Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 75—Peace Officer Standards and Training Program
Chapter 1—Administration

PROPOSED AMENDMENT

11 CSR 75-1.010 General Organization. The department is amending the Authority.

PURPOSE: The purpose of this amendment is to change the Authority.

*AUTHORITY: sections [590.110, RSMo Supp. 2003] **590.020, 590.030, 590.040, 590.050, 590.060, 590.120, and 590.190, RSMo Supp. 2007**. Original rule filed Aug. 12, 1980, effective Nov. 13, 1980. For intervening history, please consult the **Code of State Regulations**. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 2—Definitions

PROPOSED AMENDMENT

11 CSR 75-2.010 Definitions. The department is amending subsection (1)(B) and the Authority.

PURPOSE: This amendment further defines a high school program of education. The amendment also corrects the acronym GED and identifies that on-line or computer-based high school programs are not accepted by the Peace Officer and Standards Training Program as a high school program of education.

(1) For the purposes of 11 CSR 75:

(B) The term "high school diploma or its equivalent" shall mean any of the following:

1. A high school diploma from an attendance-based, accredited high school*[;]* **and not an on-line or computer-based high school program;**

2. A General Education *[Diploma]* **Development** (GED) **certificate**;

[3. Valid admission by an accredited college or university or substantial evidence of eligibility for admission by an accredited college or university; or]

3. A diploma from a high school program of education under Chapter 167, RSMo; or

4. Passage of the United States Military Armed Services Vocational Aptitude Battery Exam. In addition to passing the exam, the applicant must obtain a score on the exam that would qualify them for a position as a military peace officer.

*AUTHORITY: section [590.120, RSMo Supp. 2001] **590.190, RSMo Supp. 2007**. Original rule filed Aug. 12, 1980, effective Nov. 13, 1980. For intervening history, please consult the **Code of State Regulations**. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

PROPOSED AMENDMENT

11 CSR 75-13.010 Classification of Peace Officer Licenses. The department is amending subsections (1)(E) through (G) and the Authority.

PURPOSE: This amendment removes the license classification A-PC. The Missouri Police Corps lost all federal funding and is no longer in existence. This amendment also reflects a Class D license, which had to be developed pursuant to section 590.040.1(5), RSMo.

(1) Every peace officer license shall be classified according to the type of commission for which it is valid:

[(E) Class A-PC. Valid for any commission, except commission with the Missouri State Highway Patrol, the Missouri State Water Patrol, and the Missouri Conservation Commission. Must be a graduate of the Missouri Police Corps.]

*[(F)]***(E)** Class B. Valid for any commission, except commission by a first class county with a charter form of government, a political subdivision located within a first class county with a charter form of government, a city not within a county, the Missouri State Highway Patrol, the Missouri State Water Patrol, or the Missouri Conservation Commission.

*[(G)]***(F)** Class C. Valid only for commission within a third class county pursuant to section 590.040.1(4), RSMo and only for the particular commission held by the licensee on July 1, 2002, or a commission that the director has determined to be similar pursuant to section 590.040.2, RSMo.

(G) Class D. Valid only for commission as a reserve peace officer within a county having more than one (1) million inhabitants and with either a charter form of government or of the first classification pursuant to section 590.040.1(5), RSMo.

*AUTHORITY: sections [590.020.2, 590.030.6, and 590.040.2] **590.020, 590.030, 590.040, and 590.190**, RSMo Supp. [2004] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed April 25, 2003, effective Oct. 30, 2003. Amended: Filed Aug. 2, 2004, effective Jan. 30, 2005. Amended: Filed Nov. 1, 2004, effective April 30, 2005. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

PROPOSED AMENDMENT

11 CSR 75-13.020 Procedure to Obtain New Peace Officer License. The department is adding subsection (3)(D), amending subsections (3)(B) and (C) and section (5), adding a new section (6), renumbering the remaining sections, amending the newly numbered section (8), and amending the Authority.

PURPOSE: This amendment reflects a Class D license, which had to be developed pursuant to section 590.040.1(5), RSMo. This amendment also reflects our current requirement that all applicants be fingerprinted by way of the live-scan method as approved by the Criminal Records Division of the Missouri State Highway Patrol. Therefore, fingerprint cards no longer need to be submitted.

(3) An applicant must demonstrate qualification for a particular class of peace officer license by one (1) of the following methods:

(B) Graduation from a federal, military, or out-of-state basic training course recognized by the Director pursuant to 11 CSR 75-13.070 as qualifying the trainee for particular class of license; *[or]*

(C) Qualification for a particular class of license on the Veteran Peace Officer Point Scale pursuant to 11 CSR 75-13.060*[.]*; **or**

(D) Qualification for a class D license pursuant to section 590.040.1(5), RSMo.

(5) An applicant shall submit **a peace officer license application** to the Director*[:]*.

[(A) A peace officer license application; and

(B) Two (2) fingerprint cards for state and federal criminal history background checks, for which the Director may charge a cost-equivalent fee.]

(6) The applicant shall submit to being fingerprinted in a manner approved by the Missouri State Highway Patrol pursuant to section 43.543, RSMo, to determine if the applicant has a criminal history record on file with the Missouri criminal records repository or the Federal Bureau of Investigation. The fee associated with being fingerprinted in this manner shall be the responsibility of the applicant.

*[(6)]***(7)** The Director shall examine the qualifications of each applicant and determine whether the applicant has met all requirements for licensing, including the requirements of section 590.100, RSMo. The Director may investigate or request additional information from an applicant pursuant to section 590.110.1, RSMo.

*[(7)]***(8)** The applicant shall achieve a qualifying score on the Missouri Peace Officer License Exam (MPOLE), except that an applicant for a class R **and a class D** license shall not take the MPOLE.

*[(8)]***(9)** The Director shall grant the appropriate license or deny the applicant's request to be licensed. An applicant aggrieved by the decision of the Director may appeal pursuant to section 590.100.3, RSMo.

*AUTHORITY: sections [590.030.2 and 590.030.4] **590.020, 590.030, and 590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed Oct. 31, 2002, effective April 30, 2003. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

PROPOSED AMENDMENT

11 CSR 75-13.030 Procedure to Upgrade Peace Officer License Classification. The department is amending subsection (1)(C), section (2), and the Authority.

PURPOSE: This amendment corrects a typographical error. This amendment further reflects the fact that the POST Commission increased the minimum number of basic training hours from four hundred seventy (470) to six hundred (600). Therefore, a Class B peace officer license can no longer be obtained from a basic training center.

(1) A peace officer may qualify to upgrade the officer's license from its current class to a new class in any of three (3) ways:

(C) Qualification for the new class on the Veteran Peace Officer Point Scale pursuant to *[11 CSR 75-14.060.]* **11 CSR 75-13.060.**

(2) Individuals with a Class R license who attend an upgrade basic training course to obtain a Class *[B]* **A** license shall be required to complete the training requirement within three (3) years of the date they obtained their Class R license.

*AUTHORITY: sections [590.030.4] **590.020, 590.030, and 590.190**, RSMo Supp. [2004] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed Jan. 15, 2004, effective July 30, 2004. Amended: Filed Nov. 1, 2004, effective April 30, 2005. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

PROPOSED AMENDMENT

11 CSR 75-13.040 Relicensing of Expired Peace Officer Licenses. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections 590.030[.6,] **and 590.190,** RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

PROPOSED AMENDMENT

11 CSR 75-13.050 Missouri Peace Officer License Exam. The department is amending section (2), adding a new section (3), renumbering the remaining sections, and amending the renumbered sections (4) and (6) and the Authority.

PURPOSE: This amendment reflects a Class D license, which had to be developed pursuant to section 590.040.1(5), RSMo. This amendment further clarifies the amount of time an applicant can wait to take the MPOLE after making application for a peace officer license. This amendment further clarifies what occurs when an applicant who fails to take the MPOLE within thirty (30) days of notice of initial or a second failure.

(2) No person shall take the MPOLE unless the person is eligible to apply for, and has applied for, a peace officer license. An applicant for a class R **and a class D** license shall not take the MPOLE.

(3) A person must achieve a qualifying score on the MPOLE within one hundred twenty (120) days of application for a peace officer license.

*[(3)]***(4)** No person shall take the MPOLE after being disqualified by the Director pursuant to 11 CSR 75-13.020*[(5)]***(7)**.

*[(4)]***(5)** The qualifying score on the MPOLE shall be seventy percent (70%) correct. The Director shall determine whether a person taking the MPOLE has achieved the qualifying score.

*[(5)]***(6)** A person who fails the MPOLE may retake the MPOLE as follows:

(A) Within thirty (30) days after notification of initial failure;

(B) Within thirty (30) days after notification of a second failure;

(C) After a third failure, the person may either:

1. Wait one (1) year after notification of failure**,** and then take the MPOLE as if for the first time; or

2. Attend and graduate from a basic training course**,** and then take the MPOLE as if for the first time*[.]***; or**

(D) A person who fails to retake the MPOLE within thirty (30) days after notification of initial or a second failure may either:

1. Wait one (1) year after notification of failure, and then take the MPOLE as if for the first time; or

2. Attend and graduate from a basic training course, and then take the MPOLE as if for the first time.

*[(6)]***(7)** The Director shall have plenary authority over the MPOLE. Any determination made by the Director pursuant to this rule shall be subject to review only pursuant to section 536.150, RSMo.

