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

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 If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission.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

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

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

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

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

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

Title 1—OFFICE OF ADMINISTRATION
Division 40—Purchasing and Materials Management
Chapter 1—Procurement

PROPOSED AMENDMENT

1 CSR 40-1.060 Vendor Registration, Notification of Bidding Opportunities, Suspension and Debarment. The Division of Purchasing and Materials Management is amending sections (2)–(4).

PURPOSE: This amendment allows the Division of Purchasing and Materials Management the ability to charge vendors a fee to receive automatic e-mail notification of bidding opportunities for their selected commodity/service codes through the online registration system and have the ability to submit electronic bids.

(2) A person, business or corporation contracting with the state shall be considered as an independent contractor and shall not be considered nor represent him/herself as an employee or agency of the state. *[Unless exempt pursuant to section 351.572, RSMo,]* a corporation must be authorized to do business in Missouri by registering with the Office of the Secretary of State before proceeding with work under a contract **unless specifically exempt pursuant to section 351.572, RSMo**.

(3) *[Registered active vendors will be selected from the official vendor data base and notified of bidding opportunities on a rotational basis. Notification is not limited to registered vendors.]* **The Division of Purchasing and Materials Management will institute an annual fee to allow registered vendors the ability to receive automatic e-mail notification of bidding opportunities for their selected commodity/service codes through the online registration system and the ability to submit electronic bids.**

(4) *[If a vendor fails to respond to three (3) consecutive solicitation documents for the same class of item, the vendor's registration for that specific class of item may be inactivated. The vendor may effect reactivation by updating their vendor registration information].* **E-mail notification and online bidding capabilities will be limited to those vendors that have properly registered and paid the annual fee.**

*AUTHORITY: section 34.050, RSMo [Supp. 1999] **2000**. Original rule filed Oct. 15, 1992, effective June 7, 1993. Rescinded and readopted: Filed Oct. 20, 1997, effective May 30, 1998. Amended: Filed March 24, 2000, effective Oct. 30, 2000. Amended: Filed June 14, 2005.*

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 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 Office of Administration, Division of Purchasing and Materials Management, James Miluski, Director, PO Box 809, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	1CSR 40-1.060
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
5,231	Corporations	$50 per vendor annually
176 and 686	Partnerships and Sole Proprietorships	$50 per vendor annually
5,483	Unknown classifications	$50 per vendor annually

II. WORKSHEET

10,400 vendors x $50 registration fee + $520,000

IV. ASSUMPTIONS

There are approximately 13,000 vendors that are currently registered to do business with the State on DPMM's website. DPMM is assuming that 80% (10,400) of the currently registered vendors will pay the $50 vendor registration fee in order to continue receiving e-mail notifications of new bid solicitations.

Title 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 2—Health Requirements for Movement of Livestock, Poultry and Exotic Animals

PROPOSED AMENDMENT

2 CSR 30-2.010 Health Requirements Governing the Admission of Livestock, Poultry and Exotic Animals Entering Missouri. The director is amending sections (1), (2), (4)–(10), and (13), adding a new section (19) and renumbering sections (11)–(13).

PURPOSE: These changes will update current regulations on the movement of livestock into Missouri and changes made in sections (7) Sheep and (8) Goats will bring the regulations into compliance with federal scrapie requirements.

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) Certificate of Veterinary Inspection. *[All animals entering Missouri must be accompanied by an official Certificate of Veterinary Inspection unless specifically exempted within these rules. The certificate must be signed by an approved, accredited, licensed veterinarian stating that the animals are free of any sign of contagious or infectious disease and are in compliance with the specific requirements set forth in these rules]* **The term Certificate of Veterinary Inspection means a legible record made on an official form of the state of origin, issued by an accredited veterinarian, which shows that the animal(s) listed meets the testing, vaccination treatment and health requirements of the state of destination**, and is valid for thirty (30) days.

(2) Entry Permits. Entry permit numbers may be obtained by contacting the Missouri Department of Agriculture, Division of Animal Health, (573) 751-4359. It is specifically noted within these rules when an entry permit is required. Permits and information regarding Missouri's import requirements may be obtained at this telephone number from 7:30 a.m. to *[4:30]* **5:00** p.m. (Central *[Standard]* Time (*C[S]T*)), Monday through Friday.

(4) Cattle **and Bison**.

(A) Baby Calves—

1. Interstate movement of calves under two (2) months of age to a Missouri livestock market is prohibited unless calves are accompanied by their dams; and

2. Calves under two (2) months of age not accompanied by their dams may be imported by resident buyers only, directly to a Missouri farm, and must meet the following requirements:

A. Entry permits must be obtained on all shipments of *[baby calves]* **calves under two (2) months of age**. All calves **under two (2) months of age** will be quarantined to the receiving farm for sixty (60) days; and

B. All calves **under two (2) months of age** must be individually identified by official eartag on the Certificate of Veterinary Inspection.

(B) Brucellosis Requirements—All States—

1. A negative brucellosis test shall consist of one (1) of the following tests: Brucella Buffered Antigen (BBA) Card Test, Buffered Acidified Plate Antigen Presumptive Test or other official tests approved by the state veterinarian. All tests, regardless of method, must be confirmed at a state- or federally-approved laboratory. Any discrepancies in test results must be reported to the state veterinarian's office;

2. Test-eligible animals include all **sexually intact** animals eighteen (18) months of age and over. Finished-fed heifers under two (2) years of age are exempt from test if consigned directly to an approved slaughter establishment or to an approved market en route to an approved slaughter establishment. *[Officially calfhood vaccinated (OCV) females are exempt from brucellosis testing if under the age of twenty-four (24) months on beef breeds and twenty (20) months on dairy breeds, provided they are not parturient or post-parturient]*;

3. All animals that are test-eligible must be individually identified by official eartag, registration tattoo, registration brand or any other means of permanent identification approved by the state veterinarian on the Certificate of Veterinary Inspection; and

4. The state veterinarian may designate high incidence areas within certain states that must meet additional import restrictions and retest requirements.

(C) Classification of States. Animals that originate directly from officially classified states must meet the requirements that follow:

1. Class free states—

A. Farm of origin animals may move to approved livestock markets and slaughter establishments accompanied by a waybill, bill of lading or owner/shipper statement showing origin and destination;

B. Other animal movements must be accompanied by a Certificate of Veterinary Inspection, showing individual identification on all animals that are test-eligible; and

C. No brucellosis test or entry permit is required;

2. Class A states—

A. All animals must be accompanied by a Certificate of Veterinary Inspection showing individual identification on all animals that are test-eligible. A negative brucellosis test within thirty (30) days prior to shipment is required on all test-eligible animals. Farm of origin animals may move to an approved market or slaughter establishment accompanied by a waybill, bill of lading or owner/shipper statement showing origin and destination;

B. Animals from certified brucellosis-free herds may enter on herd status without additional testing, provided the certified herd number and current test date is shown on the Certificate of Veterinary Inspection; *[and]*

C. *[No entry permit is required;]* **Rodeo bulls must have a negative brucellosis test within twelve (12) months prior to entering the state; and**

D. No entry permit is required.

3. Class B states—

A. All females four (4) months of age or over must be OCV for brucellosis;

B. All animals must be accompanied by a Certificate of Veterinary Inspection showing individual identification on all animals that are test-eligible. A negative brucellosis test within thirty (30) days prior to shipment is required on all test-eligible animals. Farm of origin animals may move to an approved market or slaughter establishment accompanied by a waybill, bill of lading or owner/shipper statement showing origin and destination;

C. Animals from certified brucellosis-free herds may enter on herd status without additional testing, provided the certified herd number and current test date is shown on the Certificate of Veterinary Inspection;

D. Entry permits are required on all test-eligible animals (except slaughter animals). All animals entering on permit will be quarantined and retested sixty to one hundred twenty (60–120) days after arrival. Animals from certified herds are exempt from the quarantine and retest requirement;

E. Animals other than farm of origin animals consigned to approved slaughter establishments must—

(I) Be tested negative for brucellosis within thirty (30) days prior to shipment and accompanied by a Certificate of Veterinary Inspection showing individual identification of animals;

(II) Be "S"- or "B"-branded and consigned to slaughter on a VS 1-27 shipping permit; or

(III) Move in an officially sealed vehicle accompanied by a VS 1-27 shipping permit; and

4. Class C states—

A. Entry permit is required on all animals entering (Missouri) from a Class C state;

B. Animals must be accompanied by a Certificate of Veterinary Inspection showing individual identification of all animals (except steers); and

C. Only the following classes of animals are eligible for entry into Missouri from a Class C state:

(I) Steers;

(II) Spayed heifers ("spade" brand and identification required);

(III) Animals from certified brucellosis-free herds may enter Missouri with a negative brucellosis test within thirty (30) days prior to shipment, in addition to the certified herd number and current herd test date shown on the Certificate of Veterinary Inspection. All test-eligible animals entering on permit will be quarantined and retested sixty to one hundred twenty (60–120) days after arrival; and

(IV) All other animals must be "S"- or "B"-branded, accompanied by a VS 1-27 shipping permit consigned to an approved slaughter establishment.

(5) *Equidae*.

(A) All *equidae* (except nursing foals accompanied by their dams) must be accompanied by:

1. A current VS Form 10-11 (or later revision) or any officially recognized state EIA test chart showing the graphic description of all markings needed for identification; and

2. A *[n Official]* Certificate of Veterinary Inspection *[(health certificate)]* showing:

A. Identification and description of each *[and every] equidae* listed on the health certificate; and

B. Negative test results of an official Equine Infectious Anemia (EIA) test, showing test date within twelve (12) months prior to entry, the name of the EIA accredited testing laboratory, and the test accession number assigned by the laboratory.

(D) *Equidae* entering Missouri moving directly from a farm-of-origin (defined as maintained on premises for at least one hundred twenty (120) days) to a licensed livestock market/sale may be accompanied by a waybill or owner/shipper statement showing origin and destination, in lieu of **a** Certificate of Veterinary Inspection.

(F) Venezuelan Equine Encephalomyelitis (VEE) vaccination *[within fourteen (14) days of]* **prior to** entry on *equidae* originating from states in which VEE has been diagnosed within the preceding twelve (12) months. An entry permit is also required on equine from those states.

(6) Swine.

(B) Swine must be individually identified by eartag, ear notch, tattoo or other approved device except farm-of-origin swine consigned to an approved market or slaughter establishment **or swine which move under the National Animal Identification system will be identified by premises number and date of group formation**. (Swine for slaughter only may be identified by backtag, tattoo or other approved device.)

(C) Swine not under quarantine must originate from herds that have had no clinical *[symptoms]* **signs** of pseudorabies for the past twelve (12) months. Swine not under quarantine that have been pseudorabies vaccinated are not allowed to enter Missouri, except by special permission of the state veterinarian.

(D) All breeding swine, regardless of age, must be tested negative for brucellosis and pseudorabies within thirty (30) days prior to entry or originate from a validated brucellosis-free herd or validated swine brucellosis-free state and a qualified negative pseudorabies herd (herd numbers and current herd test dates must be shown on the Certificate of Veterinary Inspection) or from a stage IV or V state. *[Imported breeding swine shall be quarantined until a negative retest for brucellosis and pseudorabies is obtained. This retest shall not be less than thirty (30) nor more than sixty (60) days after entry.*

1. A retest must be completed on all imported breeding swine that do not originate from a USDA-classified swine brucellosis- and pseudorabies-free state or country.

2. Breeding swine originating from USDA-classified swine brucellosis- and pseudorabies-free states or countries must be tested as follows: in shipments of one to nine (1–9) head, a retest is required of all animals; in shipments of ten to thirty-five (10–35) head from the same herd of origin, retest is required of ten (10) animals; and in shipments over thirty-five (35) head from the same herd of origin, retest is required of thirty percent (30%), up to a maximum of thirty (30) animals.

(E) Swine entering Missouri for feeding purposes must be quarantined upon arrival and must originate from either—

1. A state classified as Stage III, IV, or V in the National Pseudorabies (PRV) Eradication Plan; or

2. A pseudorabies monitored herd in a state classified as Stage II in the National Pseudorabies (PRV) Eradication Plan.]

(7) Sheep.

(C) *[Sheep from a scabies-quarantined area must be dipped or treated by an officially approved method within ten (10) days prior to exhibition.]* **Official identification is required on any live scrapie-positive, suspect, or high-risk animal of any age and of any sexually intact exposed animal of more than one (1) year of age or any sexually intact exposed animal of less than one (1) year of age upon change of ownership (except for exposed animals moving in slaughter channels at less than one (1) year of age), whether or not the animal resides in a source or infected flock.**

(D) *[No tests are required on sheep entering Missouri.]***. Sheep from a scabies-quarantined area must be dipped or treated by an officially approved method within ten (10) days prior to exhibition.**

(E) No tests are required on sheep entering Missouri.

(8) Goats.

(C) *[No tests are required on goats entering Missouri.]* **Official identification is required on any live scrapie-positive, suspect, or high-risk animal of any age and of any sexually intact exposed animal of more than one (1) year of age or any sexually intact exposed animal of less than one (1) year of age upon change of ownership (except for exposed animals moving in slaughter channels at less than one (1) year of age), whether or not the animal resides in a source or infected flock.**

(D) No tests are required on goats entering Missouri.

(9) Dogs and Cats.

(A) Dogs and cats must be accompanied by a *[health certificate]* **Certificate of Veterinary Inspection**. Dogs and cats over four (4) months of age must be vaccinated for rabies by one (1) of the methods and within the time period published in the current *Compendium of Animal Rabies Vaccines* prepared by the National Association of State Public Health Veterinarians, Inc.

(10) Poultry.

(A) Live poultry (except those consigned directly to slaughter) shall be accompanied by a*[n official]* Certificate of Veterinary

Inspection or a VS Form 9-3 (see 2 CSR 30-2.040). If a VS Form 9-3 is used, a signed and dated owner/shipper statement must be included stating that to his/her best knowledge, the birds are healthy. Poultry known to be infected with pullorum or typhoid that are consigned directly to slaughter must be identified as such by the consignor.

(C) Hatching eggs must be accompanied by a*[n official]* Certificate of Veterinary Inspection certifying the eggs to be from pullorum-free flocks or by a VS Form 9-3.

(11) Captive Cervids.

(A) Captive cervids, prior to entering Missouri, must have an entry permit issued by the state veterinarian's office and a Certificate of Veterinary Inspection. Captive cervids that enter Missouri must be in compliance with the guidelines as incorporated by reference to the *Bovine Tuberculosis Eradication Uniform Methods and Rules, Effective January 1, 2005* and *Brucellosis in Cervidae: Uniform Methods and Rules, Effective September 30, 1998*. published by USDA, Veterinary Services, Animal Health Program, 4700 River Road, Unit 36, Riverdale, MD 20737-1231; telephone 301-734-6954; e-mail www.aphis.usda.gov/lpa/pubs/umr.html. This rule does not incorporate any subsequent amendments or additions.

(B) Brucellosis Requirements.

1. All sexually intact animals six (6) months of age or older, not under quarantine and not affected with brucellosis, must test negative for brucellosis within thirty (30) days prior to movement, except:

A. Brucellosis-free herd—captive cervids originating from certified brucellosis-free herds may enter on herd status without additional testing provided the certified herd number and current test date is shown on the Certificate of Veterinary Inspection;

B. Brucellosis-monitored herd—all sexually intact animals six (6) months of age or older must test negative for brucellosis within ninety (90) days prior to interstate movement.

(C) Tuberculosis Requirements.

1. Captive cervids not known to be affected with or exposed to tuberculosis and not in a status herd, as defined in the *Bovine Tuberculosis Eradication Uniform Methods and Rules, Effective January 1, 2005*, must have two (2) negative tuberculosis tests, not less than ninety (90) days apart, using the single cervical method. The second test must be within ninety (90) days prior to movement. Both negative test dates must be listed on the Certificate of Veterinary Inspection. Animals must have been isolated from other captive cervids during the testing period.

2. Movement from status herds.

A. Accredited herd—captive cervids originating from accredited tuberculosis-free cervid herd as defined by the *Bovine Tuberculosis Eradication Uniform Methods and Rules, Effective January 1, 2005*, may enter on herd status without additional testing provided the accredited herd number and current test date is shown on the Certificate of Veterinary Inspection.

B. Qualified herd—captive cervids originating from a qualified herd as defined by the *Bovine Tuberculosis Eradication Uniform Methods and Rules, Effective January 1, 2005*, must have one (1) negative tuberculosis test, using the single cervical method, within ninety (90) days prior to the date of movement.

C. Monitored herd—captive cervids originating from a monitored herd as defined by the *Bovine Tuberculosis Eradication Uniform Methods and Rules, Effective January 1, 2005*, must have one (1) negative tuberculosis test, using the single cervical method, within ninety (90) days prior to the date of movement.

D. Captive cervids less than twelve (12) months of age that originate from and were born in qualified or monitored herds may be moved without further tuberculosis testing, provided that they are accompanied by a Certificate of Veterinary Inspection stating that such captive cervids originated from such herds and have not been exposed to captive cervids from a lower status herd.

(D) Chronic Wasting Disease (CWD).

1. Captive cervids will not be allowed to enter the state if within the last five (5) years the animal is:

A. From an area that has been reported as a chronic wasting disease (CWD) endemic area;

B. Been in a CWD endemic area; or

C. Originate from a CWD positive captive herd.

2. Elk, elk-hybrids, red deer, sika deer, white-tailed deer, and mule deer from all states must have participated in a surveillance program since 2002 prior to entering Missouri. An additional year of surveillance will be required each year until five (5) years of surveillance is reached.

