APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the CON applications listed below. A decision is tentatively scheduled for September 11, 2023. These applications are available for public inspection at the address shown below.

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

6/30/2023

#6031 HS: Emergency Care Hospital – Independence
Independence (Jackson County)
$24,401,000, Establish 3-bed emergency care hospital

#6032 HS: Emergency Care Hospital – Northland
Kansas City (Clay County)
$36,922,650, Establish 3-bed emergency care hospital

#6029 NS: Lakeview Post Acute
Florissant (St. Louis County)
$400,000, Add 30 SNF beds

#6030 RS: Zebra Hitch Senior Living
Lee's Summit (Jackson County)
$42,000,000 Establish 134-bed ALF

#6033 HS: Missouri Baptist Medical Center
St. Louis (St. Louis County)
$2,466,602, Acquire robotic surgery unit (neuro OR)

#6035 RS: The Baptist Home, Chillicothe
Chillicothe (Livingston County)
$199,909, Add 34 ALF beds

#6034 RS: The Baptist Home at Ashland RCF
Ashland (Boone County)
$0, Establish 12-bed RCF

#6008 RS: St. Louis Assisted Living Solutions, LLC
Wentzville (St. Charles County)
$2,791,000, Establish 16-bed ALF

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by August 4, 2023. All written requests and comments should be sent to:

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
PO Box 570
Jefferson City, MO 65102

For additional information contact Alison Dorge at alison.dorge@health.mo.gov.

The Secretary of State is required by sections 347.141 and 359.481, RSMo, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to adrules.dissolutions@sos.mo.gov.

NOTICE OF WINDING UP FOR LIMITED LIABILITY COMPANY TO ALL CREDITORS AND CLAIMANTS AGAINST HOYNE LAW FIRM, LLC

Hoyne Law Firm, LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State effective May 31, 2023.

The Company hereby requests that all persons, entities, and organizations with claims against the Company present such claims by letter to: Hoyne Law Firm, LLC, attention Andrew T. Hoyne, 5 Thorndell, St. Louis, Missouri 63117.

Each claim must include:

1. The name, address and telephone number of the claimant;
2. The amount of the claim;
3. The basis of the claim;
4. The date(s) of the event(s) on which the claim is based occurred; and
5. Documentation to support the claim.

NOTICE: All claims against the Company will be barred unless the proceeding to enforce the claim is commenced within three years after the publication of this notice.

NOTICE OF WINDING UP FOR LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST GENIECAST, LLC

On May 24, 2023, Geniecast, LLC a Missouri limited liability company (the "Company"), filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State, effective on the filing date.

Any claims against the Company may be sent to Danna McKitrick, P.C. 7701 Forsyth Blvd., Suite 1200, St. Louis, MO 63105, attention Ruth A. Binger, Esq. Each claim must include the following information: 1) claimant's name address and telephone number; 2) amount of the claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; 5) documentation in support of the claim; and 6) if the claim is secured, and if so, the collateral used as security.

Any and all claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

Notice of Winding Up of Ozarks Ridgerunner IV, LLC

On June 7, 2023, Ozarks Ridgerunner IV, a Missouri Limited Liability Company (hereinafter "LLC"), filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State.

All claims against the LLC must be submitted in writing to: Kenneth Scott, 8368 W. Farm Road 84, Willard, MO 65781. Each claim must include the following information: (1) the name, address and phone number of the claimant; (2) amount of claim; (3) the date on which the claim arose; (4) basis for the claim; and (5) documentation in support of the claim.

All claims against the LLC will be barred unless a proceeding to enforce the claim is commenced within three years after the date the Notice of Winding Up is filed or published, whichever is later.

Notice of Winding Up of Ozarks Ridgerunner V, LLC

On June 7, 2023, Ozarks Ridgerunner V, a Missouri Limited Liability Company (hereinafter "LLC"), filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State.

All claims against the LLC must be submitted in writing to: Kenneth Scott, 8368 W. Farm Road 84, Willard, MO 65781. Each claim must include the following information: (1) the name, address and phone number of the claimant; (2) amount of claim; (3) the date on which the claim arose; (4) basis for the claim; and (5) documentation in support of the claim.

All claims against the LLC will be barred unless a proceeding to enforce the claim is commenced within three years after the date the Notice of Winding Up is filed or published, whichever is later.

**NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
JA RICH REAL ESTATE, LLC**

On June 6, 2023, JA Rich Real Estate, LLC, a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o Frank C. Carnahan, Esq., Carnahan Evans PC, 2805 S. Ingram Mill Road, Springfield, Missouri 65804, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number; 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last of filing or publication of this Notice.

**NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST
SOUTHERNWOOD MANAGEMENT COMPANY, LLC**

On November 10, 2022, Southernwood Management Company, LLC, a Missouri limited liability company (the "Company") filed its Notice of Winding Up for a Limited Liability Company with the Missouri Secretary of State. The effective date of said Notice was November 10, 2022.

Southernwood Management Company, LLC, hereby requests that all persons and organizations with claims against it present them immediately by letter to: Southernwood Management Company, LLC, LLC, c/o Russell Cook, Attorney at Law, 901 St. Louis St., 20th Floor, Springfield, MO 65806. Each claim must include the following information: name, address, and phone number of the claimant; amount claimed; date on which the claim arose; the basis for the claim; and documentation in support of the claim. NOTICE: Because of the dissolution of Southernwood Management Company, LLC, LLC, any and all claims against the Limited Liability Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication date of the notices authorized by Section 347.141 RSMo., whichever is published last.

**NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST
KENSINGTON INVESTMENTS, LLC**

On November 10, 2022, Kensington Investments, LLC, a Missouri limited liability company (the "Company") filed its Notice of Winding Up for a Limited Liability Company with the Missouri Secretary of State. The effective date of said Notice was November 10, 2022.

Kensington Investments, LLC, hereby requests that all persons and organizations with claims against it present them immediately by letter to: Kensington Investments, LLC, c/o Russell Cook, Attorney at Law, 901 St. Louis St., 20th Floor, Springfield, MO 65806. Each claim must include the following information: name, address, and phone number of the claimant; amount claimed; date on which the claim arose; the basis for the claim; and documentation in support of the claim. NOTICE: Because of the dissolution of Kensington Investments, LLC, any and all claims against the Limited Liability Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication date of the notices authorized by Section 347.141 RSMo., whichever is published last.

**NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST
THE JEWELED GYPSY LLC**

On June 13, 2023, THE JEWELED GYPSY LLC, filed its Notice of Winding Up for THE JEWELED GYPSY LLC with the Missouri Secretary of State. THE JEWELED GYPSY LLC requests that all persons and organizations who have claims against it present them immediately by letter to

Brock Schmutzler
The Jeweled Gypsy LLC
8310 Booth Ave
Raytown Mo, 64138

All claims must include the following information: (a) name and address of the claimant, (b) the amount claimed, (c) date on which the claim arose, (d) basis for the claim and documentation thereof, and (e) whether or not the claim was secured and, if so, the collateral used as security.

All claims against THE JEWELED GYPSY LLC will be barred unless a proceeding to enforce the claim is commenced within (three (3) years after the date of publication of this notice.