*AUTHORITY: sections 590.030[.2] **and 590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

PROPOSED AMENDMENT

11 CSR 75-13.060 Veteran Peace Officer Point Scale. The department is amending sections (3)–(6) and the Authority.

PURPOSE: This amendment reflects a Class D license, which had to be developed pursuant to section 590.040.1(5), RSMo. Persons with a Class D license will not be able to qualify on the scale. This amendment further clarifies that the credit awarded for years of service has to be for full-time commission with a law enforcement agency and that reserve officer basic training cannot be counted.

(3) The holder of a class R **or a class D** license**, or a person graduating from a reserve basic training course,** is not eligible to qualify on the scale.

(4) An applicant shall request to qualify on the veteran peace officer point scale on an application for a new peace officer license pursuant to 11 CSR 75-13.020*[(4)(A)]***(3)(C)** or on an application for a peace officer license upgrade pursuant to 11 CSR 75-13.030(1)(C).

(5) The Director shall score each applicant according to the following point system.

(A) For basic **peace officer** training:

1. 120 to 179 hours, 1 point;
2. 180 to 299 hours, 3 points;
3. 300 to 469 hours, 5 points;
4. 470 to 599 hours, 8 points;
5. 600 hours or more, 14 points.

(B) For years of experience as an active, **full-time** commissioned peace officer:

1. At least one year, up to two years: 1 point;
2. Over two years, up to three years: 2 points;
3. Over three years, up to four years: 3 points;
4. Over four years, up to five years: 4 points;
5. Over five years, up to six years: 5 points;
6. Over six years, up to seven years: 6 points;
7. Over seven years, up to eight years: 7 points;
8. Over eight years, up to nine years: 8 points;
9. Over nine years, up to ten years: 9 points;
10. Over ten years, up to sixteen years: 10 points;
11. Over sixteen years: 12 points.

(6) The Director shall recognize the applicant's qualification on the following scale:

[(A) Three through nine points, class R license;]

*[(B)]***(A)** Ten through fifteen total points, class B license;

*[(C)]***(B)** Sixteen or more total points, class A license.

*AUTHORITY: sections 590.030[.3,] **and 590.190,** RSMo Supp. [2004] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed Jan. 15, 2004, effective July 30, 2004. Amended: Filed Nov. 1, 2004, effective April 30, 2005. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

PROPOSED AMENDMENT

11 CSR 75-13.070 Recognition of Federal, Military, and Out-of-State Basic Training. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections 590.040[.1(5)] **and 590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

PROPOSED AMENDMENT

11 CSR 75-13.080 Adjustment of Peace Officer License Classification. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections 590.020[.2] **and 590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

PROPOSED AMENDMENT

11 CSR 75-13.090 Cause to Discipline Peace Officer Licensee. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections 590.080[.1(6)], **590.090, and 590.190,** RSMo Supp. [2003] **2007**. Original rule filed May 1, 2002, effective Oct.*

30, 2002. Amended: Filed Sept. 5, 2003, effective March 30, 2004. Amended: Filed July 1, 2008.

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

PROPOSED AMENDMENT

11 CSR 75-13.100 Notification of Change in Commission Status. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections 590.070[.1] and [590.070.2] **590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 14—Basic Training Centers

PROPOSED AMENDMENT

11 CSR 75-14.010 Procedure to Obtain a Basic Training Center License. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections 590.060[.2] **and 590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 14—Basic Training Centers

PROPOSED AMENDMENT

11 CSR 75-14.020 Minimum Requirements for Basic Training Centers. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections 590.060[.1] **and 590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 14—Basic Training Centers

PROPOSED AMENDMENT

11 CSR 75-14.030 Standard Basic Training Curricula and Objectives. The department is amending section (1) and the Authority.

PURPOSE: This amendment updates the Authority and section (1).

(1) The Peace Officer Standards and Training (POST) Commission shall develop a mandatory basic training curriculum for each class of peace officer license. The minimum number of training hours for each class of peace officer license shall be as follows:

[(E) Class A-PC. One thousand (1,000) hours;]

*[(F)]***(E)** Class B. Four hundred eighty (480) hours;

*[(G)]***(F)** Class C. One hundred twenty (120) hours;

*[(H)]***(G)** Class R. Two hundred ninety-seven (297) hours;
*[(I)]***(H)** Class S. Four hundred eighty (480) hours.

*AUTHORITY: sections 590.030[.1], **590.040, and 590.190,** RSMo Supp. [2004] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed April 25, 2003, effective Oct. 30, 2003. Amended: Filed Jan. 15, 2004, effective July 30, 2004. Amended: Filed Dec. 15, 2004, effective June 30, 2005. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 14—Basic Training Centers

PROPOSED AMENDMENT

11 CSR 75-14.040 Certification of Basic Training Courses. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections 590.060[.2] **and 590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 14—Basic Training Centers

PROPOSED AMENDMENT

11 CSR 75-14.050 Minimum Standards for a Certified Basic Training Course. The department is amending paragraphs (2)(B)2. and (6)(A)2., subsection (2)(C), and the Authority.

PURPOSE: This amendment clarifies the fact that we require all applicants to be fingerprinted by way of the live-scan method as approved by the Criminal Records Division of the Missouri State Highway Patrol. Therefore, fingerprint cards no longer need to be submitted. This amendment adds section 590.100, RSMo, to require the training director to remove a trainee from basic training that the Director of Public Safety determines is not eligible because of a violation of section 590.080.1, RSMo. This amendment allows those areas of basic training requiring a demonstrative skill be performed to be graded on a pass/fail basis.

(2) The procedure for delivering a basic training course shall be as follows:

(B) At least fifteen (15) days before the start of the course, the training center director shall:

1. Cause each trainee to complete a Missouri peace officer license legal questionnaire, which the training center director shall review.

2. Cause each trainee to submit *[to the Director two (2) fingerprint cards and a bank draft or money order in an amount equivalent to the cost of conducting a state and a federal criminal history background check.]* **to being fingerprinted in a manner approved by the Missouri State Highway Patrol pursuant to section 43.543, RSMo, to determine if the applicant has a criminal history record on file with the Missouri criminal records repository or the Federal Bureau of Investigation. The fee associated with being fingerprinted in this manner shall be the responsibility of the applicant.**

3. Report to the Director the existence of any known fact or circumstance that might constitute cause for the Director to disqualify any trainee from receiving a peace officer license, in which case the training center director shall obtain a waiver from **the** Director before admitting the trainee into the course.

(C) The training center director shall deny entry into the course or shall expel from the course any trainee that the Director determines to be unqualified pursuant to 11 CSR 75-14.060 **or section 590.100, RSMo**.

(6) Trainees shall be graded as follows:

(A) A trainee shall be tested for mastery of each subject area in the appropriate mandatory curriculum. A written or practical examination may test more than one (1) subject area simultaneously.

1. Mastery of firearms shall be tested by practical examination and scored on a numerical scale from zero (0) to one hundred (100). Supplemental written examinations are permitted, but the overall firearms score required for graduation pursuant to paragraph (7)(C)4. of this rule shall be based solely upon the practical examinations. The final grade of the firearms practical examination may, at the discretion of the training center director, be recorded as a pass or fail.

2. Mastery of defensive tactics, physical fitness, *[and]* driver training**, and any other basic training subject areas requiring a trainee to perform a demonstrative skill as determined by the Peace Officers Standards and Training (POST) Commission** shall be tested by practical examination and may be graded on a numerical scale from zero (0) to one hundred (100) or on a pass/fail basis. Supplemental written examinations are permitted.

3. Mastery of all other subject areas shall be tested by written or practical examination and shall be graded on a numerical scale from zero (0) to one hundred (100). Pass/fail grading is not permitted.

*AUTHORITY: sections 590.030[.1], [and] 590.040[.1], **and 590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed Nov. 15, 2002, effective April 30, 2003. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 14—Basic Training Centers

PROPOSED AMENDMENT

11 CSR 75-14.060 Eligibility for Entrance into a Basic Training Course. This department is amending section (1) and the Authority.

PURPOSE: This amendment clarifies the time frame that an applicant has to become fingerprinted prior to beginning basic training.

(1) No person shall be admitted into a certified basic training course unless such person:

(C) Is the holder of a valid high school diploma or its equivalent **pursuant to 11 CSR 75-2.010**; *[and]*

(D) Has been fingerprinted pursuant to 11 CSR 75-13.020 within one hundred twenty (120) days of, and no later than fifteen (15) days before, the start of the basic training course; and

*[(D)]***(E)** Has submitted a Missouri Peace Officer License Legal Questionnaire to the basic training center director.