3. Other captive cervids other than elk, elk-hybrids, red deer, sika deer, white-tailed deer and mule deer must have particpated in a surveillance program recognized by the state of origin prior to entering Missouri.

4. All captive white-tailed deer that entered Missouri with two (2) years of CWD monitoring in an approved surveillance program and remained in Missouri at the time of death, must be tested for CWD.

*[(11)]***(12)** Psittacine birds, except budgerigar, must have a *[c]***C**ertificate of *[v]***V**eterinary *[i]***I**nspection to enter Missouri.

*[(12)]***(13)** Ratites (Including, but not Limited to, Ostrich and Emu). A *[c]***C**ertificate of *[v]***V**eterinary *[i]***I**nspection is required on all ratites entering Missouri, except farm of origin ratites consigned to an approved slaughter establishment. Ratites must be individually identified by a means approved by the Missouri state veterinarian on the Certificate of Veterinary Inspection.

*[(13)]***(14)** Miscellaneous and Exotic Animals. All exotic animals must be accompanied by an official Certificate of Veterinary Inspection showing an individual listing of the common *[and scientific]* name(s) of the animal(s) and appropriate descriptions of animal(s) such as sex, age, weight, coloration and the permanent tag number, brand or tattoo identification.

(A) Exotic bovids eight (8) months of age and over must have a negative brucellosis test and a negative tuberculosis test within thirty (30) days prior to shipment. Exotic bovids include *Bos gaurus* (Indian bison, Gaur), *Bos javanicus* (Banteng), *Bos sauveli* (Kouprey), *Bos grunniens* (domesticated yak), *Bubalus bubalis* (water buffalo), *Bubalus mindorensis* (Tamarau), *Bubalus quarlesi* (Mountain Anoa), *Bubalus depressicornis* (Lowland Anoa) and *Snycerus caffer* (buffalo group).

[(B) Exotic cattle must meet the same brucellosis entry requirements as domestic cattle. These animals eight (8) months of age and over must be tested for tuberculosis within thirty (30) days prior to shipment.]

[(C)] **(B)** Camels, llamas, alpaca and others of that group must be identified by tattoo, microchip, eartag or other approved device and be listed individually on a Certificate of Veterinary Inspection.

[(D) Captive cervids, prior to entering Missouri, must have an entry permit issued by the state veterinarian's office and a Certificate of Veterinary Inspection. Captive cervids that enter Missouri must be in compliance with the guidelines as incorporated by reference to the Bovine Tuberculosis Eradication Uniform Methods and Rules, Effective January 22, 1999 and Brucellosis in Cervidae: Uniform Methods and Rules, Effective September 30, 1998.

1. All sexually intact animals six (6) months of age or older, not under quarantine and not affected with brucellosis, must test negative for brucellosis within thirty (30) days prior to movement, except:

A. Brucellosis-free herd—captive cervids originating from certified brucellosis-free herds may enter on herd status without additional testing provided the certified herd number and current test date is shown on the Certificate of Veterinary Inspection;

B. Brucellosis-monitored herd—all sexually intact animals six (6) months of age or older must test negative for brucellosis within ninety (90) days prior to interstate movement.

2. Captive cervids not known to be affected with or exposed to tuberculosis and not in a status herd, as defined in the Bovine Tuberculosis Eradication Uniform Methods and Rules, Effective January 22, 1999, must have two (2) negative tuberculosis tests, not less than ninety (90) days apart, using the single cervical method. The second test must be within ninety (90) days prior to movement. Both negative test dates must be listed on the Certificate of Veterinary Inspection. Animals must have been isolated from other captive cervids during the testing period.

3. Movement from status herds.

A. Accredited herd—captive cervids originating from accredited tuberculosis-free cervid herd as defined by the Bovine Tuberculosis Eradication Uniform Methods and Rules, Effective January 22, 1999, may enter on herd status without additional testing provided the accredited herd number and current test date is shown on the Certificate of Veterinary Inspection.

B. Qualified herd—captive cervids originating from a qualified herd as defined by the Bovine Tuberculosis Eradication Uniform Methods and Rules, Effective January 22, 1999, must have one (1) negative tuberculosis test, using the single cervical method, within ninety (90) days prior to the date of movement.

C. Monitored herd—captive cervids originating from a monitored herd as defined by the Bovine Tuberculosis Eradication Uniform Methods and Rules, Effective January 22, 1999, must have one (1) negative tuberculosis test, using the single cervical method, within ninety (90) days prior to the date of movement.

D. Captive cervids less than twelve (12) months of age that originate from and were born in qualified or monitored herds may be moved without further tuberculosis testing, provided that they are accompanied by a certificate stating that such captive cervids originated from such herds and have not been exposed to captive cervids from a lower status herd.

4. Captive cervids from an area that has been reported as a chronic wasting disease (CWD) endemic area or any cervid that has been in an endemic area in the last five (5) years will not be allowed to enter Missouri.

5. Elk, elk-hybrids, and mule deer from all states must have participated in a surveillance program for at least three (3) years prior to entering Missouri. Other captive cervids other than white-tailed deer must have particpated in a surveillance program recognized by the state of origin prior to entering Missouri.

6. White-tailed deer from all states must have participated in a surveillance program for at least two (2) years prior to entering Missouri. Other captive cervids must have partcipated in a surveillance program recognized by the state of origin prior to entering Missouri.

7. All captive white-tailed deer that enter Missouri with a two (2)-year status in a CWD surveillance program and remain in Missouri at the time of death must be tested for CWD.]

[(E)] **(C)** Exotic equine, donkeys, asses, burros and zebras must meet domestic equine requirements.

[(F)] **(D)** Exotic goats, sheep and antelope. No tests are required on these animals.

[(G)] **(E)** Feral swine, javalena, and peccaries must be in compliance with domestic swine requirements.

[(H)] **(F)** Elephants (Asiatic, African) must be tested negative for tuberculosis within one (1) year prior to entry.

[(I)] **(G)** Importation of skunks and raccoons into Missouri is prohibited by the *Missouri Wildlife Code*, 3 CSR 10-9.

[(J)] **(H)** Animals moving between publicly-owned American *[Association of Zoological Parks and Aquariums (AAZPA)-accredited zoos]* **Zoo and Aquariums (AZA)-accredited zoos** are exempt from section *[(13)]***(11) except cervids moving between publicly-owned American Zoo and Aquariums (AZA)-accredited zoos must meet the chronic wasting disease monitoring requirements as outlined in subsection (11)(D)**.

AUTHORITY: section 267.645, RSMo 2000. This version of rule filed Jan. 24, 1975, effective Feb. 3, 1975. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 15, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivision 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 Agriculture, Division of Animal Health, Shane Brookshire, D.V.M., State Veterinarian, PO Box 630, Jefferson City, MO 65102, by facsimile at (573) 751-6919 or via e-mail at Shane.Brookshire@mda.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 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 5—Wildlife Code: Permits

PROPOSED AMENDMENT

3 CSR 10-5.205 Permits Required; Exceptions. The commission proposes to amend subsections (1)(A) and (F).

PURPOSE: This amendment provides lessees born before January 1, 1967 with the same privileges as landowners when accompanying Youth Deer and Turkey Hunting Permit holders hunting deer or turkeys and corrects grammatical errors.

(1) Any person who chases, pursues, takes, transports, ships, buys, sells, possesses or uses wildlife in any manner must first obtain the prescribed hunting, fishing, trapping or other permit, or be exempted under 3 CSR 10-9.110, with the following exceptions:

(A) A resident landowner or lessee, as defined in this Code, may hunt, trap or fish as prescribed in Chapters 6, 7 and 8 without permit (except landowner deer and turkey hunting permits, *[m]***M**igratory *[b]***B**ird *[h]***H**unting *[p]***P**ermit, *[and]* *[c]***C**able *[r]***R**estraint *[p]***P**ermit **and Hand Fishing Permit** as prescribed), but only on land s/he owns or, in the case of the lessee, upon which s/he resides, and may transport and possess wildlife so taken.

(F) Any person at least six (6) but not older than fifteen (15) years of age may purchase a Youth Deer and Turkey Hunting Permit without display of a hunter education certificate card, and may take one (1) deer of either sex statewide, during the firearms deer hunting seasons except that only an antlerless deer may be taken in seasons open

only to antlerless deer; one (1) male turkey or turkey with visible beard during the spring turkey hunting season; and one (1) turkey of either sex during the fall firearms turkey hunting season; provided, s/he is hunting in the immediate presence of a properly licensed adult hunter who has in his/her possession a valid hunter education certificate card, or who *[are]* **is** hunting in the immediate presence of a resident landowner **or lessee** as defined in this Code on lands owned **or leased** by the resident landowner **or lessee**, provided the resident landowner **or lessee** was born before January 1, 1967. Youth Deer and Turkey Hunting Permit holders, who attain the age of eleven (11) during the prescribed permit year and have a valid hunter education certificate card, may surrender unused portion(s) of the Youth Deer and Turkey Hunting Permit and purchase other firearms deer and turkey hunting permits. Deer and turkeys taken under the Youth Deer and Turkey Hunting Permit must be included in the total season limits.

AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. Original rule filed July 22, 1974, effective Dec. 31, 1974. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 8, 2005.*

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 John W. Smith, Assistant Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 5—Wildlife Code: Permits

PROPOSED AMENDMENT

3 CSR 10-5.420 Youth Deer and Turkey Hunting Permit. The commission proposes to amend provisions of this rule.

PURPOSE: This amendment provides lessees born before January 1, 1967 with the same privileges as landowners when accompanying Youth Deer and Turkey Hunting Permit holders hunting deer or turkeys.

To pursue, take, possess and transport one (1) deer of either sex statewide, during the firearms deer hunting seasons except that only an antlerless deer may be taken in *[seasons]* **portions** open only to antlerless deer; one (1) male turkey or turkey with visible beard during the spring turkey hunting season; and one (1) turkey of either sex during the fall firearms turkey hunting season; only by persons at least six (6) but not older than fifteen (15) years of age who are hunting in the immediate presence of a properly licensed adult hunter who has in his/her possession a valid hunter education certificate card, or who are hunting in the immediate presence of a resident landowner **or lessee** as defined in this Code on lands owned **or leased** by the resident landowner **or lessee**, provided the resident landowner **or lessee** was born before January 1, 1967. Fee: seventeen dollars ($17).

AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. Original rule filed May 6, 1998, effective March 1, 1999. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 8, 2005.*

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 John W. Smith, Assistant Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

PROPOSED AMENDMENT

3 CSR 10-7.410 Hunting Methods. The commission proposes to amend subsections (1)(H) and (P).

PURPOSE: This amendment allows the use of .22 caliber and smaller firearms to hunt feral hogs and wildlife other than deer during the November and antlerless portions of the firearms deer season and more accurately describes deer season portions.

(1) Wildlife may be hunted and taken only in accordance with the following:

(H) Special Firearms Provision. During the November portion and antlerless portion of the firearms deer season in counties open to deer hunting, other wildlife and feral hogs (any hog, including Russian and European wild boar, that is not conspicuously identified by ear tags or other forms of identification and is roaming freely upon public or private lands without the landowner's permission) may be hunted only with **a pistol, revolver, or rifle firing a rimfire cartridge .22 caliber or smaller or** a shotgun and shot not larger than No. 4, except that *[this provision does not apply to]* waterfowl hunters, trappers**,** *[or to a]* landowner**s** on *[his/her]* **their** land or *[to a]* lessee**s** on *[the]* land **up**on which *[s/he]* **they** reside*[s]* **may use other methods as specified in subsection (1)(G) of this rule**.

(P) Hunter Orange. During the urban **counties**, youth, November, and antlerless portions of the firearms deer hunting season, all hunters shall wear a cap or hat, and a shirt, vest or coat having the outermost color commonly known as hunter orange which shall be plainly visible from all sides while being worn. Camouflage orange garments do not meet this requirement. This requirement shall not apply to migratory game bird hunters, to hunters using archery methods while hunting within municipal boundaries where discharge of firearms is prohibited, to hunters on federal or state public hunting areas where deer hunting is restricted to archery methods, or to hunters in closed counties during the antlerless portion of the firearms deer hunting season.

AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. Original rule filed July 22, 1974, effective Dec. 31, 1974. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 8, 2005.*

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 John W. Smith, Assistant Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 220—State Board of Pharmacy
Chapter 2—General Rules

PROPOSED AMENDMENT

4 CSR 220-2.100 Continuing Pharmacy Education. The board is proposing to amend section (10), add a new section (11), and renumber and amend the remaining section.

PURPOSE: This amendment establishes specific time frame for pharmacists to earn continuing education (CE) for renewal of a license, establishes that an incomplete or incorrect renewal application will be rejected to the applicant, and provides that when a pharmacist fails to provide appropriate CE when requested for audit puposes, the renewal application is considered false and license is not renewed, and delinquent fees will be required.

(10) **Continuing education credits must be earned from the time a renewal cycle begins, until the cycle ends as prescribed by the board. For purposes of this section, the renewal cycle begins on September 1 and ends on a biennial cycle on August 31.** Each such form of proof of completion of the required continuing education credits shall be retained by the licensee for the preceding two (2) reporting periods prior to renewal.

(11) The renewal application must be completed correctly and in its entirety in order for it to be processed and the license renewed. Any portion of the application that is incomplete or inaccurate shall result in the rejection of the renewal application and require its return to the applicant for correction.

*[(11)]***(12)** The Missouri Board of Pharmacy may elect to audit, with the appropriate accrediting body, any licensee to assess the authenticity and validity of contact hours submitted for relicensure. Failure to provide proof of completion of the necessary required continuing education credits **when requested to do so by the board,** shall be considered a violation**. In accordance with section 338.060, RSMo any licensee that has not completed and retained the required evidence of all required continuing education shall pay any delinquent fees as prescribed by the board** and may *[result in]* **be subject to** disciplinary action pursuant to 338.055, RSMo*[,]***. The board may also** initiate auditing *[or]* **of** other past renewal periods and/or require proof of completion of future continuing education credits be submitted with any application for a renewal of a license.

AUTHORITY: sections 338.060 and 338.140, RSMo 2000. Original rule filed Nov. 9, 1984, effective April 11, 1985. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 15, 2005.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately six thousand three hundred seventy-two dollars and seven cents ($6,372.07) biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will cost private entities approximately twenty thousand nine hundred dollars ($20,900) biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Board of Pharmacy, Kevin Kinkade, Executive Director, PO Box 625, Jefferson City, MO 65102, via facsimile to (573) 526-3464 or e-mail at:pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 220 - Missouri Board of Pharmacy

Chapter 2 - General Rules

Proposed Amendment - 4 CSR 220-2.100 Continuing Pharmacy Education

Prepared March 8, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Biennial Cost of Compliance
Missouri Board of Pharmacy	$6,372.07
Total Biennial Cost of Compliance for the Life of the Rule	**$6,372.07**

III. WORKSHEET

The figures below represent the expense and equipment costs:

CLASSIFICATION	Fee Amount	Number in Class	AGGREGATE COST
Letterhead	$0.15	754	$113.10
CE Form	$0.05	754	$37.70
Envelope for Mailing License(s)	$0.03	754	$22.62
Postage for Mailing License(s)	$0.35	754	$263.90
Total expense and equipment cost associated with printing and mailing applications			**$437.32**

The figures below summarize the staff responsiblities and represent the personal service costs:

The board anitipcates the staff will perform the following duties:

Executive Director - Overall supervision of CE audit process, review of audit results, possible meetings with licensees, hearings, or other legal matters involving the CE audit process. - 12 hours.

Administrative Office Support Assistant - Supervision of CE audit process, includes supervision of staff and review of forms/letters/database - 4 hours.

Licensure Technician II - Update to the board's computer database and randomly select the licensees to be audited - 10 hours.

Licensure Technician II - Responding to written and verbal inquiries regarding CE audit. - 10 hours

Temporary Employee - Preparation and mailing of audit letters and forms, review of CE audits received by checking for compliance, updating database, compiling reports from database and prepare audit results for board review, carry out board directives regarding non-compliant licensees. - 520 hours (3 months) at $9.58/hour.

Employee's salaries were calculated using their annual salary multiplied by 40.77% for fringe benefits and then were divided by 2080 hours per year to determine the hourly salary. The hourly salary was then divided by 60 minutes to determine the cost per minute. The cost per minute was then multiplied by the amount of time individual staff spent on the processing of applications. The total cost was based on the cost per application multiplied by the estimated number of applications.

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	TIME PER RENEWAL PERIOD	TOTAL COST
Executive Director	$69,144	$97,334.01	$46.80	12 hours	$561.54
Clerk IV	$28,740	$40,457.30	$19.45	4 hours	$77.80
Licenusure Tech II	$23,376	$32,906.40	$15.82	10 hours	$158.20
Licensure Tech II	$22,992	$32,365.84	$15.56	10 hours	$155.60
Temporary Employee			$9.58	520 hours	$4,981.60
					$5,934.75

The members of the board are involved for the review of audit results and decisions for action, possible meetings with licensees, hearings, or other legal matters involving the CE audit process. This generally occurs during regularly scheduled board meetings, but may require additional board meeting for purpose of meeting with non-compliant licensees. No additional cost are being calculated into this fiscal note for additional board meetings.