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*. Citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year – 47 (2022) and 48 (2023). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				47 MoReg 1457
1 CSR 10-1.010	Commissioner of Administration		48 MoReg 304	48 MoReg 959	
1 CSR 10-8.010	Commissioner of Administration		48 MoReg 557		
1 CSR 10-11.010	Commissioner of Administration	48 MoReg 789	48 MoReg 796		
1 CSR 20-3.070	Personnel Advisory Board and Division of Personnel		48 MoReg 558		
1 CSR 20-4.020	Personnel Advisory Board and Division of Personnel		48 MoReg 558		
1 CSR 20-6.010	Personnel Advisory Board and Division of Personnel		48 MoReg 306	48 MoReg 959	
1 CSR 35-2.060	Division of Facilities Management		48 MoReg 691		
1 CSR 60-1.010	Registration for Prescription Drug Monitoring Program		48 MoReg 559	48 MoReg 1310	
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-1.010	Animal Health		48 MoReg 559		
2 CSR 30-1.020	Animal Health		48 MoReg 560		
2 CSR 30-2.004	Animal Health		48 MoReg 987		
2 CSR 30-2.010	Animal Health		48 MoReg 989		
2 CSR 30-2.020	Animal Health		48 MoReg 995		
2 CSR 30-2.040	Animal Health		48 MoReg 1000		
2 CSR 30-9.100	Animal Health		48 MoReg 1180R		
2 CSR 30-9.110	Animal Health		48 MoReg 1180R		
2 CSR 30-10.010	Animal Health	48 MoReg 303	48 MoReg 306	48 MoReg 1027	
2 CSR 80-5.010	State Milk Board		48 MoReg 307	48 MoReg 1027	
2 CSR 90-20.040	Weights, Measures and Consumer Protection		48 MoReg 1009		
2 CSR 90-21.010	Weights, Measures and Consumer Protection		48 MoReg 41	48 MoReg 959	
2 CSR 90-22.140	Weights, Measures and Consumer Protection		48 MoReg 1009		
2 CSR 90.23.010	Weights, Measures and Consumer Protection		48 MoReg 1009		
2 CSR 90-25.010	Weights, Measures and Consumer Protection		48 MoReg 1010		
2 CSR 100-12.010	Missouri Agricultural and Small Business Development Authority		48 MoReg 912		
2 CSR 100-13.010	Missouri Agricultural and Small Business Development Authority		48 MoReg 915		
	DEPARTMENT OF CONSERVATION				
3 CSR 10-4.111	Conservation Commission		48 MoReg 566	48 MoReg 1310	
3 CSR 10-5.215	Conservation Commission		48 MoReg 1180		
3 CSR 10-5.250	Conservation Commission		48 MoReg 1183		
3 CSR 10-5.300	Conservation Commission		48 MoReg 1185		
3 CSR 10-5.310	Conservation Commission		48 MoReg 1187		
3 CSR 10-5.315	Conservation Commission		48 MoReg 1189		
3 CSR 10-5.320	Conservation Commission		48 MoReg 1191		
3 CSR 10-5.324	Conservation Commission		48 MoReg 1193		
3 CSR 10-5.330	Conservation Commission		48 MoReg 1193		
3 CSR 10-5.331	Conservation Commission		48 MoReg 1195		
3 CSR 10-5.340	Conservation Commission		48 MoReg 1195		
3 CSR 10-5.345	Conservation Commission		48 MoReg 1197		
3 CSR 10-5.351	Conservation Commission		48 MoReg 1199		
3 CSR 10-5.352	Conservation Commission		48 MoReg 1201		
3 CSR 10-5.359	Conservation Commission		48 MoReg 1203		
3 CSR 10-5.360	Conservation Commission		48 MoReg 1205		
3 CSR 10-5.365	Conservation Commission		48 MoReg 1207		
3 CSR 10-5.370	Conservation Commission		48 MoReg 1209		
3 CSR 10-5.425	Conservation Commission		48 MoReg 1211		
3 CSR 10-5.430	Conservation Commission		48 MoReg 1213		
3 CSR 10-5.435	Conservation Commission		48 MoReg 1215		
3 CSR 10-5.436	Conservation Commission		48 MoReg 1217		
3 CSR 10-5.440	Conservation Commission		48 MoReg 1219		
3 CSR 10-5.445	Conservation Commission		48 MoReg 1221		
3 CSR 10-5.460	Conservation Commission		48 MoReg 1223		
3 CSR 10-5.465	Conservation Commission		48 MoReg 1223		
3 CSR 10-5.540	Conservation Commission		48 MoReg 1225		
3 CSR 10-5.545	Conservation Commission		48 MoReg 1227		
3 CSR 10-5.551	Conservation Commission		48 MoReg 1229		
3 CSR 10-5.552	Conservation Commission		48 MoReg 1231		
3 CSR 10-5.554	Conservation Commission		48 MoReg 1233		
3 CSR 10-5.559	Conservation Commission		48 MoReg 1235		
3 CSR 10-5.560	Conservation Commission		48 MoReg 1235		
3 CSR 10-5.565	Conservation Commission		48 MoReg 1237		
3 CSR 10-5.567	Conservation Commission		48 MoReg 1239		
3 CSR 10-5.570	Conservation Commission		48 MoReg 1241		
3 CSR 10-5.576	Conservation Commission		48 MoReg 1243		
3 CSR 10-5.579	Conservation Commission		48 MoReg 1245		
3 CSR 10-5.580	Conservation Commission		48 MoReg 1247		
3 CSR 10-5.600	Conservation Commission		48 MoReg 1249		
3 CSR 10-5.605	Conservation Commission		48 MoReg 1249		
3 CSR 10-6.405	Conservation Commission		48 MoReg 1249		