*AUTHORITY: sections 590.060[.1] **and 590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 14—Basic Training Centers

PROPOSED AMENDMENT

11 CSR 75-14.070 Basic Training Instructor Licenses. The department is amending subsection (3)(A) and the Authority.

PURPOSE: This amendment updates the Authority and subsection (3)(A).

(3) Cause to discipline an instructor license pursuant to section 590.060.2, RSMo, shall include, but not be limited to:

(A) Any cause to discipline a peace officer license pursuant to section 590.080, RSMo, or 11 CSR 75-*[13.110]***13.090**;

*AUTHORITY: sections 590.060[.2] **and 590.190**, RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 14—Basic Training Centers

PROPOSED AMENDMENT

11 CSR 75-14.080 Minimum Requirements for a Basic Training Instructor. The department is amending subsection (3)(D) and the Authority.

PURPOSE: This amendment clarifies the requirements for some specialist instructors. This amendment also removes the term First Aid, which is no longer needed.

(3) To qualify for a specialist license, an instructor shall possess the following qualifications:

(D) A valid, current third-party or secondary license shall be required to qualify as a specialist instructor for any objective related to the following:

1. Tactical Communications if utilizing Verbal Judo, graduate of a Verbal Judo Trainer Course.

2. Hazardous Materials, graduate of a POST recognized **eight (8)-hour** Hazardous Materials Training Course.

3. Accident Investigation, graduate of *[a Basic]* **an** Accident Investigation School or Accident Reconstruction School.

4. *[First Aid (]*First Responder*[)]*, graduate of a Certified First Responder Trainer Course, or a licensed Emergency Medical Technician (EMT), Emergency Medical Technician Paramedic (EMTP), Registered Nurse (RN), Medical Doctor (MD), or Doctor of Osteopathy (DO).

5. The core curricula areas under Defensive Tactics, **with the exception of the subject area of Mechanics of Arrest and Control,** graduate of a POST recognized Law Enforcement Defensive Tactics Instructor Course.

6. The core curricula areas under Firearms, graduate of a POST recognized Firearms Instructor School of at least forty (40) hours.

7. The core curricula areas under Driver Training, graduate of a POST recognized Drivers Training Instructor Course.

8. Memoranda, Introduction to Report Writing, and Report Writing Exercises, if an individual does not have at least a four (4)-year college degree, they must be a graduate of a POST recognized Report Writing Instructor Course.

*AUTHORITY: sections 590.060[.1] **and 590.190**, RSMo Supp. [2002] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed Oct. 31, 2002, effective April 30, 2003. Amended: Filed April 25, 2003, effective Oct. 30, 2003. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 15—Continuing Education

PROPOSED AMENDMENT

11 CSR 75-15.010 Continuing Education Requirement. The department is amending subsections (4)(E) and (6)(C), section (8), and the Authority.

PURPOSE: This amendment clarifies the fact that continuing education credit can also be awarded to basic training instructors.

(4) CLEE credit may be obtained from the following sources:

(E) For serving as an instructor for a CLEE **or basic training** class pursuant to 11 CSR 75-15.020(3)(B);

(6) During any single CLEE period, no peace officer shall receive:

(C) More than twenty-four (24) hours of CLEE credit for serving as a CLEE **or basic training** instructor.

(8) *[Beginning January 1, 2003, every]* **Every** peace officer with the authority to enforce motor vehicle or traffic laws shall obtain *[at least one (1) credit hour of]* CLEE training regarding racial profiling *[each calendar year]*. Racial profiling training may be obtained from:

*AUTHORITY: sections **590.030.5(1),** 590.050[.1], **and 590.190,** RSMo Supp. [2003] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed Aug. 2, 2004, effective Jan. 30, 2005. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 15—Continuing Education

PROPOSED AMENDMENT

11 CSR 75-15.020 Minimum Standards for Continuing Education Training. The department is amending subsections (3)(B), (4)(F) and (G), and (5)(A), (D), (G), and (H), adding subsections (4)(H) and (5)(I), and amending the Authority.

PURPOSE: This amendment clarifies the fact that continuing education credit can also be awarded to basic training instructors. This amendment clarifies the fact that the date and location the course was presented needs to be on the certificate issued. This amendment clarifies the fact that the course learning objectives must be identified within the lesson plan and the course attendance policy must be maintained as part of the continuing education file.

(3) CLEE credit shall be calculated at the following rates:

(B) Two (2) hours of CLEE credit for each hour of CLEE **or basic training** instruction delivered; and

(4) Upon successful completion of the requirements of any CLEE course, the provider of the training shall present each trainee a certificate bearing:

(F) The trainee's name; *[and]*

(G) The name of the individual responsible for general administration of the course*[.]***; and**

(H) The date and location the course was presented.

(5) A CLEE provider shall retain, for a period of six (6) years after each CLEE training course, the following records:

(A) A copy of the training certificate or other record of the information required by subsections (4)(A) to (4)*[(F)]***(H)** of this rule;

(D) A list of all training objectives**, which must be identified within the lesson plan**;

(G) All instructor records; *[and]*

(H) The course evaluation plan*[.]***; and**

(I) The course attendance policy.

*AUTHORITY: sections **590.030.5(1),** 590.050[.1], **and 590.190,** RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 15—Continuing Education

PROPOSED AMENDMENT

11 CSR 75-15.030 Procedure to Obtain a Continuing Education Provider License. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections **590.030.5(1),** 590.050[.2], **and 590.190,** RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed Oct. 31, 2002, effective April 30, 2003. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 15—Continuing Education

PROPOSED AMENDMENT

11 CSR 75-15.040 Procedure to Obtain Approval for an Individual CLEE Course. The department is amending section (2) and the Authority.

PURPOSE: This amendment clarifies that courses must be submitted thirty (30) days prior to their scheduled date of delivery.

(2) An applicant shall submit to the Director a completed individual CLEE course application. **This application must be submitted a minimum of thirty (30) days prior to the scheduled delivery date of the course.** The Director may investigate the applicant or request additional information from the applicant pursuant to section 590.110.1, RSMo.

*AUTHORITY: sections **590.030.5(1),** 590.050[.2], **and 590.190,** RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 15—Continuing Education

PROPOSED AMENDMENT

11 CSR 75-15.050 Out-of-State, Federal, and Organizations Continuing Education. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections **590.030.5(1),** 590.050[.2], **and 590.190,** RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 15—Continuing Education

PROPOSED AMENDMENT

11 CSR 75-15.060 In-Service Continuing Education Training. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections **590.030.5(1),** 590.050[.2], **and 590.190,** RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 15—Continuing Education

PROPOSED AMENDMENT

11 CSR 75-15.070 Computer-Based Continuing Education Training. The department is amending section (5) and the Authority.

PURPOSE: This amendment allows the Director of Public Safety to approve the method used by the training provider to determine attendance for computer-based training courses.

(5) The course administrator shall attest to actual attendance and may ascertain attendance by any reasonably certain method, **as determined by the Director,** including tracking by the computer course software, if the tracking meets the standard of this rule. The attendance policy and methodology for ascertaining attendance shall be included in the course record file.

*AUTHORITY: sections **590.030.5(1),** 590.050[.2], **and 590.190,** RSMo Supp. [2001] **2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 75—Peace Officer Standards and Training Program
Chapter 16—Peace Officer Standards and Training Commission Fund

PROPOSED AMENDMENT

11 CSR 75-16.010 Peace Officer Standards and Training Commission Fund. The department is amending the Authority.

PURPOSE: This amendment updates the Authority.

*AUTHORITY: sections [590.120, RSMo Supp. 2003 and] 590.178, RSMo 2000 **and section 590.190, RSMo Supp. 2007**. Original rule filed May 1, 2002, effective Oct. 30, 2002. Amended: Filed Jan. 15, 2004, effective July 30, 2004. Amended: Filed July 1, 2008.*

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 Jeremy Spratt, Missouri Department of Public Safety Peace Officer Standards and Training (POST) Program Manager, 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 26—Dealer Licensure

PROPOSED RULE

12 CSR 10-26.220 Dealer Disciplinary Hearings

PURPOSE: The department must provide an opportunity for a hearing on the issue of the discipline to be imposed against a license upon a finding by the Administrative Hearing Commission that grounds exist to discipline that license. This rule establishes the procedure for scheduling and conducting that hearing.

(1) As used in this rule the following terms mean—

(A) The term "dealer" as used in this rule shall include the classes of dealers set forth in section 301.550.3, RSMo.

(B) The term "department" as used in this rule shall mean the Missouri Department of Revenue.

(C) The term "director" as used in this rule means the Director of Revenue.

(2) Within thirty (30) days of the receipt of the certification of the Administrative Hearing Commission's record, findings of fact, conclusions of law, and transcript finding that cause exists to discipline a dealer's license, the director shall set the matter for hearing and notify the dealer of the time and place of the hearing.

(3) The notice will be given by U.S. mail, first class, postage prepaid to the dealer's business address or the registered agent, if applicable, or to the dealer's attorney, and to the dealer at the dealer's address as shown on the dealer license application, together with the sanction, if any, recommended by the Motor Vehicle Bureau of the department.