IV. ASSUMPTIONS

1. Because the audit is based on the number of licensees renewed for a particular renewal period, it is not possible to know for sure how many licensees will be affected. In an attempt to approximate, the board estimates that 10% of pharmacists that renewed their license for the 2004-2006 renewal period, plus all disciplined licensees will be audited. Therefore the board estimates that approximately 754 licensees will be audited.
2. The total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

NOTE: The public fiscal note for this rule only reflects the cost for this particular process. However, private entity fees are set at an amount to cover the total actual cost incurred by the board, which includes personal service, expense and equipment and transfers.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 220 - Missouri Board of Pharmacy

Chapter 2 - General Rules

Proposed Amendment - 4 CSR 220-2.100 Continuing Pharmacy Education

Prepared March 8, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated biennial cost of compliance with the amendment by affected entities:
38	Licensees (Deliquent Continuing Education Pharmacist Renewal Fee - $500)	$19,000
38	Licensees (Deliquent Pharmacist Renewal Fee - $50)	$1,900
	Estimated Biennial Cost for the Life of the Rule	**$20,900**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The figures above are based on FY04 actuals and FY06 projections. Based on the current licensee count, the board anticipates auditing 10% of the currently licensed pharmacists and all disciplined pharamacists. The board is estimating that approximately 5% of all audited pharmacists will not comply with the continuing education requirements. Based on these estimates, the board anticipates approximately 754 pharmacists will be audited annually and of those 38 will be required to pay the deliquent fees described above.

2. It is anticipated that the total cost will recur biennially for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 220—State Board of Pharmacy
Chapter 4—Fees Charged by the Board of Pharmacy

PROPOSED AMENDMENT

4 CSR 220-4.010 General Fees. The board is proposing to add a new subsection (1)(V).

PURPOSE: This amendment adds a fee authorized by Chapter 338, RSMo.

(1) The following fees are established by the State Board of Pharmacy:

(V) Delinquent Continuing Education Pharmacist Fee $500.00

*AUTHORITY: sections 338.020, 338.035, 338.040, 338.060, 338.070, 338.140, 338.185, 338.280 and 338.350, RSMo 2000 and 338.013 and 338.220, RSMo Supp. [2003] **2004**. Emergency rule filed July 15, 1981, effective Aug. 3, 1981, expired Nov. 11, 1981. Original rule filed Aug. 10, 1981, effective Nov. 12, 1981. For intervening history, please consult the **Code of State Regulations**. Amended: Filed June 15, 2005.*

PUBLIC COST: The 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 State Board of Pharmacy, Kevin Kinkade, Executive Director, PO Box 625, Jefferson City, MO 65102, via facsimile to (573) 526-3464 or e-mail at:pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 220—State Board of Pharmacy
Chapter 5—Drug Distributor

PROPOSED AMENDMENT

4 CSR 220-5.020 Drug Distributor Licensing Requirements. The board is proposing to amend sections (3)–(5).

PURPOSE: This amendment allows for a drug distributor application to be voided if the process is not completed within six (6) months of receipt by the board, allows for issuance of temporary license after change of ownership application is received, removes thirty (30)-day grace period for filing of an application after a change of ownership occurs, adds limited liability company to be considered a separate person concerning ownership, and changes notification requirements.

(3) Drug distributor licenses shall be issued on the application of the owners. If the owner is a corporation *[or partnership]*, an officer of the corporation *[or partner]* must sign the application as the applicant. **If the owner is a partnership, a partner must sign the application as the applicant. If the owner is a limited liability partnership, a general partner must sign the application as the applicant. If the owner is a limited liability company, a member must sign the application as the applicant**.

(4) Drug distributor license applications and renewal applications shall be completed and submitted to the Board of Pharmacy along with the appropriate fees before any license is issued or renewed. Information required on the application shall include:

(E) The name(s) of the owner, operator, or both, of the licensed entity, including:

1. If a person, the name of the person;

2. If a partnership, the name of each partner and the name of the partnership;

3. If a corporation, the name of the corporate president, vice president, secretary, treasurer, chief executive officer, board of directors, and senior vice presidents or their equivalents, the corporate name(s) and the name of the state of incorporation; and

4. If a sole proprietorship, the full name of the sole proprietor and the name of the business entity; *[and]*

(F) The name of the manager in charge who meets the requirements as set forth in 4 CSR 220-5.030(2) and completes the manager-in-charge affidavit of the license application and has it notarized*[.]***; and**

(G) An application for a wholesale or pharmacy drug distributor license will become null and void if the applicant fails to complete the process for licensure within six (6) months of receipt of the application by the board.

(5) When a drug distributor changes ownership, the original license becomes void on the effective date of the change of ownership. Before any new business entity resulting from that change opens a facility as a drug distributor, it must obtain a new license from the board. *[However, a grace period of thirty (30) days may be allowed after the change of ownership.]* **A temporary license shall be issued once a completed application and fee have been received by the board. The effective date of the temporary license shall be the date the change of ownership is listed as effective on the application. Such license shall remain in effect until a permanent license is issued or denied by the board.**

(B) *[A corporation is considered by law to be a separate person. If a corporation owns a drug distributor facility, it is not necessary to obtain a new license if the owners of the stock change. However, as a separate person, if the corporation begins ownership of a drug distributor facility or ceases ownership of that facility, a new license must be obtained regardless of the relationship of the previous or subsequent owner to the corporation. It is not necessary to obtain a new license when ownership of the stock in the corporation changes. It is necessary to file written notice with the Board of Pharmacy within ten (10) days after that change occurs. This notification must be in writing and certified.]* **If a corporation owns a drug distributor facility, it is not necessary to obtain a new license if the owners of the stock change. If a limited liability partnership or a limited liability company owns a drug distributor company, it is not necessary to obtain a new license if the partners or members of the company change, as long as the partnership or company is not dissolved by that change. It is necessary to file written notice with the Board of Pharmacy within thirty (30) days after a change occurs of twenty-five percent (25%) or more in the ownership of corporation stock, or in partners in a limited liability partnership, or in members of the limited liability company. This notification must be in writing and certified. However, when a corporation, limited liability partnership, or limited liability company begins ownership of a drug distributor company or ceases ownership of a drug distributor company, a new license must be obtained regardless of the relationship between the previous and subsequent owners.**

AUTHORITY: sections 338.330, 338.333, 338.335, 338.337, 338.340 and 338.350, RSMo 2000. Original rule filed Feb. 4, 1991, effective June 10, 1991. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 15, 2005.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Board of Pharmacy, Kevin Kinkade, Executive Director, PO Box 625, Jefferson City, MO 65102, via facsimile to (573) 526-3464 or e-mail at:pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 30—Office of the Director
Chapter 5—State Services to Victims Fund Grant Program

PROPOSED AMENDMENT

11 CSR 30-5.020 Eligible Applicants. The Department of Public Safety, Office of the Director is amending section (1).

PURPOSE: This amendment changes criteria to determine the eligibility of applicant agencies to receive assistance through the State Services to Victims Fund Grant Program.

(1) As stated in section 595.050, RSMo, public and not-for-profit private agencies are eligible to apply for funds available through the State Services to Victims Fund Grant Program. Public *[and not-for-profit private]* agencies may not receive State Services to Victims Fund Grant Program funds to supplant existing funds presently being used to provide assistance to victims of crime.

AUTHORITY: section 595.060, RSMo [Supp. 1997] ***2000****. Emergency rule filed June 11, 1984, effective June 21, 1984, expired Oct. 19, 1984. Original rule filed Dec. 19, 1988, effective March 25, 1989. Amended: Filed Feb. 26, 1998, effective Aug. 30, 1998. Amended: Filed June 15, 2005.*

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 Patty Rellergert, Victim Services Grant Program, Missouri Department of Public Safety, PO Box 749, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 30—Office of the Director
Chapter 5—State Services to Victims Fund Grant Program

PROPOSED AMENDMENT

11 CSR 30-5.050 Contract Awards, Monitoring and Review. The Department of Public Safety, Office of the Director is amending section (2).

PURPOSE: This amendment changes the procedure to be used to monitor contracts funded by the State Services to Victims Fund Grant Program.

(2) *[All contracts will]* **Contracts may** be monitored **annually** by the Department of Public Safety to insure that appropriate fiscal and program records are being maintained. The contractor may be required to submit such monitoring information in writing to the Department of Public Safety. *[Each contract shall be subject to review by the Department of Public Safety at least annually.]*

AUTHORITY: section 595.060, RSMo [Supp. 1997] ***2000****. Emergency rule filed June 11, 1984, effective June 21, 1984, expired Oct. 19, 1984. Original rule filed Dec. 19, 1988, effective March 25, 1989. Amended: Filed Jan. 18, 1991, effective Aug. 30, 1991. Amended: Filed Feb. 26, 1998, effective Aug. 30, 1998. Amended: Filed June 15, 2005.*

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 Patty Rellergert, Victim Services Grant Program, Missouri Department of Public Safety, PO Box 749, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED RESCISSION

12 CSR 10-23.428 All-Terrain Vehicles Modified for Highway Use. This rule established the titling and registration procedures required when an all-terrain vehicle is modified to qualify as a motor vehicle.

PURPOSE: This rule is being rescinded because all-terrain vehicles are not designed for operation on the roadways.

AUTHORITY: section 301.010, RSMo Supp. 1989, 301.190, RSMo Supp. 1990 and 301.700, Supp. 1988. Original rule filed April 23, 1992, effective Dec. 3, 1992. Emergency rescission filed June 9, 2005, effective June 19, 2005, expires Dec. 16, 2005. Rescinded: Filed June 9, 2005.

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 Revenue, Office of Legislation and Regulations, PO

*Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 35—Children's Division
Chapter 80—Payment of Residential Facilities

PROPOSED AMENDMENT

13 CSR 35-80.020 Residential Care Agency Cost Reporting System. The division is amending section (5) and replacing Appendix A.

PURPOSE: This amendment adopts a new cost report and instructions for completion of the cost report as Appendix A. This amendment also provides notice that failure to provide cost reports may result in the residential care facilities exclusion from contracts with the Children's Division.

(5) Reporting Period and Filing Requirements.

(A) The cost report must reflect actual audited costs incurred in the provision of residential child care and related services by an agency for the most recent fiscal year. **Cost reports must be submitted in accordance with the applicable instructions and in the cost report format prescribed in Appendix A, included herein. Failure to provide cost reports may result in the residential care facilities exclusion from contracts with the Children's Division.**

[(B) An initial cost report for the twelve (12) months which ended December 31, 2003 must be submitted by March 31, 2004.]

[(C)] **(B)** An annual cost report for fiscal years ending after December 31, 2003 must be submitted within ninety (90) days of the close of the fiscal year. **The division may grant an extension for submission of the annual cost report and/or audited financial statement. Cost reports which have not been submitted for fiscal years ending in calendar year 2004 must be submitted by August 15, 2005 on the current report format contained in Appendix A. A waiver from filing a fiscal year 2004 cost report will be provided for providers that will submit a fiscal year 2005 cost report by August 15, 2005.**

*[(D)]***(C)** Audited financial statements must be submitted with cost reports. **An auditor's opinion does not have to be provided on the cost report. A preliminary fiscal year 2005 cost report may be submitted by August 15, 2005 without an audited financial statement. A final report and audited financial statement must be submitted in accordance with subsection (5)(B).**

(D) Providers must also participate in the statewide time study of direct care staff described in section (1).

*PUBLISHER'S NOTE: The forms included with this proposed amendment are printed with the emergency amendment on pages 1493–1521 of this issue of the **Missouri Register**.*

AUTHORITY: section 207.020, RSMo 2000. Emergency rule filed Jan. 16, 2004, effective Jan. 26, 2004, expired July 23, 2004. Original rule filed Jan. 16, 2004, effective Aug. 30, 2004. Emergency amendment filed Sept. 22, 2004, effective Oct. 2, 2004, expired March 30, 2005. Amended: Filed Sept. 22, 2004, effective March 30, 2005. Emergency amendment filed June 15, 2005, effective July 1, 2005, expires Dec. 1, 2005. Amended: Filed June 15, 2005.

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 Children's Division, 615 Howerton Court, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register.** No public hearing is scheduled.*

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

PROPOSED RESCISSION

13 CSR 40-2.240 Medicaid Eligibility in General Relief Prior to Application. This rule defined the limitations of Medicaid eligibility prior to application in General Relief cases.

PURPOSE: This rule is being rescinded as the General Relief State Medical Assistance program is being terminated effective August 27, 2005.

AUTHORITY: section 207.020, RSMo 1986. Original rule filed Aug. 3, 1987, effective Oct. 25, 1987. Rescinded: Filed June 8, 2005.

PUBLIC COST: This proposed rescission will cost state agencies or political subdivisions one thousand six hundred sixty-eight dollars and sixty cents ($1,668.60) 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 Social Services, Family Support Division, 615 Howerton Court, Jefferson City, MO 65109. 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. RULE NUMBER

Rule Number and Name:	13 CSR 40-2.240
Type of Rulemaking:	Proposed Rescission

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Family Support Division	**$1,668.60**

III. WORKSHEET

2,781 cases times two mailings equals 5,562 total letters, times $0.30 bulk postage per letter equals $1,668.60 total postage cost.

IV. ASSUMPTIONS

Approximately 2,781 individuals will be sent two letters notifying the affected clients. The cost will be $0.30 per letter. The administrative cost of $1,688.60 would be a general revenue cost.

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

PROPOSED RESCISSION

13 CSR 40-2.380 Grandparents as Foster Parents. This rule established the maximum benefit amount for the Grandparents as Foster Parents program after July 31, 2003.

PURPOSE: This rule is being rescinded as no funds were appropriated for Grandparents as Foster Parents benefits after June 30, 2005.

AUTHORITY: sections 207.020, RSMo 2000 and 453.322 and 453.325, RSMo Supp. 2003. Emergency rule filed July 11, 2003, effective Aug. 1, 2003, expired Jan. 27, 2004. Original rule filed Jan 23, 2004, effective July 30, 2004. Rescinded: Filed June 8, 2005.

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 Social Services, Family Support Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 2—General Scope of Medical Service Coverage

PROPOSED RESCISSION

13 CSR 70-2.020 Scope of Medical Services for General Relief Recipients. This rule provided for the scope of medical services which were covered by the Medicaid program for general relief assistance recipients.

PURPOSE: This rule is being rescinded because the eligibility category general relief, which granted Medicaid coverage to unemployed adults because of temporary or permanent disabilities, was not funded by the Missouri General Assembly beginning July 1, 2005. Senate Bill 539 as enacted by the 93rd General Assembly repealed the eligibility category general relief.

AUTHORITY: section 207.020, RSMo 1986. This rule was previously filed as 13 CSR 40-81.181. Emergency rule filed July 15, 1981, effective Aug. 1, 1981, expired Oct. 10, 1981. Original rule filed July 15, 1981, effective Oct. 11, 1981. Amended: Filed April 17, 1987, effective Sept. 11, 1987. Emergency rescission filed June 7, 2005, effective July 1, 2005, expires Dec. 27, 2005. Rescinded: Filed June 15, 2005.

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 cost private entities a range of zero (0) to 14.2 million dollars in the aggregate based on utilization.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-2.020 Scope of Medical Services for General Relief Recipients
Type of Rulemaking:	Proposed Rescission

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 count of compliance with the rule by the affected entities:
3,046	All Medicaid recipients under the general relief eligibility category	Services will be systematically denied and providers will not be reimbursed

III. WORKSHEET

The total private cost of the elimination of the general relief eligibility category is zero to $14.2 million based on the state fiscal year 2004 utilization of Medicaid services by the general relief eligibility category. The inpatient hospital portion of the private cost ($1.1 million) is being reflected on the proposed amendment to 13 CSR 70-15.030 Limitations on Payment for Inpatient Hospital Care. The outpatient hospital portion of the private cost ($1.3 million) is being reflected on the proposed amendment to 13 CSR 70-15.080 Payment Method for General Relief Recipient Hospital Outpatient Services. The private cost of this proposed amendment is $11.8 million which is the net of all other Medicaid services, excluding hospital services, utilized by the general relief eligibility category during state fiscal year 2004.

IV. ASSUMPTIONS

This rescission removes the reference to reimbursement for general relief recipients. The eligibility category general relief, which granted Medicaid coverage to unemployed adults because of temporary or permanent disabilities, was not funded by the Missouri General Assembly beginning July 1, 2005. Senate Bill 539 as enacted by the 93rd General Assembly repealed the eligibility category general relief. The elimination of the general relief eligibility category means 3,046 eligibles will lose Medicaid coverage through this optional program.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 4—Conditions of Recipient Participation, Rights and Responsibilities

PROPOSED AMENDMENT

13 CSR 70-4.090 Uninsured *[Parents'] **Women's*** Health *[Insurance]* **Program**. The division is deleting sections (1), (3), (4), and (5) and amending the rule title, the Purpose section and sections (2), (6), and (7) and renumbering sections as needed.

PURPOSE: This amendment eliminates payment for medical services for individuals losing extended transitional medical assistance from the Uninsured Parents' Health Insurance Program.

*PURPOSE: This rule establishes the Uninsured [Working Parents'] **Women's** Health [Insurance] Program. This program will provide payment for [health care coverage] **women's health services** for uninsured[, low income, working parents leaving welfare for work thereby reducing future dependence on welfare and reducing] **women who do not qualify for other medical assistance benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage, in order to reduce** the possibility of a family's future dependence on welfare as authorized pursuant to section 208.040, RSMo. The program is also authorized pursuant to the award of the Missouri State Medicaid Section 1115 Health Care Reform Demonstration Proposal approved by the [Health Care Financing Administration] **Centers for Medicare and Medicaid Services**.*

[(1) Definitions.