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
3 CSR 10-6.535	Conservation Commission		48 MoReg 1250		
3 CSR 10-7.433	Conservation Commission			48 MoReg 1310	
3 CSR 10-7.434	Conservation Commission			48 MoReg 1311	
3 CSR 10-7.435	Conservation Commission			48 MoReg 1311	
3 CSR 10-7.437	Conservation Commission			48 MoReg 1312	
3 CSR 10-7.700	Conservation Commission		48 MoReg 919		
3 CSR 10-9.240	Conservation Commission		48 MoReg 566	48 MoReg 1312	
3 CSR 10-9.350	Conservation Commission		48 MoReg 1250		
3 CSR 10-9.351	Conservation Commission		48 MoReg 1252		
3 CSR 10-9.352	Conservation Commission		48 MoReg 1252		
3 CSR 10-9.370	Conservation Commission		48 MoReg 1252		
3 CSR 10-9.420	Conservation Commission		48 MoReg 1253		
3 CSR 10-9.425	Conservation Commission		48 MoReg 1253		
3 CSR 10-9.440	Conservation Commission		48 MoReg 1255		
3 CSR 10-9.560	Conservation Commission		48 MoReg 1255		
3 CSR 10-9.565	Conservation Commission		48 MoReg 1257		
3 CSR 10-9.570	Conservation Commission		48 MoReg 1259		
3 CSR 10-9.575	Conservation Commission		48 MoReg 1260		
3 CSR 10-9.625	Conservation Commission		48 MoReg 1260		
3 CSR 10-9.627	Conservation Commission		48 MoReg 1263		
3 CSR 10-9.640	Conservation Commission		48 MoReg 1265		
3 CSR 10-10.707	Conservation Commission		48 MoReg 1265		
3 CSR 10-10.708	Conservation Commission		48 MoReg 1267		
3 CSR 10-10.720	Conservation Commission		48 MoReg 1269		
3 CSR 10-10.722	Conservation Commission		48 MoReg 1272		
3 CSR 10-10.724	Conservation Commission		48 MoReg 1272		
3 CSR 10-10.728	Conservation Commission		48 MoReg 1272		
3 CSR 10-10.732	Conservation Commission		48 MoReg 1273		
3 CSR 10-10.744	Conservation Commission		48 MoReg 1273		
3 CSR 10-10.767	Conservation Commission		48 MoReg 1275		
3 CSR 10-10.788	Conservation Commission		48 MoReg 1277		
3 CSR 10-11.180	Conservation Commission		48 MoReg 566	48 MoReg 1312	
3 CSR 10-12.110	Conservation Commission		48 MoReg 570	48 MoReg 1312	
3 CSR 10-12.115	Conservation Commission		48 MoReg 570	48 MoReg 1313	
3 CSR 10-12.135	Conservation Commission		48 MoReg 571	48 MoReg 1313	
3 CSR 10-12.140	Conservation Commission		48 MoReg 571	48 MoReg 1313	
3 CSR 10-12.150	Conservation Commission		48 MoReg 1277		
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 20-100.105	Division of Learning Service		This Issue R		
5 CSR 20-100.130	Division of Learning Services		48 MoReg 574		
5 CSR 20-100.185	Division of Learning Service		This Issue		
5 CSR 20-100.230	Division of Learning Services		48 MoReg 307		
5 CSR 20-100.255	Division of Learning Services		This Issue R		
5 CSR 20-100.340	Division of Learning Services *formerly 5 CSR 20-400.400*		48 MoReg 200	48 MoReg 1027	
5 CSR 20-200.275	Division of Learning Services		48 MoReg 955		
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5 CSR 20-400.400	Division of Learning Services *moved to 5 CSR 20-100.340*		48 MoReg 200	48 MoReg 1027	
5 CSR 20-400.440	Division of Learning Services		48 MoReg 574		
5 CSR 20-400.510	Division of Learning Services		48 MoReg 574		
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5 CSR 20-400.530	Division of Learning Services		48 MoReg 581		
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6 CSR 10-2.210	Commissioner of Higher Education		48 MoReg 596R 48 MoReg 597	48 MoReg 1314R 48 MoReg 1315	
6 CSR 10-4.030	Commissioner of Higher Education		48 MoReg 122R	48 MoReg 927R	
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6 CSR 25-1.010	Central Missouri State University		48 MoReg 122R	48 MoReg 927R	
6 CSR 250-1.010	University of Missouri		48 MoReg 122R	48 MoReg 927R	
6 CSR 250-1.020	University of Missouri		48 MoReg 123R	48 MoReg 927R	
6 CSR 250-2.010	University of Missouri		48 MoReg 123R	48 MoReg 928R	
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6 CSR 250-2.040	University of Missouri		48 MoReg 437R	48 MoReg 1028R	
6 CSR 250-2.050	University of Missouri		48 MoReg 438R	48 MoReg 1028R	
6 CSR 250-3.010	University of Missouri		48 MoReg 729R		
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6 CSR 250-4.010	University of Missouri		48 MoReg 729R		