(4) The hearing will be held in Jefferson City, Missouri. A hearing officer designated by the director shall conduct the hearing.

(5) The sole issue at the hearing shall be the appropriate disciplinary sanction to be imposed.

(6) The provisions of Chapter 536, RSMo shall apply to the hearing.

(7) Each party shall be allowed one (1) continuance; any further continuance shall only be for good cause shown. Requests for continuance shall be in writing signed by the party requesting the continuance or that party's attorney. Requests for continuance must be filed not later than ten (10) days prior to the scheduled hearing date.

(8) Each party shall be allowed to submit one (1) brief to the hearing officer within thirty (30) days of the date of the hearing. No rebuttal or reply briefs are permitted.

(9) The hearing officer shall make findings of fact, conclusions of law, and recommendations as to any sanctions to be imposed.

(10) Nothing contained herein shall prevent the dealer waiving his right to a hearing and accepting the sanction, if any, recommended by the Motor Vehicle Bureau of the department or otherwise mutually agreeing to a sanction with the department. Any waiver of the hearing and agreement as to the sanction must be in writing, signed

by both parties, and transmitted to the hearing officer prior to the date of the hearing for final approval.

(11) The director may accept, reject, or modify the hearing officer's recommendations, or impose any other sanction permitted by section 301.562, RSMo, including refusing to renew the dealer's license, as the director deems appropriate in the circumstances.

(12) The decision of the director shall become final on the date of mailing of that decision to the parties.

AUTHORITY: section 301.553.4, RSMo 2000. Original rule filed July 1, 2008.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Department of Revenue, Legal Services Division, Governmental Affairs Bureau, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice on the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

PROPOSED AMENDMENT

13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services. The division is amending sections (1), (2), (4), (10), (12), (13), (14), (20), and (21).

PURPOSE: This amendment provides for the following changes: section (1) was changed to update the division's name; section (2) was changed to clearly state the division's policy regarding how the division will implement its decisions during the appeal process; section (4) was changed to update the definition of division; section (10) was changed to eliminate the cost report filing requirements for out-of-state nursing facilities and add "incorporated by reference" language to the cost report and instructions; section (12) was changed to correct the cross reference for the interim rate; section (13) was changed to move subsection (13)(A) Global Per Diem Adjustments to 13 CSR 70-10.016; section (14) was changed to set forth the reimbursement rate for out-of-state nursing facilities and the effective date of rate changes from their state's Medicaid agency; subsections (20)(B) and (20)(E) were changed to fix the cross reference to subsection (13)(A) because it was moved to a different regulation; subsections (21)(J) and (21)(L) were changed to fix the cross reference to subsection (13)(A) because it was moved to a different regulation; and subsection (21)(N) was added.

(1) Authority. This regulation is established pursuant to the authorization granted to the Department of Social Services (department), *[Division of Medical Services]* **MO HealthNet Division** (division), to promulgate rules and regulations.

(2) Purpose. This regulation establishes a methodology for determination of reimbursement rates for nursing facilities. Subject to limitations prescribed elsewhere in this regulation, a facility's reimbursement rate shall be determined by the division as described in this regulation. Any reimbursement rate determined*[,]* by the division*[, that has been appealed in a timely manner shall not be final until there is a final decision.]* **shall be a final decision and will be implemented as set forth in the division's decision letter. The decisions of the division may be subject to review upon properly filing a complaint with the Administrative Hearing Commission (AHC). A nursing facility seeking review by the AHC must obtain a stay from the AHC to stop the division from implementing its final decision if the AHC determines the facility meets the criteria for a stay and so orders. If the facility appeals the division's decision, it is the responsibility of the nursing facility to notify any interested parties, including but not limited to hospice providers, that the rate being received is not a final rate and is subject to change.** Federal financial participation is available on expenditures for services provided within the scope of the federal Medicaid Program and made under a court order in accordance with 42 CFR 431.250.

(4) Definitions.

(X) Division. Unless otherwise specified, division refers to the *[Division of Medical Services]* **MO HealthNet Division**, the division of the Department of Social Services charged with administration of Missouri's *[Medical Assistance (Medicaid)]* **MO HealthNet** Program.

(10) Provider Reporting and Record Keeping Requirements.

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

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

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

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

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

5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period.

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

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

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

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

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

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

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

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

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

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

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

M. Schedule of capital assets with corresponding debt.

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

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

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

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

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

*[C.]***B.** Change in provider status:

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

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

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

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

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

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

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

(12) Reimbursement Rate Determination. A facility's reimbursement rate shall be determined by the division as described in this regulation. Any facility with an interim rate on December 31, 1994, shall be granted an interim rate effective for services on and after January 1, 1995, as prescribed in subsection (4)*[(EE)]***(HH)**, if applicable. A prospective rate determined from this regulation shall be retroactively effective for services beginning on the first day of the facility's second twelve (12)-month fiscal year but not earlier than January 1, 1995, and shall replace the interim on and after January 1, 1995.

(F) A facility entering the *[Medicaid]* **MO HealthNet** program after December 31, 1994, shall receive an interim rate as defined in subsection (4)*[(EE)]***(HH)** to be effective on the initial date of *[Medicaid]* **MO HealthNet** certification. A prospective rate shall be determined in accordance with this regulation from the desk audited and/or field audited facility fiscal year cost report which covers the second full twelve (12)-month fiscal year following the facility's initial date of *[Medicaid]* **MO HealthNet** certification. The HCFA Market Basket Index for 1993, 1994**,** and nine (9) months of 1995 will not be applied. This prospective rate shall be retroactively effective and shall replace the interim rate for services beginning on the first day of the facility's second full twelve (12)-month fiscal year.

(13) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed elsewhere in this regulation, a facility's reimbursement rate may be adjusted as described in this section **and 13 CSR 70-10.016**.

(A) Global Per Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments **as set forth in 13 CSR 70-10.016**. Global per diem rate adjustments shall be added to the specified cost component ceiling.

[1. FY-96 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1995, shall be granted an increase to their per diem effective October 1, 1995, of 4.6% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1. and the property insurance and property taxes detailed in paragraph (11)(D)3. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of this regulation.

2. FY-97 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1996, shall be granted an increase to their per diem effective October 1, 1996, of 3.7% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1. and the property insurance and property taxes detailed in paragraph (11)(D)3. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of this regulation.

3. NFRA. Effective October 1, 1996, all facilities with either an interim rate or a prospective rate shall have its per diem adjusted to include the current NFRA as an allowable cost in its reimbursement rate calculation.

4. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on November 1, 1996, shall be granted an increase to their per diem effective November 1, 1996, of two dollars and forty-five cents ($2.45) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the fifty-cent (50¢) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by 8.67% to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator and assistant administrator.

5. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on September 1, 1997, shall be granted an increase to their per diem effective September 1, 1997, of one dollar and ninety-eight cents ($1.98) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the forty-cent (40¢) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by 8.67% to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator and assistant administrator.

6. FY-98 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1997, shall be granted an increase to their per diem effective October 1, 1997, of 3.4% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1. and the property insurance and property taxes detailed in paragraph (11)(D)3. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of this regulation.

7. FY-99 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1998, shall be granted an increase to their per diem effective October 1, 1998, of 2.1% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., the property insurance and property taxes detailed in paragraph (11)(D)3. of this regulation and the minimum wage adjustments detailed in paragraphs (13)(A)4. and (13)(A)5.; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1, 1998, shall have their increase determined by subsection (3)(S) of this regulation.

8. FY-2000 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 1999, shall be granted an increase to their per diem effective July 1, 1999, of 1.94% of the cost determined in subsections (11)(A), (11)(B), (11)(C), the property insurance and property taxes detailed in paragraph (11)(D)3. and the minimum wage adjustments detailed in paragraphs (13)(A)4. and (13)(A)5. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on July 1, 1999, shall have their increase determined by subsection (3)(S) of this regulation.

9. FY-2004 nursing facility operations adjustment—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2003, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2003 through June 30, 2004 of four dollars and thirty-two cents ($4.32) for the cost of nursing facility operations. Effective for dates of service beginning July 1, 2004, the per diem adjustment shall be reduced to three dollars and seventy-eight cents ($3.78).

B. The operations adjustment shall be added to the facility's current rate as of June 30, 2003 and is effective for payment dates after August 1, 2003.

10. FY-2007 quality improvement adjustment—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2006, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2006 of three dollars and seventeen cents ($3.17) to improve the quality of life for nursing facility residents.

B. The quality improvement adjustment shall be added to the facility's current rate as of June 30, 2006 and is effective for dates of service beginning July 1, 2006 and after.

11. FY-2007 trend adjustment.

A. Facilities with either an interim rate or a prospective rate in effect on February 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning February 1, 2007 of three dollars and zero cents ($3.00) to allow for a trend adjustment to ensure quality nursing facility services.

B. The trend adjustment shall be added to the facility's reimbursement rate as of January 31, 2007 and is effective for dates of service beginning February 1, 2007 for payment dates after March 1, 2007.

12. FY-2008 trend adjustment.

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2007 of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services.

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2007 and is effective for dates of service beginning July 1, 2007.]