(A) Health insurance. Any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provision of health care benefits. The term "health insurance" does not include short-term, accident, fixed indemnity, limited benefit or credit insurance coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(B) Co-payment. A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as ten dollars ($10) for a professional service.

(C) Parents. For purposes of this regulations the term parents refers to biological or adoptive parent(s).]

*[(2)***(1)** *[The following uninsured individuals]* **Uninsured women who do not qualify for other medical assistance benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage,** shall be eligible to receive medical services to the extent and in the manner provided in this regulation**.** *[:*

(A) Individuals losing transitional medical assistance (TMA) who would not otherwise be insured or Medicaid eligible, with net income at or below one hundred percent (100%) of the federal poverty level for the household size—

1. Eligibility for the Uninsured Parents' Health Insurance Program for individuals losing TMA ends twelve (12) months after TMA eligibility ends; and

2. After coverage ends, the individuals with a child eligible for MC+ have the option of staying in the MC+ health plan, where managed care is available, if the parents pay the cost of the state's cost for the time period covered by the Missouri Medicaid Section 1115 Health Care Reform Demonstration Proposal as approved by the Health Care Financing Administration;]

[(B)] Uninsured women who do not qualify for other medical assistance benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage, will continue to be eligible for *[family planning and limited testing of sexually transmitted diseases (EWH),]* **women's health services only,** regardless of income, for twelve (12) consecutive months. **Women's health services are defined as: pelvic exams and pap tests, sexually transmitted disease testing and treatment (the treatments of medical complications occurring from the sexually transmitted disease are not covered for this program), family planning counseling/education on various methods of birth control, United States Department of Health and Human Services approved methods of contraception including sterilization and x-ray services related to the sterilization, and drugs (excluding antiretrovirals), supplies or devices related to the women's health services described in this rule when they are prescribed by a physician or advanced practice nurse, subject to the national drug rebate program requirements.**

[(3) Beneficiaries covered in section (2) of this rule shall be eligible for service(s) from the date their application is received. No service(s) will be covered prior to the date the application is received.]

[(4) The following services are covered for beneficiaries of the Uninsured Parents' Health Insurance Program if they are medically necessary:

(A) Inpatient hospital services;

(B) Outpatient hospital services;

(C) Emergency room services;

(D) Ambulatory surgical center, birthing center;

(E) Physician, advanced practice nurse, and certified nurse midwife services;

(F) Maternity benefits for inpatient hospital and certified nurse midwife. The health plan shall provide coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo. A shorter length of hospital stay for services related to maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. The health plan is to provide coverage for post-discharge care to the mother and her newborn. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization and be documented in the patient's medical record. The first post-discharge visit shall occur within twenty-four (24) to forty-eight (48) hours. Post-discharge care shall consist of a minimum of two (2) visits at least one (1) of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or

physician shall include, but not be limited to, physician assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. If the health plan intends to use another nationally recognized medical organization's guidelines, the state agency must approve prior to implementation of its use;

(G) Family planning services;

(H) Pharmacy benefits;

(I) Dental services to treat trauma;

(J) Laboratory, radiology and other diagnostic services;

(K) Prenatal case management;

(L) Hearing aids and related services;

(M) Eye exams and services to treat trauma or disease (one (1) pair of glasses after cataract surgery only);

(N) Home health services;

(O) Emergent (ground or air) transportation;

(P) Non-emergent transportation only for members in ME Code 78 Parents' Fair Share;

(Q) Mental health and substance abuse services;

(R) Services of other providers when referred by the health plan's primary care provider;

(S) Hospice services;

(T) Durable medical equipment (including but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs and walkers, diabetes supplies and equipment);

(U) Diabetes self-management training for persons with gestational, Type I or Type II diabetes;

(V) Services provided by local health agencies (may be provided by the health plan or through an arrangement between the local health agency and the health plan)—

1. Screening, diagnosis, and treatment of sexually transmitted diseases;

2. HIV screening and diagnostic services;

3. Screening, diagnosis, and treatment of tuberculosis; and

(W) Emergency medical services. Emergency medical services are defined as those health care items and services furnished or required to evaluate or stabilize a sudden and unforseen situation or occurrence or a sudden onset of a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent lay person, possessing average knowledge of health and medicine, to result in:

1. Placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part; or

4. Serious harm to a member or others due to an alcohol or drug abuse emergency; or

5. Injury to self or bodily harm to others; or

6. With respect to a pregnant woman who is having contractions: a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or b) that transfer may pose a threat to the health or safety of the woman or the unborn child.]

[(5) Individuals losing TMA shall owe a ten dollar ($10) co-payment for certain professional services and a five dollar ($5) co-payment in addition to the recipient portion of the professional dispensing fee for pharmacy services required by 13 CSR 70-4.051.

(A) Providers may request payment of the mandatory co-payment(s) prior to or after service delivery.

(B) The co-payment amount shall be deducted from the Medicaid maximum allowable amount for fee-for-service claims reimbursed by the Division of Medical Services.

(C) Service(s) may not be denied for failure to pay the mandatory co-payment(s).

(D) When a mandatory co-payment is not paid, the Medicaid provider will have the following options:

1. Forego the co-payment entirely;

2. Make arrangements for future payment with the recipient; or

3. File a claim with the Division of Medical Services to report the non-payment of the mandatory co-payment(s) and secure payment for the service from the Division of Medical Services.

(E) When the Division of Medical Services receives a claim from a Medicaid fee-for-service provider for non-payment of the mandatory co-payment, the division shall send a notice to the recipient—

1. Requesting that the recipient reimburse the Division of Medical Services for the mandatory co-payment made on their behalf;

2. Requesting information from the recipient to determine if the mandatory co-payment was not made because there has been a change in the financial situation of the family; and

3. Advising the recipient of the possible loss of coverage for up to six (6) months if the recipient fails to pay three (3) co-payments in one (1) year.

(F) The recipient will be allowed fourteen (14) calendar days to respond. If the recipient indicated there has been a change in the financial situation of the family, the state shall redetermine eligibility—

1. If the eligibility redetermination places the recipient in a non-mandatory co-payment category, there will be no co-payment due; or

2. If the eligibility redetermination does not place the recipient in a non-mandatory co-payment category another notice will be sent to the recipient about the mandatory co-payment provision of the program which shall include the number of co-payments that have not been paid and how many may not be paid before a recipient is terminated from the program.

(G) Notice of non-payment of mandatory co-payment(s) sent to the recipient during the course of a year shall establish a pattern of not meeting the mandatory cost sharing requirement of the program. The process to terminate eligibility shall proceed with the third failure to pay a mandatory co-payment in any one (1) year or until one (1) or more of the three (3) delinquent mandatory co-payments is made. Coverage shall begin again only after payment of one (1) or more of the three (3) co-payments or passage of six (6) months time whichever occurs first. Health care coverage shall not be retroactive.

1. A year starts at the time a co-payment is reported not paid to the Division of Medical Services;

2. Payment of a delinquent co-payment or co-payments will eliminate the failure to pay a mandatory co-payment or co-payments.

(H) Recipient(s) shall have access to a fair hearing process to appeal the disenrollment decision.

(l) If the recipient fails to pay the mandatory co-payments three (3) times within a year and is disenrolled from coverage the recipient shall not be eligible for coverage for six (6) months after the department provides notice to the recipient of disenrollment for failure to pay mandatory co-payments or until one (1) or more of the three (3) delinquent mandatory co-payments is paid. Coverage shall begin again only after payment of one (1) or more of the three (3) co-payments or passage of six (6) months whichever occurs first. Coverage shall not be retroactive.]

*[(6)]***(2)** Uninsured women who do not qualify for other benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage are not required to pay a co-payment for **women's health** services.

*[(7)]***(3)** The Department of Social Services, Division of Medical Services shall provide for granting an opportunity for a fair hearing to any applicant or recipient whose claim for benefits under the Missouri Medicaid Section 1115 Health Care Reform Demonstration Proposal is denied *[or disenrollment for failure to pay mandatory co-payments has been determined]* by the Division of Medical Services. There are established positions of state hearing officer within the Department of Social Services, Division of Legal Services in order to comply with all pertinent federal and state law and regulations. The state hearing officers shall have authority to conduct state level hearings of an appeal nature and shall serve as direct representative of the director of the Division of Medical Services.

*AUTHORITY: sections 208.040, RSMo Supp. [2001] **2004** and 208.201 and 660.017, RSMo 2000. Emergency rule filed Sept. 13, 1999, effective Sept. 23, 1999, terminated Oct. 15, 1999. Original rule filed Aug. 16, 1999, effective March 30, 2000. Amended: Filed March 29, 2001, effective Oct. 30, 2001. Emergency amendment filed June 7, 2002, effective July 1, 2002, expired Dec. 27, 2002. Amended: Filed June 11, 2002, effective Nov. 30, 2002. Emergency amendment filed June 7, 2005 effective July 1, 2005, expires Dec. 27, 2005. Amended: Filed June 15, 2005.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions an estimated 1.4 million dollars in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities a range of zero (0) to 3.1 million dollars in the aggregate based on utilization over the life of the rule.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-4.090 Uninsured Women's Health Program
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Social Services Division of Medical Services	$1.4 million

III. WORKSHEET

The private cost of uninsured women eligible for women's health services is 1.4 million dollars based on the state fiscal year 2004 utilization of Medicaid services by this eligibility category. This is an existing cost of services which remain after the elimination of the extended transitional Medicaid Assistance coverage.

The cost of mailing recipient notices to the affected individuals is $234 which is included in the total cost of this amendment. The recipient notices are for 1,150 individuals at $.203 per notice.

IV. ASSUMPTIONS

The proposed amendment eliminates medical services for individuals losing extended transitional medical assistance from the Uninsured Parents' Health Insurance Program.

The proposed amendment eliminates the one-year extended transitional medical assistance coverage for low-income parents with income up to 100% of the federal poverty level transitioning off Medicaid. This is an optional 1115 Waiver group. The proposed amendment eliminates 1,150 eligibles upon implementation.

With this reduction, the only remaining adult group in the 1115 Waiver is Women's Health Services for uninsured women who do not qualify for other medical assistance benefits and would lose their Medicaid eligibility sixty days after the birth of their child or a miscarriage.

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-4.090 Uninsured Women's Health Program
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the count of compliance with the rule by the affected entities:
1,150	All Medicaid recipients under the uninsured parents' health insurance program excluding uninsured women	Services will be systematically denied and providers will not be reimbursed

III. WORKSHEET

The total private cost of the elimination of the uninsured parents' health insurance program, excluding uninsured women eligible for women's health services, is zero to 3.1 million dollars based on the state fiscal year 2004 utilization of Medicaid services by this eligibility category.

IV. ASSUMPTIONS

The proposed amendment eliminates medical services for individuals losing extended transitional medical assistance from the Uninsured Parents' Health Insurance Program.

The proposed amendment eliminates the one-year extended transitional medical assistance coverage for low-income parents with income up to 100% of the federal poverty level transitioning off Medicaid. This is an optional 1115 Waiver group. The proposed amendment eliminates 1,150 eligibles upon implementation.

With this reduction, the only remaining adult group in the 1115 Waiver is Women's Health Services for uninsured women who do not qualify for other medical assistance benefits and would lose their Medicaid eligibility sixty days after the birth of their child or a miscarriage.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The Division of Medical Services is amending sections (1), (2), (3), (5), (6), (12), (13), (14), (15), (16), (17), and (18).

PURPOSE: This proposed amendment describes how the "case mix index" will be updated, documents the trend indices for State Fiscal Years 2005 and 2006, removes references to the General Relief program, removes references to "swing bed rate," describes the calculation of the safety net adjustment for specific hospitals, and describes the calculation of Medicaid payments for the uninsured beginning in State Fiscal Year 2006.

(1) General Reimbursement Principles.

(C) The Title XIX reimbursement for hospitals, excluding those located outside Missouri and in-state federal hospitals, shall include per diem payments, outpatient payments, disproportionate share payments; various Medicaid Add-On payments, as described in this rule; or a safety net adjustment, paid in lieu of Direct Medicaid Payments described in section (15) and Uninsured Add-Ons described in subsection (18)(B). Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Per diem reimbursement—The per diem rate is established in accordance with section (3).

2. Outpatient reimbursement is described in 13 CSR 70-15.160.

3. Disproportionate share reimbursement—The disproportionate share payments described in section (16), and subsection (18)(B) include both the federally mandated reimbursement for hospitals which meet the federal requirements listed in section (6) and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation. These Safety Net and Uninsured Add-Ons shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured unless otherwise permitted by federal law.

4. Medicaid Add-Ons—Medicaid Add-Ons are described in sections (13), **(14),** (15), (19) and (21) and are in addition to Medicaid per diem payments. These payments are subject to the federal Medicare Upper Limit test.

5. Safety Net Adjustment—The payments described in subsection (16)(A) are paid in lieu of Direct Medicaid Payments described in section (15) and Uninsured Add-Ons described in subsection (18)(B).

(2) Definitions.

(D) Case mix index. The average Diagnosis Related Grouping (DRG) relative weight as determined from claims information filed with the Missouri Department of Health and Senior Services. This calculation will include both fee-for-service and managed care information. The DRG weight used in the calculation is the same for all years and is the weight that is associated with the latest year of data that is being analyzed (i.e., for SFY 2004, weights for *[2002]* **2003** are applied to all years). **The DRG weights will be updated annually using the information published by the Centers for Medicare and Medicaid Services (CMS) in the *Federal Register*.**

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

(B) Trend Indices (TI). Trend indices are determined based on the four (4)-quarter average DRI Index for DRI-Type Hospital Market Basket as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital indexed as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY).

1. The TI are—
   - A. SFY 1994—4.6%
   - B. SFY 1995—4.45%
   - C. SFY 1996—4.575%
   - D. SFY 1997—4.05%
   - E. SFY 1998—3.1%
   - F. SFY 1999—3.8%
   - G. SFY 2000—4.0%
   - H. SFY 2001—4.6%
   - I. SFY 2002—4.8%
   - J. SFY 2003—5.0%
   - K. SFY 2004—6.2%
   - **L. SFY 2005—6.7%**
   - **M. SFY 2006—5.7%**

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

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

(5) Administrative Actions.

(B) Records.

1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR 413.20. For purposes of this plan, statistical and financial records shall include beneficiaries' medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by Missouri Medicaid (excluding cross-over claims) respectively. Separate logs for inpatient and outpatient services should be maintained for Medicaid recipients covered by managed care (MC+). All records must be available upon request to representatives, employees or contractors of the Missouri Medical Assistance Program, Missouri Department of Social Services, General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:

A. A separate Medicaid log for each fiscal year must be maintained by either date of service or date of payment by Medicaid for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission. The information from the Medicaid log should be used to complete the Medicaid worksheet in the hospital's cost report;

B. Data required to be recorded in logs for each claim include:

(I) Recipient name and Medicaid number;

(II) Dates of service;

(III) If inpatient claim, number of days paid for by Medicaid, classified by adults and peds, each subproviders, newborn or specific type of intensive care;

(IV) Charges for paid inpatient days and inpatient ancillary charges for paid days classified by cost center as reported in the cost report or allowed outpatient services, classified by cost center as reported on cost report;

(V) Noncovered charges combined under a separate heading;

(VI) Total charges;

(VII) Any partial payment made by third-party payers (claims paid equal to or in excess of Medicaid payment rates by third-party payers shall not be included in the log);

(VIII) Medicaid payment received or the adjustment taken; and

(IX) Date of remittance advice upon which paid claim or adjustment appeared;

C. A year-to-date total must appear at the bottom of each log page or after each applicable group total or a summation page of all subtotals for the fiscal year activity must be included with the log; and

D. Not to be included in the outpatient log are claims or line item outpatient charges denied by Medicaid or claims or charges paid from an established Medicaid fee schedule. This would include payments *[for General Relief (GR) recipients, payments]* for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, payments for certain specified clinical diagnostic laboratory services, or payments for services provided by the hospital through enrollment as a Medicaid provider-type other than hospital outpatient.

2. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand to those individuals or organizations as listed in paragraph (5)(B)1. of this rule.

3. The Missouri Division of Medical Services shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 413.20. If an audit by, or on behalf of, the state or federal government has begun but is not completed at the end of the three (3)-year period, or if audit findings have not been resolved at the end of the three (3)-year period, the reports shall be retained until resolution of the audit findings.

4. The Missouri Division of Medical Services shall maintain any responses received on this plan, subsequent changes to this plan and rates for a period of three (3) years from the date of receipt.

(6) Disproportionate Share.

(F) Hospital-specific DSH cap. Unless otherwise permitted by federal law, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured. *[The hospital-specific DSH cap shall be computed using the fourth prior year desk reviewed cost report trended thru the state fiscal year. If the sum of disproportionate share payments exceeds the estimated hospital-specific DSH cap, the difference shall be deducted in order as necessary from safety net payment, other disproportionate share lump sum payments, direct Medicaid payments, and if necessary, as a reduced per diem.]*

(12) Inappropriate Placements.

(A) The hospital per diem rate as determined under this plan and in effect on October 1, 1981, shall not apply to any recipient who is receiving inpatient hospital care when s/he is only in need of nursing home care.

1. If a hospital has an established intermediate care facility/skilled nursing facility (ICF/SNF) or SNF-only Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital's ICF/SNF or SNF-only rate.

[2.. If a hospital does not have an established Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the state swing bed rate.

*[3.]***2.** No Medicaid payments will be made on behalf of any recipient who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

(13) Trauma Add-On Payments. Hospitals that meet the following will receive additional Add-On payments.