6 CSR 250-4.020	University of Missouri		48 MoReg 730R		
6 CSR 250-4.030	University of Missouri		48 MoReg 730R		
6 CSR 250-5.010	University of Missouri		48 MoReg 730R		
6 CSR 250-5.020	University of Missouri		48 MoReg 730R		
6 CSR 250-6.010	University of Missouri		48 MoReg 731R		
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6 CSR 250-6.030	University of Missouri		48 MoReg 731R		
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6 CSR 250-7.010	University of Missouri		48 MoReg 1013R		
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6 CSR 250-7.040	University of Missouri		48 MoReg 1014R		
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7 CSR 10-7.030	Missouri Highways and Transportation Commission		48 MoReg 124	48 MoReg 1029	
7 CSR 265-9.010	Motor Carrier and Railroad Safety		48 MoReg 125	48 MoReg 1029	
7 CSR 265-9.020	Motor Carrier and Railroad Safety		48 MoReg 125	48 MoReg 1029	
7 CSR 265-9.050	Motor Carrier and Railroad Safety		48 MoReg 126	48 MoReg 1029	
7 CSR 265-9.100	Motor Carrier and Railroad Safety		48 MoReg 126	48 MoReg 1029	
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8 CSR 40-2.100	State Board of Mediation		48 MoReg 312	48 MoReg 1030	
8 CSR 40-2.140	State Board of Mediation		48 MoReg 312	48 MoReg 1030	
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9 CSR 30-6.010	Certification Standards		This Issue		
9 CSR 30-7.010	Certification Standards		47 MoReg 1768	48 MoReg 928	
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11 CSR 30-8.010	Office of the Director		48 MoReg 202R		
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11 CSR 40-2.022	Division of Fire Safety		48 MoReg 127	48 MoReg 930	
11 CSR 45-7.010	Missouri Gaming Commission		47 MoReg 1711	48 MoReg 815	
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12 CSR 10-2.019	Director of Revenue		48 MoReg 920R		
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12 CSR 10-2.140	Director of Revenue		48 MoReg 1015		
12 CSR 10-2.436	Director of Revenue	48 MoReg 185	48 MoReg 204	48 MoReg 930	
12 CSR 10-2.725	Director of Revenue		48 MoReg 438	48 MoReg 1315	
12 CSR 10-6.030	Director of Revenue		48 MoReg 1015		
12 CSR 10-9.140	Director of Revenue		48 MoReg 1278R		
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12 CSR 10-9.290	Director of Revenue		48 MoReg 1280R		
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12 CSR 10-24.030	Director of Revenue		48 MoReg 439	48 MoReg 1315	
12 CSR 10-26.230	Director of Revenue		48 MoReg 440	48 MoReg 1315	
12 CSR 10-26.231	Director of Revenue	48 MoReg 353	48 MoReg 441	48 MoReg 1315	
12 CSR 10-42.050	Director of Revenue		48 MoReg 802		
12 CSR 10-43.020	Director of Revenue		48 MoReg 441	48 MoReg 1316	
12 CSR 10-43.030	Director of Revenue		48 MoReg 442	48 MoReg 1316	
12 CSR 10-112.020	Director of Revenue		48 MoReg 1019		
12 CSR 10-113.200	Director of Revenue		48 MoReg 314	48 MoReg 960	
12 CSR 10-113.400	Director of Revenue		48 MoReg 315	48 MoReg 960	
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13 CSR 35-71.015	Children's Division	48 MoReg 1149	48 MoReg 1281		
13 CSR 35-71.095	Children's Division		48 MoReg 315	48 MoReg 1316	
13 CSR 70-3.200	MO HealthNet Division	48 MoReg 555	48 MoReg 600	48 MoReg 1316	
13 CSR 70-3.230	MO HealthNet Division		48 MoReg 144	48 MoReg 962	
13 CSR 70-4.120	MO HealthNet Division		48 MoReg 921		
13 CSR 70-10.020	MO HealthNet Division	48 MoReg 1150	48 MoReg 1282		
13 CSR 70-10.030	MO HealthNet Division	48 MoReg 791	48 MoReg 804		
13 CSR 70-15.070	MO HealthNet Division		48 MoReg 1306		
13 CSR 70-15.110	MO HealthNet Division	This Issue			
13 CSR 70-15.160	MO HealthNet Division	This Issue	This Issue		
13 CSR 70-20.042	MO HealthNet Division		47 MoReg 1437 48 MoReg 144	47 MoReg 1786W 48 MoReg 962	
13 CSR 70-20.320	MO HealthNet Division		48 MoReg 734		
13 CSR 70-70.010	MO HealthNet Division		48 MoReg 734		
13 CSR 70-90.010	MO HealthNet Division		47 MoReg 1716	48 MoReg 816	
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19 CSR 30-40.420	Division of Regulation and Licensure	48 MoReg 5	48 MoReg 44	48 MoReg 817	