(14) Exceptions.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set *[by one (1) of the following methods]* **as follows**:

1. For **out-of-state** providers which provided services *[of less than one thousand (1,000) patient days]* for Missouri Title XIX recipients, the reimbursement rate shall be the rate paid for comparable services and level of care by the state in which the provider is located. **The reimbursement rate will remain in effect until—**

A. *[The reimbursement rate will remain in effect until:*

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

[(II) The provider exceeds one thousand (1,000) patient days for Missouri Title XIX recipients. The provider must notify, in writing, the director of the Institutional Reimbursement Unit of the division if they have exceeded one thousand (1,000) patient days for Missouri Title XIX recipients within thirty (30) days of their fiscal year end. The provider will be required to submit a Missouri Title XIX cost report to the division by the first day of the sixth month following their fiscal year end. This cost report shall serve as the provider's rate setting cost report and the provider shall have their per diem rate set as detailed below in paragraph (14)(B)2.

2. For providers which provided services of one thousand (1,000) or more patient days for Missouri Title XIX recipients, the reimbursement rate shall be the lower of:

A. The rate paid for comparable services and level of care by the state in which the provider is located; or

B. The rate as calculated baed on the provider's rate setting cost report as determined from this regulation.]

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

(20) Rebasing of Nursing Facility Rates.

(B) The rebased rates shall be phased in, as set forth below:

1. A preliminary rebased rate shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed above in paragraphs (20)(A)1.–9.

2. The total increase resulting from the rebase each year shall be calculated as follows:

A. Each facility's current rate as of June 30 of each year shall be compared to the preliminary rebased rate effective July 1 of the following SFY. For example, for SFY 2005, the facility's rate as of June 30, 2004 shall be compared to the preliminary rebased rate effective July 1, 2004; for SFY 2006, the facility's rate as of June 30, 2005 shall be compared to the preliminary rebased rate effective July 1, 2005; etc.

(I) The high volume adjustment, if applicable, and the NFRA shall not be included in the current rate or the preliminary rebased rate for comparison purposes in determining the total increase.

(II) The high volume adjustment, if applicable, and the current NFRA shall be added to the rate determined below in subparagraph (20)(B)2.B.

B. If the preliminary rebased rate is greater than the current rate, the difference between the two (2) shall represent the total increase that will be phased in by granting one-third (1/3) of the total increase each year. For SFY 2005, one-third (1/3) of the total increase shall be added to the facility's current rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in *[(13)(A)9.]***13 CSR 70-10.016.** The high volume adjustment, if applicable, and the current NFRA shall be added to that total and shall be the facility's prospective rate for SFY 2005.

C. If the preliminary rebased rate is less than the current rate, the facility shall continue to receive its current rate with any applicable adjustments for high volume and NFRA for the SFY.

(E) Prospective Rate Determination for Newly Medicaid Certified Nursing Facilities. As set forth in subsection (12)(F), a nursing facility never previously certified for participation in the Medicaid program shall receive an interim rate upon entering the Medicaid program and have its prospective rate set on its second full twelve (12)-month cost report following the facility's initial date of certification. The prospective rate shall be calculated in accordance with the provisions of the regulation in effect from the beginning of the facility's rate setting period through the date the prospective rate is determined, as detailed below. If industry-wide rate changes were implemented during this period the provision of the regulation relating to the effective date of the rate change shall be the governing regulation for those dates of service. For example, for a rate setting period of January 1, 2004 through December 31, 2004, the facility's initial prospective rate effective January 1, 2004 shall be set in accordance with the regulations in effect at that time and rate changes that occurred after January 1, 2004 shall be calculated in accordance with the regulation applicable to each rate change throughout the period, as follows: the facility's initial prospective rate effective January 1, 2004 shall be set in accordance with the regulations in effect at that time (sections (1)–(19)); nursing facility rates were rebased effective July 1, 2004 per section (20); the rebase provisions were modified effective April 1, 2005 under subsection (20)(D); the per diem rate calculation effective for dates of service beginning July 1, 2005 are detailed in section (21); a quality improvement adjustment of three dollars and seventeen cents ($3.17) per day was granted effective July 1, 2006 in *[paragraph (13)(A)10.]* **13 CSR 70-10.016**; etc.

1. A nursing facility that did not have a prospective rate established when rates were rebased on July 1, 2004, shall have its prospective rate for dates of service beginning on or after July 1, 2004 through June 30, 2005 established on the rate setting cost report in accordance with section (20), consistent with the rest of the nursing facility industry.

2. As set forth in paragraphs (20)(B)1. and 2., a preliminary rate shall be calculated and compared to the facility's rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in *[paragraph (13)(A)9.]* **13 CSR 70-10.016**, to determine the total increase. The NFRA shall not be included in the preliminary rate or the June 30, 2004 rate for comparison purposes in determining the total increase.

A. If the facility will have a prospective rate established on June 30, 2004 once the prospective rate setting process is complete, the prospective rate shall be the rate for comparison purposes in determining the total increase.

B. If the facility will not have a prospective rate established on June 30, 2004 once the prospective rate setting process is complete, the division will calculate a June 30, 2004 computed rate which will be used as the rate for comparison purposes in determining the total increase as follows:

(I) The rate setting cost report as determined in subsection (12)(F) shall be used.

(II) The allowable costs from the rate setting cost report will be negatively trended back to June 30, 2004 using the indices from the most recent publication of the Health-Care Cost Review available to the division using the "CMS Nursing Home without Capital Market Basket" table. The allowable costs shall be negatively trended using the second quarter indices for each year, beginning with the index for the year relative to the end of the rate setting period back to and including the index for 2005. For example, a rate setting cost report for the period July 1, 2006 through June 30, 2007, shall have a 2007 rate setting year. The allowable costs shall be negatively trended by the 2007 second quarter index, the 2006 second quarter index**,** and the 2005 second quarter index. The resulting allowable costs shall be used to determine the June 30, 2004 computed rate.

(III) The computed rate shall be calculated in accordance with sections (1)–(19) of this regulation, prior to the rebase, using the regulations applicable to calculating a June 30, 2004 rate including the cost component ceilings, interest, rate of return, etc. in effect on June 30, 2004.

3. If the preliminary rate is greater than the June 30, 2004 rate, the facility shall receive one-third **(1/3)** of the total increase of the preliminary rate over the June 30, 2004 rate, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in *[paragraph (13)(A)9.]* **13 CSR 70-10.016.** The one-third **(1/3)** increase shall be added to the June 30, 2004 rate, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in *[paragraph (13)(A)9.]* **13 CSR 70-10.016.** The NFRA in effect shall be added to that total to determine the prospective rate.

4. If the preliminary rate is less than the June 30, 2004 rate, the facility's June 30, 2004 rate plus the NFRA in effect shall become the prospective rate.

(21) Per Diem Rate Calculation Effective for Dates of Service Beginning July 1, 2005. Effective for dates of service beginning July 1, 2005, the rebase provisions set forth in section (20) shall not apply. Effective for dates of service beginning July 1, 2005, the per diem rates shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation, except that the data indicated in this section (21) shall be used.

(J) The rates effective for dates of service beginning July 1, 2005 shall be determined, as set forth below:

1. A preliminary rate for July 1, 2005 shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed above in subsections (21)(A)–(I).

2. The total increase resulting from the July 1, 2005 preliminary rate calculation shall be calculated as follows:

A. Each facility's rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in *[paragraph (13)(A)9.]* **13 CSR 70-10.016**, shall be compared to the July 1, 2005 preliminary rate calculation.

(I) The high volume adjustment, if applicable, and the NFRA shall not be included in the June 30, 2004 rate or the July 1, 2005 preliminary rate for comparison purposes in determining the total increase.

(II) The high volume adjustment, if applicable, and the current NFRA shall be added to the rate determined below in subparagraphs (21)(J)2.B. and (21)(J)2.C.

B. If the July 1, 2005 preliminary rate is greater than the June 30, 2004 rate including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in *[paragraph (13)(A)9.]* **13 CSR 70-10.016**, the difference between the two (2) shall represent the total increase. Effective for dates of service beginning July 1, 2005, one-third (1/3) of the total increase shall be added to the facility's rate as of June 30, 2004 including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in *[paragraph (13)(A)9.]* **13 CSR 70-10.016.** The high volume adjustment, if applicable, and the current NFRA shall be added to that total and shall be the facility's prospective rate for dates of service beginning July 1, 2005.

C. If the July 1, 2005 preliminary rate is less than the June 30, 2004 rate including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in *[paragraph (13)(A)9.]* **13 CSR 70-10.016**, the facility's prospective rate shall be the facility's rate as of June 30, 2004 including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in *[paragraph (13)(A)9.]* **13 CSR 70-10.016** plus the high volume adjustment, if applicable, and the current NFRA.

(N) Nursing facilities who qualify to have their prospective rate set in accordance with the provisions of subsection (20)(E) shall continue to receive the rate determined from subsection (20)(E) for dates of service beginning July 1, 2005.