(B) Trauma Add-On Computation. *[On an annual basis, the division will calculate the trauma Add-On payments for qualifying hospitals]* **Each state fiscal year, to be effective July 1 of that state fiscal year, the division will calculate the trauma add-on payments for qualifying hospitals** as follows:

1. The case mix index for Medicaid patients will be determined for the fourth prior year and the second prior year based on a federal fiscal year;

2. The percentage change will be calculated for the same time period above and then inflated **by 1.5** to estimate a percentage change from the fourth prior year through the prior year (for example, for SFY 2004, the percentage change for 2000 to 2002 will be inflated to estimate a percentage change from 2000 through 2003);

3. If this estimated percentage change is positive, the hospital's current year trended cost per day prior to the assessment per day and utilization adjustment per day (estimated for SFY 2004 using the 2000 cost report with some exceptions) will be inflated by the same amount to arrive at the current year case mix adjusted cost per day;

4. The difference between the current year case mix adjusted cost per day and the current year trended cost per day prior to the assessment per day and utilization adjustment per day will be multiplied by the current year's estimated Medicaid days, resulting in the trauma Add-On payment to the hospital;

5. For subsequent years, the calculation of the trauma Add-On payment will be determined in the same manner. However, payments will be the greater of the current year calculated payment or the previous year's payment.

(C) Trauma Payment Adjustment Option.

1. If the qualifying hospital for the trauma Add-On payment has a declining case mix index for three (3) consecutive years, *[the department has the option of reviewing whether an adjustment is appropriate]* **the hospital will no longer be eligible to receive the trauma add-on payment**.

[(D) The Division of Medical Services will require a signed affidavit attesting to the validity of the data.]

*[(E)]***(D)** Trauma Add-On payments and trauma outlier payments will be subject to appropriations. If the amount appropriated is less than the base year amount, the current year's payments for both trauma Add-Ons and trauma outliers will be prorated based on the ratio of trauma Add-On payments to trauma outlier payments in the base year.

(14) Trauma Outlier Payments.

(A) *[Effective for services on or after July 1, 2002, o]***O**utlier adjustments for trauma inpatient services involving exceptionally high cost for Missouri Medicaid eligible recipients will be made to hospitals meeting the criteria established below:

1. Hospital must be a Level I, II, or III trauma center as designated by the Missouri Department of Health and Senior Services.

(B) Claims for all dates of service eligible for trauma outlier review must—

1. Have been submitted to the Division of Medical Services fiscal agent *[or the MC+ health plan]* in their entirety for routine claims processing, and claim payment must have been made before the claims are submitted to the division for outlier review; and

2. Be submitted for outlier review with all documentation as required by the Division of Medical Services by the end of the third quarter of the current state fiscal year. The prior year's information will be used to determine the trauma outlier payment for the current state fiscal year (for example, SFY 2004 trauma outlier payments will be based on 2003 data). Out-of-state trauma claims may be included.

3. The claims for trauma inpatient services may include services provided to Medicaid eligible individuals from states outside Missouri when provided in a Missouri hospital.

4. The claim must be an inpatient that originated in the hospital emergency room or a direct admit from another hospital's emergency room and must have a *[primary]* diagnosis code that is included in the table of valid trauma diagnosis codes listed below:

800.00–959.99
980.00–981.99
983.00–983.99
986.00–987.99
989.00–989.99
991.00–994.99
E800.00–E999.99

5. The payment for the claim as determined by the product of days of service times the appropriate year cost per day (including the assessment per day and the utilization adjustment per day) must be less than the cost of the claim as determined by product of charges times the hospital specific cost-to-charge ratio.

(15) Direct Medicaid Payments.

(A) Direct Medicaid Payments. Direct Medicaid payments will be made to hospitals for the following allowable Medicaid costs not included in the per diem rate as calculated in section (3):

1. The increased Medicaid costs resulting from the FRA assessment *[not included in the cost report ending prior to January 1, 2001]* **becoming an allowable cost on January 1, 1999**;

2. The unreimbursed Medicaid costs applicable to the trend factor which is not included in the per diem rate;

3. The unreimbursed Medicaid costs for capital and medical education not included in the trended per diem cost as a result of the application of the sixty percent (60%) minimum utilization adjustment in paragraph (3)(A)4.;

4. The increased cost per day resulting from the utilization adjustment. The increase**d** cost per day results from lower utilization of inpatient hospital services by Medicaid recipients now covered by an MC+ health plan;

5. The poison control adjustment shall be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a Medicaid managed care region; and

6. The increased cost resulting from including out-of-state Medicaid days in total projected Medicaid days.

(16) Safety Net Adjustment. A safety net adjustment, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons, shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph (6)(A)4. The safety net adjustment payment shall be made prior to the end of each federal fiscal year.

[(A) The safety net adjustment for facilities which qualify under subparagraph (6)(A)4.A. of this regulation shall be computed in accordance with the Direct Medicaid Payment calculation described in section (15) and the Uninsured Add-Ons calculation in subsection (18)(B) of this regulation. The safety net adjustment will include the last three (3) quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.]

[(B)] **(A)** The safety net adjustment for facilities which qualify under subparagraph (6)(A)4.B.*[,]* **or** (6)(A)4.C. *[or (6)(A)4.D.]* of this regulation shall be computed in accordance with the Direct Medicaid Payment calculation described in section (15) and *[one hundred percent (100%) of]* the uninsured costs calculation described in subsection (18)*[(B)]***(D)** of this regulation. **The safety net adjustment for the facilities that qualify under this subsection shall be calculated by adding an additional ten percent (10%) to the percentage that will be used to distribute either the total annual projected cost of the uninsured population that is related to hospital services, or the DSH cap for hospitals, whichever is lower (i.e., if ninety percent (90%) is used to distribute the annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals, whichever is lower, then one hundred percent (100%) would be used for the facilities that qualify under this subsection).** The safety net adjustment will include the last three (3) quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

(B) The safety net adjustment for facilities which qualify under subparagraph (6)(A)4.D. of this regulation shall be computed in accordance with the Direct Medicaid Payment calculation described in section (15) and the uninsured costs calculation described in subsection (18)(B) of this regulation. The safety net adjustment will include the last three (3) quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

(17) OBRA 93 Limitation. In accordance with OBRA 93, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured**, unless otherwise permitted by federal law**. *[The OBRA 93 Limitation shall be computed using the fourth prior year desk-reviewed cost report trended through the current state fiscal year. If the sum of disproportionate share payments exceeds the estimated OBRA 93 Limitation, the difference shall be deducted in order as necessary from the Safety Net payment, other disproportionate share lump sum payments, direct Medicaid payments and if necessary as a reduced per diem.]*

(18) In accordance with state and federal laws regarding reimbursement of unreimbursed costs and the costs of services provided to uninsured patients, reimbursement for each State Fiscal Year (SFY) (July 1–June 30) shall be determined as follows:

(D) Uninsured add-ons effective July 1, 2005 for all facilities except DMH safety net facilities as defined in subparagraph (6)(A)4.D. DMH safety net facilities will continue to be calculated in accordance with subsection (18)(B). The uninsured add-on for all facilities except DMH safety net facilities will be based on the following:

1. Determination of the cost of the uninsured:

A. Allocate the uninsured population as determined from the Current Population Survey (CPS), Annual Social and Economic Supplement (Table HI05) as published by the U.S. Census Bureau, to the same categories of age (COA) and age groups as the managed care rate cells as determined by the Managed Care Unit of the Division of Medical Services;

B. Determine the total annual projected cost of the uninsured population by multiplying the number of uninsured for each rate cell by the average contract per member per month (PMPM) for that individual managed care rate cell multiplied by twelve (12); and

C. Determine the amount of the total annual projected cost of the uninsured population that is related to hospital services by multiplying the total annual projected cost of the uninsured population as calculated in (18)(D)2. above by the percentage of the contract PMPM for each individual rate cell that is related to hospital services. This would be the maximum amount of uninsured add-on payments that could be made to hospitals. This amount is also subject to the DSH cap;

2. Proration to individual hospitals of the cost of the uninsured calculated in paragraph (18)(D)1.

A. Determine each individual hospital's uninsured add-on payment by dividing the individual hospital's uninsured cost as determined from the fourth prior year cost report by the total uninsured cost for all hospitals as determined from the fourth

prior year cost report, multiplied by either the total annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals whichever is lower; and

3. For new hospitals that do not have a base cost report, uninsured payments shall be estimated as follows:

A. Hospitals receiving uninsured payments shall be divided into quartiles based on total beds;

B. Uninsured payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average uninsured payment per bed; and

C. The numbers of beds for the new hospital without the base cost report shall be multiplied by the average uninsured payment per bed.

*AUTHORITY: sections 208.152 and 208.471, RSMo Supp. [2003] **2004** and 208.153 and 208.201, RSMo 2000. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consult the **Code of State Regulations**. Amended: Filed June 15, 2005.*

PUBLIC COST: This proposed amendment is expected to cost state agencies and political subdivisions an estimated $110,275,104 in SFY 2006.

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PUBLIC COST

I. RULE NUMBER

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

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification 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:
139	Hospitals	Annual estimated cost: SFY 2006 = $110,275,104

III. WORKSHEET

For SFY 2006, the estimated annual impact is based on the following:

DSH calculation using proposed methodology	$467,030,755
DSH calculation using current methodology	356,755,651
Estimated annual impact	$110,275,104

IV. ASSUMPTIONS

The increased cost is based on the change in methodology for calculating the DSH payments.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.030 Limitatons on Payment for Inpatient Hospital Care. The Division of Medical Services is amending sections (1) and (3), deleting sections (6) and (7) by eliminating the reference of general relief and renumbering the remaining section.

PURPOSE: This amendment removes the reference to reimbursement for general relief recipients. The eligibility category general relief, which granted Medicaid coverage to unemployed adults because of temporary or permanent disabilities, was not funded by the Missouri General Assembly beginning July 1, 2005. Senate Bill 539 as enacted by the 93rd General Assembly repealed the eligibility category general relief.

(1) For inpatient hospital admissions that have been certified under 13 CSR 70-15.020 and for admissions that do not require certification, the number of days which Medicaid will cover for each admission and continuous period of hospitalization shall be limited to the lowest of subsection (1)(A), (B) or (C). *[General Relief (GR) recipients are further limited in section (7) of this rule.]*

(3) *[Except for reimbursement rates applicable to GR recipients, inpatient services as described in section (6) of this rule, r]***R**eimbursement shall be made at the applicable per diem rate in effect as of the initial date of admission and for only allowable days during which the recipient is eligible.

[(6) Effective for all inpatient hospital admissions of GR assistance recipients on or after September 1, 1981, Medicaid payment for covered services provided during the allowable days of each admission shall be made at the lesser of—

(A) The rate which was in effect between the hospital and the Medicaid program on September 1, 1981; or

(B) The rate which was in effect between the hospital and the Medicaid program as of the beginning date of the hospital admission.

(7) Effective for inpatient hospital stays for GR assistance recipients beginning on or after January 1, 1982, Medicaid coverage of the number of days during any one (1) continuous period of hospitalization will be limited to a maximum of twenty-one (21) days during which the recipient is Medicaid-eligible and if twenty-one (21) days should be the lesser of allowable days as derived from provisions of sections (1) and (2).]

*[(8)]***(6)** Exception Process.

(A) An exception process to the coverage of inpatient days as determined under provisions of section (1) shall be established for post-payment consideration of inpatient claims exceeding fifteen (15) days beyond the allowable days, if requested by the provider, and the date of receipt was prior to September 1, 1986.

(B) For requests received on or after September 1, 1986, for admissions prior to July 1, 1988, post-payment consideration of inpatient claims will only be made for claims exceeding thirty (30) days beyond the allowed days. Only the days exceeding thirty (30) days beyond the allowed days are eligible for approval; days one through thirty (1–30) in excess of the allowed days are not eligible for consideration of approval nor additional reimbursement. There will be no post-payment consideration of inpatient claims for admissions on and after July 1, 1988.

(C) The state agency will conduct reviews, approve and specify any additional days which may be allowed beyond the number of days already paid, or may review recommendations submitted by either a duly appointed Medicaid utilization review subcommittee or a medical consultant licensed to practice medicine in Missouri. At its discretion, the state may concur with a recommendation and approve all days for payment, disagree and not pay any days or modify and pay some portion of the days recommended.

(D) Reimbursement for any additional days approved for acute care will be made at the hospital's per diem rate in effect on the date of admission. If a hospital has an established intermediate care facility/skilled nursing facility (ICF/SNF) or SNF-only Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for any additional days approved for only ICF or SNF level of care provided in the inpatient hospital setting will be made at the hospital's ICF/SNF or SNF-only rate. If a hospital does not have an established ICF/SNF or SNF-only Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for any additional days approved for only ICF or SNF level of care will be made at the statewide swing bed rate. No additional days will be approved and no Medicaid payments will be made on behalf of any recipient who it is determined received inpatient hospital care when s/he did not need either inpatient hospital services or nursing home ICF or SNF services.

(E) Requests for post-payment consideration of inpatient claims must be received no later than one (1) year from the date of discharge.

*AUTHORITY: sections 208.153, [RSMo Supp. 1991] **208.162,** and 208.201, RSMo [Supp. 1987] **2000**. This rule was previously filed as 13 CSR 40-81.051. Emergency rule filed April 7, 1981, effective April 20, 1981, expired July 10, 1981. Original rule filed April 7, 1981, effective July 11, 1981. For intervening history, please consult the **Code of State Regulations**. Amended: Filed June 15, 2005.*

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

PRIVATE COST: This proposed amendment will cost private entities a range of zero (0) to 1.1 million dollars based on the state fiscal year 2004 utilization of Medicaid inpatient hospital services by those in the general relief eligibility category.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-15.030 Limitations on Payment for Inpatient Hospital Care
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
3,046	Medicaid General Relief Recipients	There will be full compliance since this category of Medicaid eligibles is being eliminated.

III. WORKSHEET

The total private cost of the elimination of the general relief eligibility category is zero to $14,200,000 based on the state fiscal year 2004 utilization of Medicaid services by the General Relief eligibility category. The portion for all other Medicaid services, excluding hospital services, utilized by the General Relief eligibility category is $11,800,000 and is being reflected in the proposed rescission of 13 CSR 70-2.020 Scope of Medical Services for General Relief Recipients. The outpatient hospital portion of the private cost ($1,300,000) is being reflected on the proposed amendment to 13 CSR 70-15.080 Payment Method for General Relief Recipient Hospital Outpatient Services. The private cost of this proposed amendment is $1,100,000 based on the state fiscal year 2004 utilization of Medicaid inpatient services by the General Relief eligibility category.

IV. ASSUMPTIONS

This amendment removes the reference to reimbursement for general relief recipients. The eligibility category general relief, which granted Medicaid coverage to unemployed adults because of temporary or permanent disabilities, was not funded by the Missouri General Assembly beginning July 1, 2005. Senate Bill 539 as enacted by the 93rd General Assembly repealed the eligibility category general relief.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

PROPOSED RESCISSION

13 CSR 70-15.080 Payment Method for General Relief Recipient Hospital Outpatient Services. This rule established the method of payment to be used in computing Medicaid program reimbursement for covered hospital outpatient services provided to General Relief assistance recipients.

PURPOSE: This rule is being rescinded because the eligibility category general relief which granted Medicaid coverage to unemployed adults because of temporary or permanent disabilities was not funded by the Missouri General Assembly beginning July 1, 2005. Senate Bill 539 as enacted by the 93rd General Assembly repealed the eligibility category general relief.

AUTHORITY: section 207.020, RSMo 1986. This rule was previously filed as 13 CSR 40-81.180. Emergency rule filed July 15, 1981, effective Aug. 1, 1981 expired Oct. 10, 1981. Original rule filed July 15, 1981, effective Oct. 11, 1981. Rescinded: Filed June 15, 2005.

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 cost private entities a range of zero (0) to $1,300,000 based on the state fiscal year 2004 utilization of Medicaid outpatient hospital services by General Relief eligibility category.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-15.080 Payment Method for General Relief Hospital Outpatient Services
Type of Rulemaking:	Proposed Rescission

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 business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
3,046	Medicaid General Relief Recipients	There will be full compliance since this category of Medicaid eligibles is being eliminated.

III. WORKSHEET

The total private cost of the elimination of the General Relief eligibility category is zero to $14.2 million based on the state fiscal year 2004 utilization of Medicaid services by the General Relief eligibility category. The portion for all other Medicaid services, excluding hospital services, utilized by the General Relief eligibility category is $11,800,000 and is being reflected in the proposed rescission of 13 CSR 70-2.020 Scope of Medical Services for General Relief Recipients. The inpatient hospital portion of the private cost ($1,100,000) is being reflected on the proposed amendment to 13 CSR 70-15.030 Limitations on Payment for Inpatient Hospital Care. The private cost of this proposed amendment is $1.3 million based on the state fiscal year 2004 utilization of Medicaid outpatient hospital services by the General Relief eligibility category.

IV. ASSUMPTIONS

This amendment removes the reference to reimbursement for general relief recipients. The eligibility category general relief, which granted Medicaid coverage to unemployed adults because of temporary or permanent disabilities, was not funded by the Missouri General Assembly beginning July 1, 2005. Senate Bill 539 as enacted by the 93rd General Assembly repealed the eligibility category general relief.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA). The division is adding section (13).

PURPOSE: This amendment will establish the Federal Reimbursement Allowance (FRA) assessment for State Fiscal Year 2006 at five and fifty-four hundredths percent (5.54%).