19 CSR 30-40.430	Division of Regulation and Licensure	48 MoReg 11	48 MoReg 54	48 MoReg 822	
19 CSR 30-40.710	Division of Regulation and Licensure	48 MoReg 13	48 MoReg 56	48 MoReg 823	
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19 CSR 30-95.010	Division of Regulation and Licensure	48 MoReg 353R	48 MoReg 442R	48 MoReg 1031R	
19 CSR 30-95.020	Division of Regulation and Licensure	48 MoReg 354R	48 MoReg 442R	48 MoReg 1031R	
19 CSR 30-95.025	Division of Regulation and Licensure	48 MoReg 354R	48 MoReg 443R	48 MoReg 1031R	
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19 CSR 30-95.080	Division of Regulation and Licensure	48 MoReg 357R	48 MoReg 445R	48 MoReg 1033R	
19 CSR 30-95.090	Division of Regulation and Licensure	48 MoReg 358R	48 MoReg 445R	48 MoReg 1033R	
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19 CSR 30-105.050	Division of Regulation and Licensure		48 MoReg 641		
19 CSR 30-105.060	Division of Regulation and Licensure		48 MoReg 645		
19 CSR 30-105.070	Division of Regulation and Licensure		48 MoReg 645		
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19 CSR 60-50	Missouri Health Facilities Review Committee				48 MoReg 932 48 MoReg 965 48 MoReg 1320
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19 CSR 73-2.080	Missouri Board of Nursing Home Administrators		48 MoReg 957		
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19 CSR 100-1.020	Division of Cannabis Regulation	48 MoReg 363	48 MoReg 453	48 MoReg 1040	
19 CSR 100-1.030	Division of Cannabis Regulation	48 MoReg 367	48 MoReg 456	48 MoReg 1043	
19 CSR 100-1.040	Division of Cannabis Regulation	48 MoReg 373	48 MoReg 462	48 MoReg 1048	
19 CSR 100-1.050	Division of Cannabis Regulation	48 MoReg 383	48 MoReg 473	48 MoReg 1053	
19 CSR 100-1.060	Division of Cannabis Regulation	48 MoReg 384	48 MoReg 474	48 MoReg 1055	
19 CSR 100-1.070	Division of Cannabis Regulation	48 MoReg 398	48 MoReg 488	48 MoReg 1062	
19 CSR 100-1.080	Division of Cannabis Regulation	48 MoReg 401	48 MoReg 491	48 MoReg 1064	
19 CSR 100-1.090	Division of Cannabis Regulation	48 MoReg 401	48 MoReg 491	48 MoReg 1064	
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19 CSR 100-1.160	Division of Cannabis Regulation	48 MoReg 424	48 MoReg 517	48 MoReg 1119	
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20 CSR	Construction Claims Binding Arbitration Cap				48 MoReg 529
20 CSR	Non-Economic Damages in Medical Malpractice Cap				48 MoReg 326
20 CSR	Sovereign Immunity Limits				47 MoReg 1801
20 CSR	State Legal Expense Fund Cap				48 MoReg 529
20 CSR 500-1.100	Property and Casualty		48 MoReg 522		
20 CSR 2010-2.140	Missouri State Board of Accountancy		48 MoReg 1308R 48 MoReg 1308		
20 CSR 2040-5.070	Office of Athletics		48 MoReg 207	48 MoReg 931	
20 CSR 2110-2.030	Missouri Dental Board		48 MoReg 702R	This Issue R	
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20 CSR 2200-3.010	State Board of Nursing		48 MoReg 810		
20 CSR 2200-6.030	State Board of Nursing		48 MoReg 811		
20 CSR 2200-6.040	State Board of Nursing		48 MoReg 811		
20 CSR 2200-6.060	State Board of Nursing		48 MoReg 812		
20 CSR 2200-8.010	State Board of Nursing		48 MoReg 813		
20 CSR 2220-2.175	State Board of Pharmacy		48 MoReg 317	48 MoReg 964	
20 CSR 2220-2.400	State Board of Pharmacy		48 MoReg 740		
20 CSR 2220-2.410	State Board of Pharmacy		48 MoReg 742		
20 CSR 2230-2.050	State Board of Podiatric Medicine		48 MoReg 702R	This Issue R	
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20 CSR 2234-1.050	Board of Private Investigator and Private Fire Investigator Examiners		48 MoReg 1309		
20 CSR 2234-3.010	Board of Private Investigator and Private Fire Investigator Examiners		48 MoReg 147	48 MoReg 832	
20 CSR 2234-3.040	Board of Private Investigator and Private Fire Investigator Examiners		48 MoReg 147	48 MoReg 832	
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20 CSR 2235-5.030	State Committee Psychologists		48 MoReg 148	48 MoReg 833	
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20 CSR 4240-18.010	Public Service Commission		48 MoReg 926		