AUTHORITY: section[s] 208.159, RSMo 2000 ***and sections*** *208.153* ***and*** *208.201****, RSMo Supp. 2007*** *[and CCS for SCS for HCS for HB1011, 93rd General Assembly]. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. For intervening history see the* ***Code of State Regulations****. Amended: Filed July 1, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate for SFY 2009.

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

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

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

PROPOSED RULE

13 CSR 70-10.016 Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates

PURPOSE: This rule sets forth the global per diem adjustments to be applied to nursing facility reimbursement rates, established in 13 CSR 70-10.015, and HIV nursing facility reimbursement rates, established

in 13 CSR 70-10.080. The global per diem adjustments were previously included in 13 CSR 70-10.015 and 13 CSR 70-10.080.

(1) Authority. This regulation is established pursuant to the authorization granted to the Department of Social Services (department), MO HealthNet Division (division), to promulgate rules and regulations.

(2) Purpose. This regulation sets forth the global per diem adjustments to be applied to nursing facility reimbursement rates, established in 13 CSR 70-10.015, and Human Immunodeficiency Virus (HIV) nursing facility reimbursement rates, established in 13 CSR 70-10.080. All principles and definitions set forth in 13 CSR 70-10.015 are applicable to nursing facilities, and all principles and definitions set forth in 13 CSR 70-10.080 are applicable to HIV nursing facilities. The terms "facility" or "facilities" as used in this regulation shall apply to both nursing facilities and HIV nursing facilities.

(3) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed in 13 CSR 70-10.015, a nursing facility's reimbursement rate may be adjusted as described in this section. Subject to the limitations prescribed in 13 CSR 70-10.080, an HIV nursing facility's reimbursement rate may be adjusted as described in this section.

(A) Global Per Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments. Global per diem rate adjustments shall be added to the specified cost component ceiling.

1. FY-96 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1995, shall be granted an increase to their per diem effective October 1, 1995, of four and six-tenths percent (4.6%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in paragraph (11)(D) of 13 CSR 70-10.015; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

2. FY-97 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1996, shall be granted an increase to their per diem effective October 1, 1996, of three and seven-tenths percent (3.7%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in paragraph (11)(D) of 13 CSR 70-10.015; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

3. Nursing Facility Reimbursement Allowance (NFRA). Effective October 1, 1996, all facilities with either an interim rate or a prospective rate shall have its per diem adjusted to include the current NFRA as an allowable cost in its reimbursement rate calculation.

4. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on November 1, 1996, shall be granted an increase to their per diem effective November 1, 1996, of two dollars and forty-five cents ($2.45) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the fifty-cent (50¢) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by eight and sixty-seven hundredths percent (8.67%) to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator, and assistant administrator.

5. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on September 1, 1997, shall be granted an increase to their per diem effective September 1, 1997, of one dollar and ninety-eight cents ($1.98) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the forty-cent (40¢) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by eight and sixty-seven hundredths percent (8.67%) to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator, and assistant administrator.

6. FY-98 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1997, shall be granted an increase to their per diem effective October 1, 1997, of three and four-tenths percent (3.4%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in paragraph (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

7. FY-99 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1998, shall be granted an increase to their per diem effective October 1, 1998, of two and one-tenth percent (2.1%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., the property insurance and property taxes detailed in paragraph (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities and the minimum wage adjustments detailed in paragraphs (3)(A)4. and (3)(A)5. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1998, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

8. FY-2000 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 1999, shall be granted an increase to their per diem effective July 1, 1999, of one and ninety-four hundredths percent (1.94%) of the cost determined in subsections (11)(A), (11)(B), (11)(C), the property insurance and property taxes detailed in paragraph (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities and the minimum wage adjustments detailed in paragraphs (3)(A)4. and (3)(A)5. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on July 1, 1999, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

9. FY-2004 nursing facility operations adjustment—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2003, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2003, through June 30, 2004, of four dollars and thirty-two cents ($4.32) for the cost of nursing facility operations. Effective for dates of service beginning July 1, 2004, the per diem adjustment shall be reduced to three dollars and seventy-eight cents ($3.78).

B. The operations adjustment shall be added to the facility's current rate as of June 30, 2003, and is effective for payment dates after August 1, 2003.

10. FY-2007 quality improvement adjustment—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2006, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2006, of three dollars and seventeen cents ($3.17) to improve the quality of life for nursing facility residents.

B. The quality improvement adjustment shall be added to the facility's current rate as of June 30, 2006, and is effective for dates of service beginning July 1, 2006, and after.

11. FY-2007 trend adjustment.

A. Facilities with either an interim rate or a prospective rate in effect on February 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning February 1, 2007, of three dollars and zero cents ($3.00) to allow for a trend adjustment to ensure quality nursing facility services.

B. The trend adjustment shall be added to the facility's reimbursement rate as of January 31, 2007, and is effective for dates of service beginning February 1, 2007, for payment dates after March 1, 2007.

12. FY-2008 trend adjustment.

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2007, of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services.

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2007, and is effective for dates of service beginning July 1, 2007.

13. FY-2009 trend adjustment.

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2008, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2008, of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services.

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2008, and is effective for dates of service beginning July 1, 2008.

AUTHORITY: section 208.159, RSMo 2000 and sections 208.153 and 208.201, RSMo Supp. 2007. Original rule filed July 1, 2008.

PUBLIC COST: This proposed rule will cost public entities or political subdivisions approximately $52,354,686 annually until amended.

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

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

FISCAL NOTE
PUBLIC COST

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

Rule Number and Name:	13 CSR 70-10.016 Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Social Services, MO HealthNet Division	$52,354,686 *

III. WORKSHEET

SFY 2009:
Nusing Facility:

Estimated Paid Days Impacted: SFY 2009	8,725,781
x Rate Increase	$6.00
Total Estimated Impact: SFY 2009	$52,354,686
State Share	$19,371,234
Federal Share (63.00%)	$32,983,452

IV. ASSUMPTIONS

Estimated Paid Days:
Nursing Facility:
The estimated paid days for SFY 2009 are based on the actual Medicaid days paid for nursing facility services during SFY 2007, increased by 2.0% for 2008 and by an additional 0.5% for 2009.

* The $52,354,686 is the estimated cost for SFY 2009. After SFY 2009 this amount will become part of the core budget and continue annually until amended.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

PROPOSED AMENDMENT

13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/MR Services. The division is amending sections (2)–(8), (10), (11), and (13).

PURPOSE: This amendment outlines how the Fiscal Year 2009 trend factor and catch up increase will be applied to adjust per diem rates for ICF/MRs participating in the MO HealthNet program. It also changes the name of the state's medical assistance program to MO HealthNet and revises the name of the program's administering agency to MO HealthNet Division to comply with state law. The amendment also changes reference to program recipients to participants.

(2) General Principles.

(A) The *[Missouri Medical Assistance P]***MO HealthNet p**rogram shall reimburse qualified providers of ICF/MR services based solely on the individual *[Medicaid recipient's]* **MO HealthNet participant's** days of care (within benefit limitations) multiplied by the facility's Title XIX per diem rate less any payments made by *[recipients]* **participants**.

(B) Effective November 1, 1986, the Title XIX per diem rate for all ICF/MR facilities participating on or after October 31, 1986, shall be the lower of—

1. The average private pay charge;

2. The Medicare per diem rate, if applicable;

3. The rate paid to a facility on October 31, 1986, as adjusted by updating its base year to its 1985 fiscal year. Facilities which do not have a full twelve (12)-month 1985 fiscal year shall not have their base years updated to their 1985 fiscal years. Changes in ownership, management, control, operation, leasehold interests by whatever form for any facility previously certified for participation in the *[Medicaid P]***MO HealthNet p**rogram at any time that results in increased capital costs for the successor owner, management**,** or leaseholder shall not be recognized for purposes of reimbursement; and

4. However, any provider who does not have a rate on October 31, 1986, and whose facility meets the definition in subsection *[(3)(K)]* **(3)(J)** of this rule, will be exempt from paragraph (2)(B)3. and the rate shall be determined in accordance with applicable provisions of this rule.

[(C) In no case may the per diem reimbursement rate under the provisions of this rule exceed the level-of-care ceiling.]

*[(D)]***(C)** This plan has an effective date of November 1, 1986, at which time prospective per diem rates shall be calculated for the remainder of the state's FY-87 and future fiscal years. Per diem rates established by updating facilities' base years to FY-85 may be subject to retroactive and prospective adjustment based on audit of the facilities' new base year period.

*[(E)]***(D)** The Title XIX per diem rates as determined by this plan shall apply only to services furnished on or after November 1, 1986.

(3) Definitions.

(A) Allowable cost areas. Those cost areas which are allowable for allocation to the *[Medicaid P]***MO HealthNet p**rogram based upon the principles established in this rule. The allowability of cost areas, not specifically addressed in this rule**,** will be based upon criteria of the *Medicare Provider Reimbursement Manual* (HIM-15) and section (7) of this rule.