(13) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2006. The FRA assessment for State Fiscal Year (SFY) 2006 shall be determined at the rate of five and fifty-four hundredths percent (5.54%) of the hospital's total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics. The base financial data for 2002 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year. The financial data that is submitted by the hospitals to the Missouri Department of Health and Senior Services is required as part of 19 CSR 10-33.030 Reporting Financial Data by Hospitals. If the pertinent information is not available through the Department of Health and Senior Services' hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report that is required to be submitted pursuant to 13 CSR 70-15.010(5)(A).

*AUTHORITY: sections 208.201, 208.453 and 208.455, RSMo 2000. 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 7, 2005, effective June 17, 2005, expires Dec. 13, 2005. Amended: Filed June 15, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate in SFY 2006.

PRIVATE COST: This proposed amendment is expected to cost private entities $709,765,443 in SFY 2006.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

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

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification 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:
131	Hospitals	Annual estimated cost: SFY 2006 = $709,765,443

III. WORKSHEET

The fiscal note is based on establishing the SFY 2006 FRA assessment percentage at five and fifty-four hundredths percent (5.54%).

IV. ASSUMPTIONS

The SFY 2006 FRA assessment is based on total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses of approximately $12,828,419,801 multiplied by five and fifty-four hundredths percent (5.54%). The 131 hospitals reported above include 40 hospitals that are owned or controlled by state, county, city or hospital districts. The impact of these hospitals is $115,570,883.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.160 Prospective Outpatient Hospital Services Reimbursement Methodology. The Division of Medical Services is amending section (1).

PURPOSE: This amendment removes the reference to reimbursement for general relief recipients. The eligibility category general relief, which granted Medicaid coverage to unemployed adults because of temporary or permanent disabilities, was not funded by the Missouri General Assembly beginning July 1, 2005. Senate Bill 539 as enacted by the 93rd General Assembly repealed the eligibility category general relief.

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

(C) Outpatient hospital services reimbursement limited by rule.

[1. All services provided to General Relief (GR) recipients will be reimbursed from the Medicaid fee schedule in accordance with provisions of 13 CSR 70-2.020.]

*[2.]***1.** Effective for dates of service September 1, 1985, and annually updated, certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.

*[3.]***2.** Services of hospital-based physicians and certified registered nurse anesthetists shall be billed on an HCFA-1500 professional claim form which is incorporated by reference as part of this rule, and reimbursed from a Medicaid fee schedule or the billed charge, if less.

*[4.]***3.** 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 under Title XVIII.

*AUTHORITY: sections 208.152, 208.153, **208.162,** and 208.201, RSMo 2000 and 208.471, RSMo Supp. [2003] **2004**. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. Amended: Filed May 3, 2004, effective Oct. 30, 2004. Amended: Filed June 15, 2005.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate in SFY 2006.

PRIVATE COST: This proposed amendment will cost private entities a range of zero (0) to 1.3 million dollars based on SFY 2004 utilization.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must by received within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-15.160 Prospective Outpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
3,046	Medicaid General Relief Recipients	There will be full compliance since this category of Medicaid eligibles is being eliminated.

III. WORKSHEET

The total private cost of the elimination of the General Relief eligibility category is zero to 14.2 million dollars based on the state fiscal year 2004 utilization of Medicaid services by the General Relief eligibility category. The portion for all other Medicaid services, excluding hospital services, utilized by the General Relief eligibility category is 11.8 million dollars and is being reflected in the proposed rescission of 13 CSR 70-2.020 Scope of Medical Services for General Relief Recipients. The inpatient hospital portion of the private cost (1.1 million dollars) is being reflected on the proposed amendment to 13 CSR 70-15.030 Limitations on Payment for Inpatient Hospital Care. The private cost of this proposed amendment is 1.3 million dollars based on the state fiscal year 2004 utilization of Medicaid outpatient hospital services by the General Relief eligibility category.

IV. ASSUMPTIONS

This amendment removes the reference to reimbursement for general relief recipients. The eligibility category general relief, which granted Medicaid coverage to unemployed adults because of temporary or permanent disabilities, was not funded by the Missouri General Assembly beginning July 1, 2005. Senate Bill 539 as enacted by the 93rd General Assembly repealed the eligibility category general relief.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 35—Dental Program

PROPOSED AMENDMENT

13 CSR 70-35.010 Dental Benefits and Limitations, Medicaid Program. The Division of Medical Services is amending the Purpose statement and sections (1), (2), (3), (4), (9), and (10); deleting sections (5), (6), (7), and (8); adding a new section; and deleting all forms following this regulation in the *Code of State Regulations*.

PURPOSE: This amendment informs Medicaid providers where they can find information about the Medicaid dental benefit and eliminates dental coverage for all recipients who are not eligible needy children, pregnant women or blind persons as approved through Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly.

*PURPOSE: This rule describes the dental services for which the Division of [Family] **Medical** Services shall pay when the service is provided to an eligible assistance recipient, the service is provided by a licensed dentist, **licensed dental hygienist,** or licensed and certified dental specialist who has entered into an agreement for that purpose with the division and the service is listed as a covered item [either] in [the new rule or] the **Medicaid Dental Manual** sponsored by the division. [This rule or t]The **Medicaid Dental Manual** [also] describes the dental services which shall be paid under limitations and those which shall not be paid under present conditions.*

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) Administration. The Missouri Medicaid dental program shall be administered by the Division of Medical Services, Department of Social Services. The dental services covered and not covered, the limitations under which services are covered and the maximum allowable fees for all covered services shall be determined by the Division of Medical Services*[.]* **and shall be included in the Medicaid Dental Provider Manual, which is incorporated by reference and made part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website at www.dss.mo.gov/dms, July 15, 2005. This rule does not incorporated any subsequent amendments or additions.** Dental services covered by the Missouri Medicaid program shall include only those which are clearly shown to be medically necessary. The division reserves the right to effect changes in services, limitations and fees with proper notification to Medicaid dental providers.

(2) Provider Participation. A dentist shall be licensed by the dental board of the state in which s/he is practicing and shall have signed a participation agreement to provide dental services under the Missouri Medicaid program. An oral surgeon or other dentist specialist shall be licensed in his/her specialty area by the dental board of the state in which s/he is practicing. In those states not having a specialty licensure requirement, the dentist specialist shall be a graduate of and hold a certificate from a graduate training program in that specialty in an accredited dental school. In either case, the dental specialist shall have signed a participation agreement to provide dental services under the Missouri Medicaid program. **A dental hygienist shall be licensed by the dental board of the state for at least three (3) consecutive years and practicing in a public health setting to provide fluoride treatments, teeth cleaning and sealants to Medicaid/MC+ eligible children ages zero (0) to twenty (20).**

(3) Recipient Eligibility. The Medicaid dental provider shall ascertain the patient's Medicaid status before any service is performed. The recipient's Medicaid/**MC+** eligibility is determined by the **Family Support** Division *[of Family Services]*. The recipient's eligibility shall be verified from a current Medicaid/**MC+** identification card or a letter of new approval in the recipient's possession. The patient must be a Medicaid-eligible recipient under the Missouri **Medicaid/MC+** program on the date the service is performed. The Division of Medical Services is not allowed to pay for any service to a patient who is not eligible under the Missouri Medicaid/**MC+** program. **Medicaid reimbursement of dental services shall be limited to Medicaid eligible needy children or persons receiving Medicaid under a category of assistance for pregnant women or the blind. Dental services for all other categories of assistance must be prior authorized, physician-ordered and related to trauma of the mouth, jaw, teeth, or other contiguous sites as a result of injury or treatment of a medical condition without which the health of the individual would be adversely affected.**

(4) Prior Authorization. *[Prior authorization shall be required in the following two (2) cases: a) initial placement or replacement of all full dentures (upper, lower or both) and b) placement or replacement of all partial dentures.]* When prior authorization is required, the form provided by the Division of Medical Services or its contracted agent shall be used. The dental service shall not be started until written approval has been received. Telephone approval shall not be given. Prior authorization shall be effective for a period of one hundred twenty (120) days from the date of written approval. Prior authorization approves the medical necessity of the requested dental service. It shall not guarantee payment for that service as the patient must be a Medicaid-eligible recipient on the date the service is performed. The division reserves the right to request documentation regarding any specific request for prior authorization.

[(5) Claims. The Medicaid dental provider shall submit his/her usual charge to the general public on the claim form provided by the Division of Medical Services or its contracted agent. Medicaid reimbursement for dental services is based on an established fee schedule as published in Section 19 of the Dental Manual. When a claim is reimbursed by Medicaid (or Medicare-Medicaid), no amount in addition to copayment or coinsurance amounts as specified in Section 19 of the Dental Manual shall be collected from the recipient, his/her immediate family or anyone else. The reimbursement provided by Medicaid (or Medicare-Medicaid) shall be accepted in full settlement of the dental claim. The recipient shall be responsible for any noncovered service (no reimbursement). The division reserves the right to request documentation regarding any specific dental claim.]

[(6) Other Source Payment. The Medicaid payment for dental services cannot duplicate or replace benefits available to the recipient from any other source, public or private. A settlement received from private insurance or litigation as the result of an accident must be used toward payment of the dental care. Medicaid shall be the last source of payment on any claim. Any payment received from a private insurance carrier or other acceptable source shall be listed on the claim form. If the settlement received is equal to or exceeds the fee which could be allowed by Medicaid, no payment shall be made by Medicaid.]

[(7) Dental Certification. A dental certification form as provided by the Division of Medical Services or its contracted agent shall be completed in the case of any denture, partial or full, except for those flipper-type partials identified in the Dental Services Provider Manual. This completed form shall be attached to the claim and the request for prior authorization.]

[(8) Dental Manual. A Medicaid Dental Manual shall be produced by the Division of Medical Services and shall be distributed to all dental providers participating in the Missouri Medicaid program. It shall contain a list of covered and noncovered services, the limitations under which services are covered and other pertinent data to supplement this rule. The Health Care Financing Administration's Common Procedure Coding System (HCPCS) Level 1, 2 or 3 procedure codes, which includes a modification of the American Dental Association's (ADA) Code on Dental Procedures and Nomenclature shall be used in the manual. Maximum allowable fees by the Missouri Medicaid Dental Program shall be published in provider manuals and bulletins.]

*[(9)]***(5)** Services, Covered and Noncovered. *[The list shown in this section represents the groupings of medically necessary services covered by the Missouri Medicaid program.]* The *Medicaid Dental Manual* shall provide the detailed listing of procedure codes and pricing information **for services covered by the Missouri Medicaid Dental program**.

[(A) Anesthesia. General anesthesia administered in the office is a covered service. General anesthesia administered in the hospital for dental care is payable to the hospital. Local anesthesia is not paid under a separate procedure code and is included in the treatment fee. Nitrous oxide is not covered;

(B) Crowns, Bridges, Inlays. A crown of chrome or stainless steel is a covered item. A crown of polycarbonate material is a covered item for an anterior tooth. Crowns of other materials are not covered. Cast restorations indicated by an early periodic screening diagnosis and treatment (EPSDT) screen are covered;

(C) Full Dentures. One (1) upper full denture, one (1) lower full denture, or one (1) complete set (upper and lower) of full dentures is covered. A full denture must be constructed of acrylic material and must meet the following criteria: full arch impression, bite registration, each tooth set individually in wax, try-in of teeth set individually in wax before denture processing, insertion of the processed denture and six (6)-month follow-up adjustments, to be a covered item. Service in the case of any full denture is not completed and shall not be claimed until the denture is placed. Noncovered items include temporary full dentures, full overdentures and immediate placement full dentures;

(D) Partial Dentures. A partial denture shall replace permanent teeth and must be constructed of acrylic material to be a covered item. Service in the case of any partial denture is not completed and shall not be claimed until the denture is placed. Noncovered items include temporary partial dentures and partial overdentures. Immediate placement partial dentures are noncovered except for those flipper-type partials identified in the Dental Services Provider Manual under procedure codes D5820, D5820W5, D5820W6, D5820W9, D5821, D5821W5, D5821W6, D5821W9;

(E) Denture Adjustment and Repair. Denture adjustment is a covered service but not to the originating dentist of a new denture until six (6) months after the denture is placed. Repair of a broken denture may be accomplished on the same date of service as denture duplication or reline;

(F) Denture Duplication and Reline. Duplication of a partial or full denture is a covered service. Reline of a partial or full denture, either chairside or laboratory, is covered. Duplications and relines are not covered within twelve (12) months of initial placement of an original denture. Additional denture relines or duplications are limited to once within three (3) years from the date of the last preceding reline or duplication. Denture duplication or reline may be accomplished on the same date of service as repair of a broken denture;

(G) Emergency Treatment. Emergency dental care does not require prior authorization and is covered whether performed by a licensed dentist or a licensed dentist specialist. Emergency care is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention reasonably could be expected to result in—placing the patient's health in serious jeopardy or serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Emergency care not listed in the Medicaid Dental Manual shall be explained on the claim. An emergency oral examination is not paid under a separate procedure code and is included in the treatment fee. Palliative treatment on the same date of service as other dental care on the same tooth is not covered. Denture dental services are not subject to emergency treatment consideration;

(H) Examinations, Visits, Consultations. An initial oral examination in the office is covered. Subsequent office medical services are covered. A professional visit to a nursing home is covered and shall include the fee for an oral examination. A professional visit to a hospital is covered and shall include the fee for an oral examination. A consultation by a dentist is a covered service and shall include the fee for an oral examination;

(I) Extractions. Extraction fees for permanent and deciduous teeth, as listed in the Medicaid Dental Manual, apply whether the service is performed in the office, hospital or ambulatory surgical center. Preoperative X rays involving extractions may be covered but postoperative X rays are not covered;

(J) Preventive Treatment. Fluoride treatment may be covered but is limited to the application of stannous fluoride or acid phosphate fluoride. Sodium fluoride treatments are not covered. Fluoride treatment shall include both the upper and lower arch and shall be a separate service from prophylaxis. Fluoride treatment for recipients under age twenty-one (21) is covered. Fluoride treatment for recipients age twenty-one (21) and over is limited to individuals with rampant caries, or those who are undergoing radiation therapy to head and neck, or those with diminished salivary flow, or individuals who are mentally retarded or have cemental or roof surface caries secondary to gingival recession. For recipients ages five through twenty (5–20), topical application of sealants as outlined in Section 19 of the Medicaid Dental Manual is covered. Dietary planning, oral hygiene instruction and training in preventive dental care are not covered;

(K) Hospital Dental Care. Dental services provided in an inpatient hospital or an outpatient hospital place of service are subject to the same general benefits and limitations applicable to all dental services and all are not selectively restricted based on place of service;

(L) Injections. Procedure codes for the injections which are covered shall be shown in Section 19 of the Dental Manual;

(M) Oral Surgery (or Other Qualified Dentist Specialist). Oral surgery is limited to medically necessary care. Cosmetic oral surgeries shall not be paid. Procedures as covered for a certified oral surgeon (or other qualified dentist specialist)

shall be indicated in the Medicaid Dental Manual. A medically necessary oral surgery procedure not specifically listed in the Medicaid Dental Manual may be billed using the procedure code identified in the dental manual as Unspecified. The Unspecified procedure must be explained on the claim form.

(N) Orthodontic Treatment/Space Management Therapy. Medically necessary minor orthodontic appliances for interceptive and oral development as listed in the Medicaid Dental Manual are covered. Fixed space maintainers are covered for the premature loss of deciduous teeth. Medically necessary orthodontic treatment and space maintainers for recipients under age twenty-one (21) is covered when indicated by an EPSDT screen and prior authorized;

(O) Periodontic Treatment. A gingivectomy or gingivolplasty is allowed for epileptic patients on Dilantin therapy, or medically necessary drug-induced hyperplasia. Limited occlusal adjustment is covered when it is necessary as emergency treatment. Other periodontic procedures are not covered;

(P) Prophylaxis (Preventive). Prophylaxis may be a covered service for the upper arch, the lower arch or both arches. Prophylaxis shall be a separate service from fluoride treatment and shall include scaling and polishing of the teeth;

(Q) Pulp Treatment (Endodontic). A pulpotomy on deciduous teeth is covered and shall include complete amputation of the vital coronal nerve, with placement of a suitable drug over the remaining exposed tissue. The fee excludes final restoration. Pulp vitality tests and pulp caps are not covered;

(R) Restorations (Fillings). Fees for any restorative care listed in the Medicaid Dental Manual apply whether the service is performed in the office, hospital, ambulatory surgical center or nursing facility. Amalgam fillings are covered for Class I, Class II and Class V restorations on posterior teeth. A maximum fee shall apply for any one (1) posterior tooth and shall include polishing, local anesthesia and treatment base. Silicate cement, acrylic or composite fillings are not covered for Class I and Class II restorations but are covered for Class III, Class IV and Class V restorations on anterior teeth. A maximum fee shall apply for any one (1) anterior tooth and shall include polishing, local anesthesia and treatment base. Fillings of other materials are not covered, except when a sedative filling is necessary as emergency treatment. X rays may be covered;

(S) Root Canal Therapy (Endodontic). Root canal therapy is a covered service for permanent teeth. The fee excludes final restoration but includes all in treatment X rays. Preoperative and postoperative X rays may be reimbursed. An apicoectomy is a covered service for permanent teeth but not on the same day as a root canal. Excluding a pulpotomy, other endodontic procedures are not covered; and

(T) X rays. X rays shall not be submitted routinely with a request for prior authorization or with a claim, unless the practitioner shall have been specifically requested to submit X rays. X rays shall be taken at the discretion of the dental practitioner. Films which are not of diagnostic value shall not be claimed. X rays to be covered shall be of the intraoral type, except when a panoramic-type film is required. A preoperative full-mouth X-ray survey of permanent or deciduous teeth, or mixed dentition, is covered as described in the Medicaid Dental Manual. Medically necessary X rays of an edentulous mouth are covered.]