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2 CSR 30-10.100	Inspection of Meat and Poultry	48 MoReg 303	Jan. 24, 2023	July 22, 2023
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12 CSR 10-26.231	Maximum Dealer Administrative Fees	48 MoReg 353	Feb. 14, 2023	Aug. 12, 2023
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13 CSR 35-71.015	Background Checks for Personnel of Residential Care Facilities and Child Placing Agencies	48 MoReg 1149	June 13, 2023	Dec. 9, 2023
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13 CSR 70-3.200	Ambulance Service Reimbursement Allowance	48 MoReg 555	Feb. 22, 2023	Aug. 20, 2023
13 CSR 70-10.020	Prospective Reimbursement Plan for Nursing Facility and HIV Nursing Facility Services	48 MoReg 1150	May 31, 2023	Nov. 26, 2023
13 CSR 70-10.030	Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services	48 MoReg 791	March 30, 2023	Sept. 25, 2023
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	This Issue	June 30, 2023	Dec. 26, 2023
13 CSR 70-15.160	Outpatient Hospital Services Reimbursement Methodology	This Issue	June 30, 2023	Dec. 26, 2023
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15 CSR 60-17.010	Experimental Interventions to Treat Gender Dysphoria	48 MoReg 1177	April 27, 2023	Term. May 16, 2023
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19 CSR 30-20.125	Unlicensed Assistive Personnel Training Program	48 MoReg 1177	June 6, 2023	Dec. 2, 2023
19 CSR 30-95.010	Definitions	48 MoReg 353	Feb. 3, 2023	Aug. 1, 2023
19 CSR 30-95.020	General Provisions	48 MoReg 354	Feb. 3, 2023	Aug. 1, 2023
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19 CSR 30-95.030	Qualifying Patient/Primary Caregiver	48 MoReg 355	Feb. 3, 2023	Aug. 1, 2023
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19 CSR 30-95.050	Cultivation Facility	48 MoReg 356	Feb. 3, 2023	Aug. 1, 2023
19 CSR 30-95.060	Infused Products Manufacturing Facility	48 MoReg 357	Feb. 3, 2023	Aug. 1, 2023
19 CSR 30-95.070	Testing Facility	48 MoReg 357	Feb. 3, 2023	Aug. 1, 2023
19 CSR 30-95.080	Dispensary Facility	48 MoReg 357	Feb. 3, 2023	Aug. 1, 2023
19 CSR 30-95.090	Seed-to-Sale Tracking	48 MoReg 358	Feb. 3, 2023	Aug. 1, 2023
19 CSR 30-95.100	Transportation Facility	48 MoReg 358	Feb. 3, 2023	Aug. 1, 2023
19 CSR 30-95.110	Physicians	48 MoReg 359	Feb. 3, 2023	Aug. 1, 2023
Division of Cannabis Regulation				
19 CSR 100-1.010	Definitions	48 MoReg 359	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.020	Generally Applicable Provisions	48 MoReg 363	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.030	Complaints, Inspections, and Investigations	48 MoReg 367	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.040	Consumers, Qualifying Patients, and Primary Caregivers	48 MoReg 373	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.050	Physicians and Nurse Practitioners	48 MoReg 383	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.060	Facility Applications and Selection	48 MoReg 384	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.070	Facility Ownership and Employment	48 MoReg 398	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.080	Facility Employee Training	48 MoReg 401	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.090	Facility Security	48 MoReg 401	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.100	Facilities Generally	48 MoReg 403	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.110	Testing	48 MoReg 411	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.120	Packaging, Labeling, and Product Design	48 MoReg 415	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.130	Inventory Control and Seed-to-Sale Tracking	48 MoReg 416	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.140	Transportation and Storage	48 MoReg 422	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.150	Marijuana Waste Disposal	48 MoReg 423	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.160	Cultivation Facility	48 MoReg 424	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.170	Manufacturing Facilities	48 MoReg 425	Feb. 3, 2023	Aug. 1, 2023