(B) Average private pay charge. The average private pay charge is the usual and customary charge for non-*[Medicaid]***MO HealthNet** patients determined by dividing total non-*[Medicaid]***MO HealthNet** days of care into total revenue collected for the same service that is included in the *[Medicaid]* **MO HealthNet** per diem rate, excluding negotiated payment methodologies with the Veterans Administration and the Missouri Department of Mental Health.

[(I) Level-of-care ceiling. One hundred thirty-five percent (135%) of the weighted mean rate for the nonstate-operated ICF/MR level-of-care group in effect on March 1, 1990; provided, that on July 1, 1990, and annually after that the per diem reimbursement rate as adjusted by the negotiated trend factor may be used as the basis for the level-of-care ceiling computed for the subsequent year.]

*[(J)]***(I)** Medicare rate. This is the allowable cost of care permitted by Medicare standards and principles of reimbursement.

*[(K)]***(J)** New construction. Newly built facilities or parts, for which an approved Certificate of Need (CON) or applicable waivers were obtained and which were newly completed and operational on or after November 1, 1986.

*[(L)]***(K)** New owners. Original owners of new construction.

*[(M)]***(L)** Providers. A provider under the Prospective Reimbursement Plan is a non*[-]*state-operated ICF/MR facility with a valid participation agreement, in effect on or after October 31, 1986, with the Missouri Department of Social Services for the purpose of providing long-term care (LTC) services to Title XIX-eligible *[recipients]* **participants**. Facilities certified to provide intermediate care services to the mentally retarded under the Title XIX program may be offered a *[Medicaid]* **MO HealthNet** participation agreement on or after January 1, 1990, only if 1) the facility has no more than fifteen (15) beds for mentally retarded residents**,** and 2) there is no other licensed residential living facility for mentally retarded individuals within a radius of one-half (1/2) mile of the facility seeking participation in the *[Medicaid P]***MO HealthNet p**rogram.

*[(N)]***(M)** Reasonable and adequate reimbursement. Reimbursement levels which meet the needs of an efficiently and economically operated facility and which in no case exceed normal market costs.

*[(O)]***(N)** Related parties. Parties are related when—

1. An individual or group, regardless of the business structure of either, where, through their activities, one (1) individual's or group's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in the dealings;

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

3. As used in section (3), the following terms mean:

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

B. Ownership interest means the possession of equity in the capital, in the stock**,** or in the profits of an entity;

C. Ownership or controlling interest is when a person or corporation(s)—

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

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

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

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note**,** or other obligation secured by an entity,

if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from the obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

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

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

D. Relative means persons related by blood or marriage to the fourth degree of consanguinity; and

E. Entity means any person, corporation, partnership**,** or association.

*[(P)]***(O)** Rural. Those counties which are not defined as urban.

*[(Q)]***(P)** Urban. The urban counties are standard metropolitan statistical areas including Andrew, Boone, Buchanan, Cass, Christian, Clay, Franklin, Greene, Jackson, Jasper, Jefferson, Newton, Platte, Ray, St. Charles, St. Louis**,** and St. Louis City.

(4) Prospective Reimbursement Rate Computation.

(A) Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/MR services certified to participate in Missouri's *[Medicaid]* **MO HealthNet** program.

1. ICF/MR facilities.

A. Except in accordance with other provisions of this rule, the *[Missouri Medical Assistance P]***MO HealthNet p**rogram shall reimburse providers of these LTC services based on the individual *[Medicaid-recipient]* **MO HealthNet-participant** days of care multiplied by the Title XIX prospective per diem rate less any payments collected from *[recipients]* **participants**. The Title XIX prospective per diem reimbursement rate for the remainder of *[s]***S**tate Fiscal Year 1987 shall be the facility's per diem reimbursement payment rate in effect on October 31, 1986, as adjusted by updating the facility's allowable base year to its 1985 fiscal year. Each facility's per diem costs as reported on its Fiscal Year 1985 Title XIX cost report will be determined in accordance with the principles set forth in this rule. If a facility has not filed a 1985 fiscal year cost report, the most current cost report on file with the department will be used to set its per diem rate. Facilities with less than a full twelve (12)-month 1985 fiscal year will not have their base year rates updated.

B. For *[s]***S**tate FY-88 and dates of service beginning July 1, 1987, the negotiated trend factor shall be equal to two percent (2%) to be applied in the following manner: Two percent (2%) of the average per diem rate paid to both state- and nonstate-operated ICF/MR facilities on June 1, 1987, shall be added to each facility's rate.

C. For *[s]***S**tate FY-89 and dates of service beginning January 1, 1989, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/MR facilities on June 1, 1988 shall be added to each facility's rate.

D. For *[s]***S**tate FY-91 and dates of service beginning July 1, 1990, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/MR facilities on June 1, 1990, shall be added to each facility's rate.

E. FY-96 negotiated trend factor. All nonstate-operated ICF/MR facilities shall be granted an increase to their per diem rates effective for dates of service beginning January 1, 1996, of six dollars and seven cents ($6.07) per patient day for the negotiated trend factor. This adjustment is equal to four and six-tenths percent (4.6%) of the weighted average per diem rates paid to non*[-]*state-operated ICF/MR facilities on June 1, 1995, of one hundred thirty-one dollars and ninety-three cents ($131.93).

F. State FY-99 trend factor. All non*[-]*state-operated ICF/MR facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1998, of four dollars and forty-seven cents ($4.47) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/MR facilities on June 30, 1998, of one hundred forty-eight dollars and ninety-nine cents ($148.99).

G. State FY-2000 trend factor. All nonstate-operated ICF/MR facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1999, of four dollars and sixty-three cents ($4.63) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/MR facilities on April 30, 1999, of one hundred fifty-four dollars and forty-three cents ($154.43). This increase shall only be used for increases for the salaries and fringe benefits for direct care staff and their immediate supervisors.

H. State FY-2001 trend factor. All nonstate-operated ICF/MR facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 2000, of four dollars and eighty-one cents ($4.81) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/MR facilities on April 30, 2000, of one hundred sixty dollars and twenty-three cents ($160.23). This increase shall only be used for increases for salaries and fringe benefits for direct care staff and their immediate supervisors.

I. State FY-2007 trend factor. All nonstate-operated ICF/MR facilities shall be granted an increase of seven percent (7%) to their per diem rates effective for dates of service billed for *[s]***S**tate Fiscal Year 2007. This adjustment is equal to seven percent (7%) of the per diem rate paid to nonstate-operated ICF/MR facilities on June 30, 2006.

J. State FY-2008 trend factor. Effective for dates of service beginning July 1, 2007, all nonstate-operated ICF/MR facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/MR facilities on June 30, 2007.

K. State FY-2009 trend factor. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/MR facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/MR facilities on June 30, 2008.

L. State FY-2009 catch up increase. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/MR facilities shall be granted an increase to their per diem rates of thirteen and ninety-five hundredths percent (13.95%). This adjustment is equal to thirteen and ninety-five hundredths percent (13.95%) of the per diem rate paid to nonstate-operated ICF/MR facilities on June 30, 2008. This increase is intended to provide compensation to providers for the years (2003, 2004, 2005, and 2006) where no trend factor was given. The catch up increase was based on the CMS PPS Skilled Nursing Facility Input Price Index (four (4) quarter moving average).

2. Adjustments to rates. The prospectively determined reimbursement rate may be adjusted only under the following conditions:

A. When information contained in a facility's cost report is found to be fraudulent, misrepresented**,** or inaccurate, the facility's reimbursement rate may be reduced, both retroactively and prospectively, if the fraudulent, misrepresented**,** or inaccurate information as originally reported resulted in establishment of a higher reimbursement rate than the facility would have received in the absence of this information. No decision by the *[Medicaid]* **MO HealthNet** agency to impose a rate adjustment in the case of fraudulent, misrepresented**,** or inaccurate information in any way shall affect the *[Medicaid]* **MO HealthNet** agency's ability to impose any sanctions authorized by statute or rule. The fact that fraudulent, misrepresented**,** or inaccurate information reported did not result in establishment of a higher reimbursement rate than the facility would have received in the absence of the information also does not affect the *[Medicaid]* **MO**

HealthNet agency's ability to impose any sanctions authorized by statute or rules;

B. In accordance with subsection (6)(B) of this rule, a newly constructed facility's initial reimbursement rate may be reduced if the facility's actual allowable per diem cost for its first twelve (12) months of operation is less than its initial rate;

C. When a facility's *[Medicaid]* **MO HealthNet** reimbursement rate is higher than either its private pay rate or its Medicare rate, the *[Medicaid]* **MO HealthNet** rate will be reduced in accordance with subsection (2)(B) of this rule;

D. When the provider can show that it incurred higher cost due to circumstances beyond its control**,** and the circumstances are not experienced by the nursing home or ICF/MR industry in general, the request must have a substantial cost effect. These circumstances include, but are not limited to:

(I) Acts of nature, such as fire, earthquakes**,** and flood, that are not covered by insurance;

(II) Vandalism, civil disorder, or both; or

(III) Replacement of capital depreciable items not built into existing rates that are the result of circumstances not related to normal wear and tear or upgrading of existing system;

E. When an adjustment to a facility's rate is made in accordance with the provisions of section (6) of this rule; or

F. When an adjustment is based on an Administrative Hearing Commission or court decision.

(B) In the case of newly constructed nonstate-operated ICF/MR facilities entering the *[Missouri Medicaid P]***MO HealthNet p**rogram after October 31, 1986, and for which no rate has previously been set, the director or his/her designee may set an initial rate for the facility as in his/her discretion s/he deems appropriate. The initial rate shall be subject to review by the advisory committee under the provisions of section (6) of this rule.