[(10)] **(6)** General Regulations. General regulations of the Missouri Medicaid program apply to the dental program.

(7) Records Retention. The enrolled Medicaid dental provider shall agree to keep any records necessary to disclose the extent of services the provider furnishes to recipients. These records must be retained for five (5) years from the date of service. Fiscal and medical records coincide with and fully document services billed to the Medicaid agency. Providers must furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal or retain adequate documentation for services billed to the Medicaid program, as specified above, is a violation of this regulation.

AUTHORITY: sections 208.152, RSMo Supp. [1990] ***2004****, 208.153, [RSMo Supp. 1991] and 208.201, RSMo [Supp. 1987]* ***2000, and Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly, 2005****. This rule was previously filed as 13 CSR 40-81.040. Original rule filed Jan. 21, 1964, effective Jan. 31, 1964. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed June 15, 2005.*

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 a range of zero (0) to 28.4 million dollars annually based on the state fiscal year 2004 utilization of Medicaid Dental Program services.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-35.010 Dental Program
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would like be affected:	Estimate in the aggregate as to the count of compliance with the rule by the affected entities:
370,000 The above number is net after adjusting for eligibles who no longer qualify for Medicaid based on Senate Bill 539 provisions	All Medicaid recipients excluding eligible needy children, pregnant women, and blind persons unless physician-ordered dental services are related to trauma or a medical condition	Services will be systematically denied and providers will be not be reimbursed unless physician-ordered dental services related to trauma or a medical condition are prior authorized

III. WORKSHEET

The private cost of this proposed amendment is $28.4 million based on the state fiscal year 2004 utilization of Medicaid Dental Program services. The amount excludes payments for services for children, pregnant women and blind.

IV. ASSUMPTIONS

The proposed amendment revises the Dental Program benefit for recipients who are not Medicaid eligible needy children and for those who are not receiving Medicaid assistance through a category of assistance for pregnant women and the blind to include coverage for all dental services, unless the prior authorized, physician-ordered dental service is related to: trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury; or treatment of a medical condition without which the health of the individual would be adversely affected.

The Dental Program benefit for Medicaid eligible needy children and individuals eligible to receive Medicaid under a category of assistance for pregnant women and the blind will remain unchanged and includes coverage for all dental services.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 60—Durable Medical Equipment Program

PROPOSED AMENDMENT

13 CSR 70-60.010 Durable Medical Equipment Program. The Division of Medical Services is amending the Purpose and sections (1), (2), (6), and (8).

PURPOSE: This amendment eliminates coverage of certain items of durable medical equipment for individuals who are not Medicaid eligible needy children or receiving Medicaid under a category of assistance for pregnant women or the blind.

*PURPOSE: This rule establishes the regulatory basis for the administration of the Medicaid durable medical equipment program, designation of professional persons who may dispense durable medical equipment and the method of reimbursement for durable medical equipment. This rule provides for such methods and procedures relating to the utilization of, and the payment for, care and services available under the Medicaid program as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. Specific details of the conditions for provider participation, criteria and methodology of provider reimbursement, recipient eligibility and amount, duration and scope of services covered are included in the durable medical equipment provider program manual which is incorporated by reference in this rule and available at the website [www.medicaid.state.mo.us] **www.dss.mo.gov/dms**.*

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) Administration. The Medicaid durable medical equipment (DME) program shall be administered by the Department of Social Services, Division of Medical Services. The services and items covered and not covered, the program limitations and the maximum allowable fees for all covered services shall be determined by the Department of Social Services, Division of Medical Services and shall be included in the DME provider manual, which is incorporated by reference *[in]* **and made a part of** this rule *[and available through]* **as published by** the Department of Social Services, Division of Medical Services**, 615 Howerton Cout, Jefferson City, MO 65102, at its** website at *[www.medicaid.state.mo.us. The division reserves the right to affect changes in services, limitations and fees with notification to DME providers.]* **www.dss.mo.gov/dms, July 15, 2005. This rule doees not incorporate any subsequent amendments or additions.**

(2) Persons Eligible. Any person who is eligible for Title XIX benefits as determined by the **Family Support** Division *[of Family Services]* is eligible for DME when the DME is medically necessary as determined by the treating physician or advanced practice nurse in a collaborative practice arrangement. **Covered services are limited as specified in section (6) of this rule.**

(6) Covered Services. It is the provider's responsibility to determine the coverage benefits for a Medicaid eligible recipient based on his or her type of assistance as outlined in the DME manual. Reimbursement will be made to qualified participating DME providers only for DME items, determined by the recipient's treating physician or advanced practice nurse in a collaborative practice arrangement to be medically necessary*[, and]*. **Covered services include the following items: prosthetics, excluding an artificial larynx; ostomy supplies; diabetic supplies and equipment; oxygen and respiratory equipment, excluding CPAPs, BiPAPs, nebulizers, IPPB machines, humidification items, suction pumps and apnea monitors; and wheelchairs, excluding wheelchair accessories and scooters. Covered services for Medicaid eligible needy children or persons receiving Medicaid under a category of assistance for pregnant women or the blind** shall include but not be limited to: prosthetics; orthotics; oxygen and respiratory care equipment; parenteral nutrition; ostomy supplies; **diabetic supplies and equipment; decubitus care equipment;** wheelchairs; **wheelchair accessories and scooters;** augmentative communication devices; and hospital beds. Specific procedure codes that are covered under the DME program are listed in Section 19 of the DME provider manual, which is incorporated by reference *[in]* **and made a part of** this rule **as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website at www.dss.mo.gov/dms, July 15, 2005. This rule does not incorporate any subsequent amendment or additions**. These items must be for use in the recipient's home when ordered in writing by the recipient's physician or advanced practice nurse in a collaborative practice arrangement. Although an item is classified as DME, it may not be covered in every instance. Coverage is based on the fact that the item is reasonable and necessary for treatment of the illness or injury, or to improve the functioning of a malformed or permanently inoperative body part and the equipment meets the definition of DME. Even though a DME item may serve some useful, medical purpose, consideration must be given by the physician or advanced practice nurse in a collaborative arrangement and the DME supplier to what extent, if any, it is reasonable for Medicaid to pay for the item as opposed to another realistically feasible alternative pattern of care. Consideration should be given by the physician or advanced practice nurse in a collaborative practice arrangement and the DME supplier as to whether the item serves essentially the same purpose as equipment already available to the recipient. If two (2) different items each meet the need of the recipient, the less expensive item must be employed, all other conditions being equal.

(8) Durable medical equipment for recipients who are in a nursing facility or inpatient hospital. DME is not covered for those recipients residing in a nursing home. DME is included in the nursing home per diem rate and not paid for separately with the exception of *[augmentative communication devices,]* custom and power wheelchairs, *[orthotic and]* prosthetic devices, *[total parenteral nutrition,]* and volume ventilators. DME that is used while the recipient is in inpatient hospital care is not paid for separately under the DME program. These costs are recognized as part of the hospital's inpatient per diem rate.

AUTHORITY: sections 208.153 and 208.201, RSMo 2000. Original rule filed Nov. 1, 2002, effective April 30, 2003. Amended: Filed June 15, 2005.

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 a range of zero (0) to 24.9 million dollars annually based on utilization.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice, in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-60.010 Durable Medical Equipment Program
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the count of compliance with the rule by the affected entities:
370,000 The above number is net after adjusting for eligibles who no longer qualify for Medicaid based on Senate Bill 539 provisions	All Medicaid recipients excluding eligible needy children, pregnant women, and blind persons	Services will be systematically denied and providers will not be reimbursed

III. WORKSHEET

The private cost of this proposed amendment is $24.9 million based on the state fiscal year 2004 utilization of Medicaid Durable Medical Equipment Program services. The amount excludes payments for services for children, pregnant women and blind.

IV. ASSUMPTIONS

The proposed amendment revises the Durable Medical Equipment Program benefit for recipients who are not Medicaid eligible needy children and for those who are not receiving Medicaid assistance through a category of assistance for pregnant women and the blind to include coverage of the following items: prosthetics excluding an artificial larynx; ostomy supplies; diabetic supplies and equipment; oxygen and respiratory equipment excluding CPAPs, BiPAPs, nebulizers, IPPB machines, humidification items, suction pumps and apnea monitors; and wheelchairs excluding wheelchair accessories and scooters.

The Durable Medical Equipment Program benefit for Medicaid eligible needy children and individuals eligible to receive Medicaid under a category of assistance for pregnant women and the blind will remain unchanged and includes but is not limited coverage of the following items: prosthetics; orthotics; oxygen and respiratory care equipment; parenteral nutrition; ostomy supplies; diabetic supplies and equipment, decubitus care equipment, wheelchairs, wheelchair accessories and scooters; augmentative communication devices; and hospital beds.

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

PROPOSED AMENDMENT

19 CSR 60-50.430 Application Package. The Committee proposes to amend paragraph (4)(C)1. and section (6).

PURPOSE: This rule is amended because the Missouri CON Rulebook has been updated to include the 2010 population projections just released that are necessary to incorporate five (5)-year planning horizons.

(4) The Proposal Description shall include documents which:

(C) Proposals for new hospitals, new or additional long-term care (LTC) beds, or new major medical equipment must define the community to be served:

1. Describe the service area(s) population using year *[2005]* **2010** populations and projections which are consistent with those provided by the Bureau of Health Data Analysis which can be obtained by contacting:

Chief, Bureau of Health Data Analysis
Center for Health Information Management and Evaluation (CHIME)
Department of Health and Senior Services
PO Box 570, Jefferson City, MO 65102
Telephone: (573) 751-6278

There will be a charge for any of the information requested, and seven to fourteen (7–14) days should be allowed for a response from the CHIME. Information requests should be made to CHIME such that the response is received at least two (2) weeks before it is needed for incorporation into the CON application.

2. Use the maps and population data received from CHIME with the CON Applicant's Population Determination Method to determine the estimated population, as follows:

A. Utilize all of the population for zip codes entirely within the fifteen (15)-mile radius for LTC beds or geographic service area for hospitals and major medical equipment;

B. Reference a state highway map (or a map of greater detail) to verify population centers (see Bureau of Health Data Analysis information) within each zip code overlapped by the fifteen (15)-mile radius or geographic service area;

C. Categorize population centers as either "in" or "out" of the fifteen (15)-mile radius or geographic service area and remove the population data from each affected zip code categorized as "out";

D. Estimate, to the nearest ten percent (10%), the portion of the zip code area that is within the fifteen (15)-mile radius or geographic service area by "eyeballing" the portion of the area in the radius (if less than five percent (5%), exclude the entire zip code);

E. Multiply the remaining zip code population (total population less the population centers) by the percentage determined in (4)(C)2.D. (due to numerous complexities, population centers will not be utilized to adjust overlapped zip code populations in Jackson, St. Louis, and St. Charles counties or St. Louis City; instead, the total population within the zip code will be considered uniform and multiplied by the percentage determined in (4)(C)2.D.);

F. Add back the population center(s) "inside" the radius or region for zip codes overlapped; and

G. The sum of the estimated zip codes, plus those entirely within the radius, will equal the total population within the fifteen (15)-mile radius or geographic service area.

3. Provide other statistics, such as studies, patient origin or discharge data, Hospital Industry Data Institute's information, or consultants' reports, to document the size and validity of any proposed user-defined "geographic service area";

(6) The most current version of Forms MO 580-2501, MO 580-2502, MO 580-2503, MO 580-2504, MO 580-2505, MO 580-1861, MO 580-1869 and MO 580-1863 may be obtained by mailing a written request to the Certificate of Need Program (CONP), 915G Leslie Boulevard, Jefferson City, MO 65101, or in person at the CONP Office, or, if technically feasible, by downloading a copy of the forms from the CONP website at *[www.dhss.state.mo.us/con]* **www.dhss.mo.gov/con**.

AUTHORITY: section 197.320, RSMo 2000. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed June 8, 2005, effective July 1, 2005, expires Dec. 30, 2005. Amended: Filed June 8, 2005.*

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed amendment with Thomas R. Piper, Director, Certificate of Need Program, 915G Leslie Blvd., Jefferson City, MO 65101. To be considered, comments must be received by 12:00 p.m.(noon) on August 15, 2005. A public hearing has been scheduled for August 15, 2005, at 10:00 a.m. at the Certificate of Need Program Office located at 915G Leslie Blvd., Jefferson City, Missouri.

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

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

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-7.431 is amended.

This rule establishes seasons and limits for deer hunting and is excepted by section 536.021, RSMo from the requirement for filing as a proposed amendment.

The Department of Conservation amended 3 CSR 10-7.431 by changing provisions for hunting deer.

3 CSR 10-7.431 Deer Hunting Seasons: General Provisions

PURPOSE: This amendment establishes general provisions for hunting deer and updates the annual Fall Deer and Turkey Hunting Regulations and Information booklet.

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 annual *Fall Deer & Turkey Hunting Regulations and Information* booklet for 2005 is hereby adopted as a part of this Code and by this reference herein incorporated. A printed copy of this booklet can be obtained from the Missouri Department of Conservation, PO Box 180, Jefferson City, MO 65102-0180 and is online at www.missouriconservation.org. This rule does not incorporate any subsequent amendments or additions.

(2) Deer shall mean white-tailed deer and mule deer. Antlered deer shall mean deer with at least one (1) antler at least three inches (3") long, except as provided in 3 CSR 10-7.435. Deer may be pursued, taken, killed, possessed or transported only as permitted in this Code.

(3) Persons hunting or pursuing deer must possess a prescribed deer hunting permit. Resident landowners and lessees can qualify for no-cost permits; nonresident landowners can qualify for reduced-cost permits.

(4) Deer may be pursued or taken only from one-half (1/2) hour before sunrise until one-half (1/2) hour after sunset.

(5) Deer Hunting Methods.

(A) Archery: longbows and compound bows.

(B) Muzzleloader: muzzleloading or cap-and-ball firearms, .40 caliber or larger, not capable of being loaded from the breech.

(C) Any legal method: archery and muzzleloader methods; crossbows; shotguns; handguns or rifles firing centerfire ammunition.

(D) Prohibited, in use or possession:

1. Methods restricted by local ordinance.

2. Self-loading firearms with capacity of more than eleven (11) cartridges in magazine and chamber combined.

3. Ammunition propelling more than one (1) projectile at a single discharge, such as buckshot.

4. Full hard metal case projectiles.

5. Fully automatic firearms.

(6) Deer may not be hunted, pursued, taken or killed:

(A) While in a stream or other body of water.

(B) From a boat with a motor attached.

(C) With the aid of a motor-driven land conveyance or aircraft.

(D) With the aid of dogs, in use or possession.

(E) With the aid of artificial light or night vision equipment.

(F) Within any area enclosed by a fence greater than seven feet (7') in height that could contain or restrict the free range of deer. Exceptions are provided in other rules or by written authorization of the director.

(G) With the aid of bait (grain or other feed placed or scattered so as to constitute an attraction or enticement to deer). Scents and minerals, including salt, are not regarded as bait. An area is considered baited for ten (10) days following complete removal of bait. Hunters can be in violation even if they did not know an area was baited. It is illegal to place bait in a way that causes others to be in violation of the baiting rule.

(7) During the firearms deer hunting season and during managed firearms deer hunts on those areas where such hunts are held, all persons hunting any game and also adults accompanying youths hunting deer on a Youth Deer and Turkey Hunting Permit, must wear a hat and a shirt, vest, or coat of the color commonly known as hunter orange, which must be plainly visible from all sides. The following are exempt from this requirement:

(A) Migratory game bird hunters;

(B) Archery permittees during the muzzleloader portion;
(C) All hunters in counties closed during the urban counties and antlerless portions;
(D) Hunters using archery methods while hunting within municipal boundaries where discharge of firearms is prohibited;
(E) Hunters on federal or state public hunting areas and during managed hunts where deer hunting is restricted to archery or crossbow methods; and
(F) Hunters of small game and/or furbearers during the muzzleloader portion.

(8) Hunters who kill or injure a deer must make a reasonable effort to retrieve and tag it, but this does not authorize trespass.

(9) Hunters who take a deer must tag it immediately with the transportation tag portion of the permit; detaching the transportation tag voids the permit. All deer taken must be accurately reported through the Telecheck Harvest Reporting System by 10:00 p.m. on the day taken by the taker or in the taker's immediate presence. The Telecheck confirmation number must be recorded immediately on the deer hunting permit as indicated on the permit, and immediately attached to the deer by the taker. The transportation tag and deer hunting permit with confirmation number must remain attached to the intact or field-dressed carcass until the deer is processed. All deer must be reported through the Telecheck Harvest Reporting System prior to being removed from the state.

(10) Deer (or parts thereof) reported in accordance with established procedures, when labeled with the full name, address, and confirmation number of the taker, may be possessed, transported, and stored by anyone. Commercially processed deer meat may be donated to not-for-profit charitable organizations under guidelines established by the director.

SUMMARY OF PUBLIC COMMENT: Seasons and limits are excepted from the requirement of filing as a proposed amendment under section 536.021, RSMo.

This amendment filed June 8, 2005, effective **July 15, 2005**.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-7.432 is amended.

This rule establishes seasons and limits for deer hunting and is excepted by section 536.021, RSMo from the requirement for filing as a proposed amendment.