AGENCY		PUBLICATION	EFFECTIVE	EXPIRATION
19 CSR 100-1.180	Dispensary Facility	48 MoReg 426	Feb. 3, 2023	Aug. 1, 2023
19 CSR 100-1.190	Microbusinesses	48 MoReg 429	Feb. 3, 2023	Aug. 1, 2023
Department of Commerce and Insurance				
State Board of Pharmacy				
20 CSR 2220-2.410	Class B Hospital Pharmacy Compounding for Drug Shortages	Next Issue	July 6, 2023	Jan. 1, 2024

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

ORDER	SUBJECT MATTER	FILED DATE	PUBLICATION
	2023		
23-06	Rescinds Executive Order 17-20	June 29, 2023	Next Issue
23-05	Declares drought alerts for 60 Missouri counties in accordance with the Missouri Drought Mitigation and Response Plan	May 31, 2023	48 MoReg 1179
23-04	Designates members of the governor's staff as having supervisory authority over each department, division, or agency of state government	April 14, 2023	48 MoReg 911
23-03	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to severe storm systems	March 31, 2023	48 MoReg 795
23-02	Extends Executive Order 22-08, the State of Emergency, and waivers until February 28, 2023	January 24, 2023	48 MoReg 433
23-01	Orders the commencement of the Missourians Aging with Dignity Initiative, with directives to support all citizens as they age	January 19, 2023	48 MoReg 431
	2022		
22-11	Extends Executive Order 22-08, the State of Emergency, and waivers until January 31, 2023	December 29, 2022	48 MoReg 193
22-10	Declares that the current State of Emergency shall permit certain vehicles be temporarily exempt from some hours of service requirements	December 21, 2022	48 MoReg 191
22-09	Declares a call and order into active service of the organized militia and directs the Missouri State Emergency Operations Plan be activated due to forecasted severe winter storm systems	December 20, 2022	48 MoReg 189
22-08	Declares a State of Emergency and waives certain regulations to allow other registered entities to fill liquefied petroleum gas containers owned by Gygr-Gas	December 15, 2022	48 MoReg 117
22-07	Extends Executive Order 22-04 to address drought-response efforts until March 1, 2023	November 28, 2022	48 MoReg 39
22-06	Closes executive branch state offices for Friday, November 25, 2022	November 7, 2022	47 MoReg 1708
Proclamation	Convenes the One Hundred First General Assembly in the First Extraordinary Session of the Second Regular Session regarding extension of agricultural tax credits and to enact legislation amending Missouri income tax	August 22, 2022	47 MoReg 1420
22-05	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to severe storm systems	July 26, 2022	47 MoReg 1279
22-04	Declares a drought alert for 53 Missouri counties and orders the director of the Department of Natural Resources to activate and designate a chairperson for the Drought Assessment Committee	July 21, 2022	47 MoReg 1277
Proclamation	In accordance with *Dobbs*, Section 188.017, RSMo, is hereby effective as of the date of this order	June 24, 2022	47 MoReg 1075
22-03	Terminates the State of Emergency declared in Executive Order 22-02	February 7, 2022	47 MoReg 411
22-02	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to forecasted severe winter storm systems	February 1, 2022	47 MoReg 304
22-01	Establishes and Designates the Missouri Early Childhood State Advisory Council	January 7, 2022	47 MoReg 222

The rule number and the MoReg publication date follow each entry to this index.

Rulemaking Classes

Are you new to rulemaking or in need of a refresher course to assist you in filing rules or understanding the rulemaking process?

The Administrative Rules Division offers group and individual classes for rule drafting and preparation of rule packets. Please call Curtis at (573) 751-2022 or email curtis.treat@sos.mo.gov to schedule a class.

We offer both in-person and virtual classes.

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