The Department of Conservation amended 3 CSR 10-7.432 by changing provisions for hunting deer.

3 CSR 10-7.432 Deer: Archery Hunting Season

PURPOSE: This amendment changes the archery deer hunting season, limits and provisions for hunting.

(1) The archery deer hunting season is September 15, 2005, through January 15, 2006, excluding the November portion of the firearms deer hunting season. Use archery methods only; firearms may not be possessed.

(2) Archery Deer Hunting Permits.
(A) Resident or Nonresident Archer's Hunting Permit. Valid for two (2) deer statewide, except that only one (1) antlered deer may be taken prior to the November portion of the firearms deer hunting season.
(B) Resident or Nonresident Archery Antlerless Deer Hunting Permit. Valid for one (1) antlerless deer in any open county. Persons may purchase and fill any number of these permits, where valid. A Nonresident Archer's Hunting Permit must be purchased before purchasing Nonresident Archery Antlerless Deer Hunting Permits.

SUMMARY OF PUBLIC COMMENT: Seasons and limits are excepted from the requirement of filing as a proposed amendment under section 536.021, RSMo.

This amendment filed June 8, 2005, effective **July 15, 2005**.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-7.433 is amended.

This rule establishes seasons and limits for deer hunting and is excepted by section 536.021, RSMo from the requirement for filing as a proposed amendment.

The Department of Conservation amended 3 CSR 10-7.433 by changing provisions for hunting deer.

3 CSR 10-7.433 Deer: Firearms Hunting Seasons

PURPOSE: This amendment establishes the firearms deer hunting seasons, limits and provisions for hunting.

(1) The firearms deer hunting season is comprised of five (5) portions.
(A) Urban counties portion: October 7 through 10, 2005; use any legal deer hunting method to take antlerless deer in open counties.
(B) Youth portion: October 29 and 30, 2005; for persons at least six (6) but not older than fifteen (15) years of age and qualifying landowner or lessee youth age fifteen (15) and younger; use any legal deer hunting method to take one (1) deer statewide.
(C) November portion: November 12 through 22, 2005; use any legal deer hunting method to take deer statewide.
(D) Muzzleloader portion: November 25 through December 4, 2005; use muzzleloader methods to take deer statewide.
(E) Antlerless portion: December 10 through 18, 2005; use any legal deer hunting method to take antlerless deer in open counties.

(2) Firearms Deer Hunting Permits.
(A) Youth Deer and Turkey Hunting Permit: for persons at least six (6) but not older than fifteen (15) years of age; valid for one (1) deer statewide, except that only antlerless deer may be taken during the urban counties and antlerless portions of the season.
(B) Resident or Nonresident Firearms Any-Deer Hunting Permit: valid for one (1) deer statewide, except that only antlerless deer may

be taken during the urban counties and antlerless portions of the season.

(C) Resident or Nonresident Firearms Antlerless Deer Hunting Permit: valid for one (1) antlerless deer in any open county. Persons may purchase any number of these permits and fill them where valid. A Nonresident Firearms Any-Deer Hunting Permit must be purchased before purchasing Nonresident Firearms Antlerless Deer Hunting Permits.

(3) A person may take only one (1) antlered deer during the firearms deer hunting season. Deer taken at managed deer hunts are not included in this limit.

(4) Other wildlife may be hunted during the firearms deer hunting season with the following restrictions:

(A) During the November portion statewide and the antlerless portion in open counties, other wildlife may be hunted only with pistol, revolver, or rifle firing a rimfire cartridge .22 caliber or smaller or a shotgun and shot not larger than No. 4; except that waterfowl hunters, trappers, landowners on their land or lessees on land upon which they reside may use other methods as specified in 3 CSR 10-7.410(1)(G).

(B) Furbearers may be hunted using any legal deer hunting method during established furbearer hunting seasons by persons holding an unfilled Firearms Deer Hunting Permit, and:

1. A Resident Small Game Hunting Permit; or
2. A Nonresident Furbearer Hunting and Trapping Permit.

(C) Furbearers may not be chased, pursued, or taken with the aid of dogs during daylight hours from November 1 through the end of the November portion statewide and the antlerless portion in open counties.

(D) Squirrels and rabbits may not be chased, pursued, or taken with the aid of dogs during daylight hours of the November portion in Butler, Carter, Dent, Iron, Madison, Oregon, Reynolds, Ripley, Shannon, and Wayne counties.

(5) Feral hogs, defined as any hog, including Russian and European wild boar, not conspicuously identified by ear tags or other forms of identification and roaming freely on public or private lands without the landowner's permission (refer to section 270.400 of *Missouri Revised Statutes*), may be taken in any number during the firearms deer hunting season as follows:

(A) Hunters must possess a valid small game hunting or unfilled firearms deer hunting permit and abide by the methods of pursuit allowed for deer as well as any other restrictions that may apply on specific public areas.

(B) During the November portion statewide and the antlerless portion in open counties:

1. Firearms deer permittees may only use methods allowed for deer.
2. Small game permittees may only use pistol, revolver, or rifle firing a rimfire cartridge .22 caliber or smaller or a shotgun with shot not larger than No. 4.
3. Dogs may not be used.

(C) During the youth and muzzleloader portions statewide and the urban counties portion in open counties:

1. Deer permittees may only use methods allowed for deer.
2. Small game permittees may only use methods allowed for small game.

(D) Resident landowners and lessees on qualifying land are not required to have any permit and may use any method to take feral hogs throughout the year.

SUMMARY OF PUBLIC COMMENT: Seasons and limits are excepted from the requirement of filing as a proposed amendment under section 536.021, RSMo.

This amendment filed June 8, 2005, effective **July 15, 2005**.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-7.434 is amended.

This rule establishes seasons and limits for deer hunting and is excepted by section 536.021, RSMo from the requirement for filing as a proposed amendment.

The Department of Conservation amended 3 CSR 10-7.434 by changing provisions for hunting deer.

3 CSR 10-7.434 Deer: Landowner Privileges

PURPOSE: This amendment establishes season limits and provisions for landowners.

(1) Resident landowners and lessees as defined in 3 CSR 10-20.805 can obtain no-cost deer hunting permits from any permit vendor. When requesting such permits, landowners must specify the number of acres owned and county of ownership.

(A) Those with five (5) or more continuous acres can each receive one (1) Resident Landowner Firearms Any-Deer Hunting Permit, one (1) Resident Landowner Archer's Hunting Permit, and two (2) Resident Landowner Archery Antlerless Deer Hunting Permits.

(B) In addition to the permits listed in subsection (1)(A), those with seventy-five (75) or more acres located in a single county or at least seventy-five (75) continuous acres bisected by a county boundary can receive a maximum of two (2) Resident Landowner Firearms Antlerless Deer Hunting Permits. Landowners with at least seventy-five (75) acres in more than one county must comply with landowner antlerless deer limits for each county.

(2) Nonresident landowners as defined in 3 CSR 10-20.805 may apply to purchase reduced-cost Nonresident Landowner Archery and Firearms Deer Hunting Permits.

(3) All landowner deer hunting permits are valid only on qualifying property.

(4) All landowners and lessees who take deer on landowner permits may also purchase and fill other deer hunting permits but must abide by seasons, limits, and restrictions.

(5) Persons defined as landowners include:

(A) General partners of partnerships;

(B) Officers of resident or foreign corporations;

(C) Officers or managing members of resident limited liability companies; and

(D) Officers of benevolent associations organized pursuant to Chapter 352 of the *Revised Statutes of Missouri*.

SUMMARY OF PUBLIC COMMENT: Seasons and limits are excepted from the requirement of filing as a proposed amendment under section 536.021, RSMo.

This amendment filed June 8, 2005, effective **July 15, 2005**.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-7.437 is amended.

This rule establishes seasons and limits for deer hunting and is excepted by section 536.021, RSMo from the requirement for filing as a proposed amendment.

The Department of Conservation amended 3 CSR 10-7.437 by changing provisions for hunting deer.

3 CSR 10-7.437 Deer: Antlerless Deer Hunting Permit Availability

PURPOSE: This amendment changes the title of the rule and establishes deer harvest limits by county.

(1) Archery Deer Hunting Season.

(A) Resident and Nonresident Archery Antlerless Deer Hunting Permits are not valid in the counties of: Bollinger, Butler, Cape Girardeau, Carter, Dunklin, Iron, Madison, Mississippi, New Madrid, Pemiscot, Reynolds, Scott, Stoddard, and Wayne.

(2) Firearms Deer Hunting Season.

(A) Resident and Nonresident Firearms Antlerless Deer Hunting Permits are not valid in the counties of: Bollinger, Butler, Cape Girardeau, Carter, Dunklin, Iron, Madison, Mississippi, New Madrid, Pemiscot, Reynolds, Scott, Stoddard, and Wayne.

(B) Only one (1) Resident or Nonresident Firearms Antlerless Deer Hunting Permit per person may be filled in the counties of: Crawford, Dent, Douglas, Franklin, Gasconade, Jefferson, Maries, Osage, Ozark, Perry, Phelps, Pulaski, Ripley, Shannon, St. Francois, Ste. Genevieve, Taney, Texas, and Washington.

(C) Any number of Resident or Nonresident Firearms Antlerless Deer Hunting Permits may be filled in the counties of: Adair, Andrew, Atchison, Audrain, Barry, Barton, Bates, Benton, Boone, Buchanan, Caldwell, Callaway, Camden, Carroll, Cass, Cedar, Chariton, Christian, Clark, Clay, Clinton, Cole, Cooper, Dade, Dallas, Daviess, DeKalb, Gentry, Greene, Grundy, Harrison, Henry, Hickory, Holt, Howard, Howell, Jackson, Jasper, Johnson, Knox, Laclede, Lafayette, Lawrence, Lewis, Lincoln, Linn, Livingston, McDonald, Macon, Marion, Mercer, Miller, Moniteau, Monroe, Montgomery, Morgan, Newton, Nodaway, Oregon, Pettis, Pike, Platte, Polk, Putnam, Ralls, Randolph, Ray, St. Charles, St. Clair, St. Louis, Saline, Schuyler, Scotland, Shelby, Stone, Sullivan, Vernon, Warren, Webster, Worth, and Wright.

SUMMARY OF PUBLIC COMMENT: Seasons and limits are excepted from the requirement of filing as a proposed amendment under section 536.021, RSMo.

This amendment filed June 8, 2005, effective **July 15, 2005**.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-7.438 is amended.

This rule establishes seasons and limits for deer hunting and is excepted by section 536.021, RSMo from the requirement for filing as a proposed amendment.

The Department of Conservation amended 3 CSR 10-7.438 by changing provisions for hunting deer.

3 CSR 10-7.438 Deer: Regulations for Department Areas

PURPOSE: This amendment updates the annual Fall Deer and Turkey Hunting Regulations and Information booklet.

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.

Deer may be hunted on lands owned or leased by the department and on lands managed by the department under cooperative agreement as authorized in the annual *Fall Deer and Turkey Hunting Regulations and Information* booklet for 2005. This publication is incorporated by reference. A copy of this booklet is published by and can be obtained from the Missouri Department of Conservation, PO Box 180, Jefferson City, MO 65102-0180. It is also available online at www.missouriconservation.org. This rule does not incorporate any subsequent amendments or additions.

SUMMARY OF PUBLIC COMMENT: Seasons and limits are excepted from the requirement of filing as a proposed amendment under section 536.021, RSMo.

This amendment filed June 8, 2005, effective **July 15, 2005**.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-7.455 is amended.

This amendment relates to checking requirements for hunting seasons and is excepted by section 536.021, RSMo from the requirement for filing as a proposed amendment.

The Department of Conservation amended 3 CSR 10-7.455 by establishing provisions for hunting seasons for turkey during the 2005 season.

3 CSR 10-7.455 Turkeys: Seasons, Methods, Limits

PURPOSE: This amendment clarifies checking requirements.

(2) Hunters who take a turkey must tag it immediately with the transportation tag portion of the permit; detaching the transportation tag voids the permit. All turkeys taken must be accurately reported through the Telecheck Harvest Reporting System by 10:00 p.m. on the day taken by the taker or in the taker's immediate presence. The Telecheck confirmation number must be recorded immediately on the turkey hunting permit as indicated on the permit, and immediately attached to the turkey by the taker. The transportation tag and turkey hunting permit with confirmation number must remain attached to the turkey with the head and plumage intact until the turkey is processed. All turkeys must be reported through the Telecheck Harvest Reporting System prior to being removed from the state.

(5) A resident landowner or lessee as defined in 3 CSR 10-20.805, possessing a landowner turkey hunting permit, may take and possess turkeys in accordance with this rule on his/her land or, in the case of the lessee, on the land on which s/he resides and shall report the turkeys through the Telecheck Harvest Reporting System as required in this rule.

(7) Turkeys (or parts thereof) reported in accordance with established procedures, when labeled with the full name, address, and confirmation number of the taker, may be possessed, transported, given away, and stored by anyone.

SUMMARY OF PUBLIC COMMENT: Seasons and limits are excepted from the requirement of filing as a proposed amendment under section 536.021, RSMo.

This amendment filed June 8, 2005, effective **July 15, 2005**.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under sections 332.031, RSMo 2000 and 332.181, RSMo Supp. 2004, the board adopts a rule as follows:

4 CSR 110-2.071 License Renewal—Dentists and Dental Hygienists **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on April 1, 2005 (30 MoReg 609–612). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under sections 332.031, RSMo 2000 and 332.171.2, RSMo Supp. 2004, the board rescinds a rule as follows:

4 CSR 110-2.090 Certification of Dental Specialists **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on April 1, 2005 (30 MoReg 613). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under sections 332.031, RSMo 2000 and 332.171.2, RSMo Supp. 2004, the board adopts a rule as follows:

4 CSR 110-2.090 Certification of Dental Specialists **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on April 1, 2005 (30 MoReg 613–615). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under section 332.031.3, RSMo 2000, the board amends a rule as follows:

4 CSR 110-2.170 Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 616). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 110—Missouri Dental Board
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Dental Board under sections 332.031, RSMo 2000 and 332.181 and 332.261, RSMo Supp. 2004, the board amends a rule as follows:

4 CSR 110-2.240 Continuing Dental Education **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 616–618). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 2—Licensing of Physicians and Surgeons

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.090.2, and 334.125, RSMo 2000, the board adopts a rule as follows:

4 CSR 150-2.153 Reinstatement of an Inactive License **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on April 1, 2005 (30 MoReg 619–621). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 3—Licensing of Physical Therapists and Physical Therapist Assistants

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.125, 334.570 and 334.675, RSMo 2000, the board amends a rule as follows:

4 CSR 150-3.060 Biennial Registration **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 622). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.125, RSMo 2000 and 334.706.3(2), RSMo Supp. 2004, the board rescinds a rule as follows:

4 CSR 150-6.010 Definitions **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on April 1, 2005 (30 MoReg 622). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.125, RSMo 2000 and 334.706.3(2), RSMo Supp. 2004, the board adopts a rule as follows:

4 CSR 150-6.010 Definitions **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on April 1, 2005 (30 MoReg 622–623). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.125, RSMo 2000 and 334.702, 334.704, 334.706, 334.708, 334.710 and 334.712, RSMo Supp. 2004, the board amends a rule as follows:

4 CSR 150-6.020 Applicants for Licensure as Athletic Trainers **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005

(30 MoReg 623–624). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under section 334.706, RSMo Supp. 2004, the board amends a rule as follows:

4 CSR 150-6.025 Examination **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 624). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.125, RSMo 2000 and 334.702, 334.704, 334.706, 334.708, 334.710 and 334.712, RSMo Supp. 2004, the board amends a rule as follows:

4 CSR 150-6.030 Licensure by Reciprocity **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 624–625). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.125, RSMo 2000 and 334.702, 334.704, 334.706, 334.708, 334.710 and 334.712, RSMo Supp. 2004, the board amends a rule as follows:

4 CSR 150-6.040 Code of Ethics **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 625). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.125, RSMo 2000 and 334.706.3(2), RSMo Supp. 2004, the board amends a rule as follows:

4 CSR 150-6.050 Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 625). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.125, RSMo 2000 and 334.706 and 334.710, RSMo Supp. 2004, the board amends a rule as follows:

4 CSR 150-6.060 Renewal of Licensure **is amended**.

A notice of the proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 625–626). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under section 334.706, RSMo Supp. 2004, the board amends a rule as follows:

4 CSR 150-6.070 Name and/or Address Changes **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 626). 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 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 7—Licensing of Physician Assistants

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under section 334.735.1(8), RSMo 2000, the board amends a rule as follows:

4 CSR 150-7.135 Physician Assistant Supervision Agreements **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 626–627). 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 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership and Benefits

ORDER OF RULEMAKING

By the authority vested in the County Employees' Retirement Board under section 50.1032, RSMo 2000, the board amends a rule as follows:

16 CSR 50-2.110 Rehires **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2005 (30 MoReg 647). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

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

EXPEDITED APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. A decision is tentatively scheduled for July 22, 2005.These applications are available for public inspection at the address shown below:

Date Filed

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

06/10/05

#3780 RP: Waterford Ladies Home
Blue Springs (Jackson County)
$364,462, Long-term care bed expansion through the purchase of 7 residential care facility II beds from Carmel Hills Living Center, Independence (Jackson County)

#3784 NS: Life Care Center of Bridgeton
St. Louis (St. Louis County)
$4,085,000, Renovate/modernize facility

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 July 13, 2005. All written requests and comments should be sent to:

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
915 G Leslie Boulevard
Jefferson City, MO 65101

For additional information contact
Donna Schuessler, 573-751-6403.