(5) Covered Services and Supplies.

(A) ICF/MR services and supplies covered by the per diem reimbursement rate under this plan, and which must be provided, as required by federal or state law or rule and include, among other services, the regular room, dietary and nursing services, or any other services that are required for standards of participation or certification. Also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service**,** and enemas;

2. Items which are furnished routinely and relatively uniformly to all *[recipients]* **participants**, for example, gowns, water pitchers, soap, basins**,** and bed pans;

3. Items such as alcohol, applicators, cotton balls, bandaids**,** and tongue depressors;

4. All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners**,** and nonlegend vitamins. Any nonlegend drug in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; all must be provided as needed within the existing per diem rate;

5. Items which are utilized by individual *[recipients]* **participants** but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment**,** and other durable, nondepreciable medical equipment;

6. Additional items as specified in the appendix to this plan when required by the patient;

7. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, including dietary supplements written as a prescription item by a physician;

8. All laundry services except personal laundry which is a noncovered service;

9. All general personal care services which are furnished routinely and relatively uniformly to all *[recipients]* **participants** for their personal cleanliness and appearance shall be covered services, for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos**,** and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service;

10. All consultative services as required by state or federal law or regulation or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report. Failure to do so will result in the penalties specified in section (9) of this rule;

11. Semiprivate room and board and private room and board when necessary to isolate a *[recipient]* **participant** due to a medical or social condition, such as contagious infection, irrational loud speech**,** and the like. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service**,** and a *[Medicaid recipient]* **MO HealthNet participant** or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. *[Medicaid recipients]* **MO HealthNet participants** may not be placed in private rooms and charged any additional amount above the facility's *[Medicaid]* **MO HealthNet** per diem unless the *[recipient]* **participant** or responsible party in writing specifically requests a private room prior to placement in a private room and acknowledges that an additional amount not payable by *[Medicaid]* **MO HealthNet** will be charged for a private room;

12. Twelve (12) days per any period of six (6) consecutive months during which a *[recipient]* **participant** is on a temporary leave of absence from the facility. Temporary leave of absence days must be specifically provided for in the *[recipient's]* **participant's** plan of care. Periods of time during which a *[recipient]* **participant** is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence; and

13. Days when *[recipients]* **participants** are away from the facility overnight on facility-sponsored group trips under the continuing supervision and care of facility personnel.

(6) Rate Determination. All nonstate-operated ICF/MR providers of LTC services under the *[Missouri Medicaid]* **MO HealthNet** program who desire to have their rates changed or established must apply to the *[Division of Medical Services]* **MO HealthNet Division**. The department may request the participation of the Department of Mental Health in the analysis for rate determination. The procedure and conditions for rate reconsideration are as follows:

(A) Advisory Committee. The director, Department of Social Services, shall appoint an advisory committee to review and make recommendations pursuant to provider requests for rate determination. The director may accept, reject**,** or modify the advisory committee's recommendations.

1. Membership. The advisory committee shall be composed of four (4) members representative of the nursing home industry in Missouri, three (3) members from the Department of Social Services**,** and two (2) members which may include, but are not limited to, a consumer representative, an accountant or economist**,** or a representative of the legal profession. Members shall be appointed for terms of twelve (12) months. The director shall select a chairman from the membership who shall serve at the director's discretion.

2. Procedures.

A. The committee may hold meetings when five (5) or more members are present and may make recommendations to the department in instances where a simple majority of those present and voting concur.

B. The committee shall meet no less than one (1) time each quarter**,** and members shall be reimbursed for expenses.

C. The *[Division of Medical Services]* **MO HealthNet Division** will summarize each case and, if requested by the advisory committee, make recommendations. The advisory committee may

request additional documentation as well as require the facility to submit to a comprehensive operational review to determine if there exists an efficient and economical delivery of patient services. The review will be made at the discretion of the committee and may be performed by it or its designee. The findings from a review may be used to determine the per diem rate for the facility. Failure to submit requested documentation shall be grounds for denial of the request.

D. The committee, at its discretion, may issue its recommendation based on written documentation or may request further justification from the provider sending the request.

E. The advisory committee shall have ninety (90) days from the receipt of each complete request, provided the request is on behalf of a facility which has executed a valid Title XIX participation agreement, or the receipt of any additional documentation to submit its recommendations in writing to the director. If the committee is unable to make a recommendation within the specified time limit, the director or his/her designee, if the committee establishes good cause, may grant a reasonable extension.

F. Final determination on rate adjustment. The director's, or his/her designee's, final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the committee's recommendation.

G. The director's, or his/her designee's, final determination on the advisory committee's recommendation shall become effective on the first day of the month in which the request was made, providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective the first day of the following month;

(B) In the case of new construction where a valid Title XIX participation agreement has been executed, a request for a rate must be submitted in writing to the *[Missouri Division of Medical Services]* **MO HealthNet Division** and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate**,** and documented records satisfactory to the single state agency. Until an initial per diem rate is established, the *[Division of Medical Services]* **MO HealthNet Division** shall grant a tentative per diem rate for that period. In no case may a facility receive a per diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of newly built facility or part of the facility which is less than two (2) years of age and enters the Title XIX Program on or after November 1, 1986, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for new construction. Owners of new construction which have an approved CON are certified for participation and which have a valid Title XIX participation agreement shall submit a budget in accordance with the principles of section (7) of this rule and other documentation as the committee may request.

2. The establishment of the permanent rate for all new construction facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7) of this rule. This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety (90)-day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for new construction facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection *[(3)(J)]* **(3)(A)** of this rule.

4. The cost report, audited or unaudited, will be reviewed by the *[Division of Medical Services]* **MO HealthNet Division,** and each facility's actual allowable per diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per diem cost is less than its initial per diem reimbursement rate, the facility's rate will be reduced to its actual allowable per diem cost. This reduction will be effective on the first day of the second full facility fiscal year.

5. If a facility's actual allowable per diem cost is higher than its initial per diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost report and actual operating costs;

(C) In the case of existing facilities not previously certified to participate in the Title XIX program, a request for a per diem reimbursement rate must be submitted in writing to the *[Division of Medical Services]* **MO HealthNet Division** and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate**,** and documented records satisfactory to the single state agency. Until the time as a per diem rate is established, the *[Division of Medical Services]* **MO HealthNet Division** shall grant a tentative per diem rate for that period. In no case may a facility receive a per diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of a facility described in subsection (6)(C) of this rule and entering the Title XIX program on or after March 1, 1990, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for first full facility's fiscal year.

2. The establishment of the permanent rate for all existing facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7) of this rule. This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety (90)-day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for existing facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection *[(3)(J)]* **(3)(A)** of this rule.

4. The cost report, audited or unaudited, will be reviewed by the *[Division of Medical Services]* **MO HealthNet Division,** and each facility's actual allowable per diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per diem cost is less than its initial per diem reimbursement rate, the facility's rate will be reduced to its actual allowable per diem cost. This reduction will be effective on the second day of the first full facility fiscal year.

5. If a facility's actual allowable per diem cost is higher than its initial per diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost report and actual operating costs;

(D) Rate Reconsideration.

1. The committee may review the following conditions for rate reconsideration:

A. Those costs directly related to a change in a facility's case mix; and

B. Requests for rate reconsideration which the director, in his/her discretion, may refer to the committee due to extraordinary circumstances contained in the request and as defined in subparagraph (4)(A)2.D. of this rule.

2. The request for an adjustment must be submitted in writing to the *[Missouri Division of Medical Services]* **MO HealthNet Division** and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by complete, accurate**,** and documented records satisfactory to

the single state agency. The facility must demonstrate that the adjustment is necessary, proper**,** and consistent with efficient and economical delivery of covered patient care services.

3. However, for state fiscal years after Fiscal Year 1987, in no case may a facility receive a per diem reimbursement rate higher than the class ceiling for that facility in effect on June 30 of the preceding fiscal year adjusted by the negotiated trend factor.

4. The following will not be subject to review:

A. The negotiated trend factor;

B. The use of prospective reimbursement rate; and

C. The cost base for the June 30 per diem rate except as specified in this rule;

(E) Rate Adjustments. The department may alter a facility's per diem rate based on—

1. Court decisions;

2. Administrative Hearing Commission decisions;

3. Determination through desk audits, field audits**,** and other means, which establishes misrepresentations in or the inclusion of unallowable costs in the cost report used to establish the per diem rate. In these cases**,** the adjustment shall be applied retroactively;

4. Adjustments determined by the department without the advice of the rate advisory committee.

A. Prospective payment adjustment (PPA). A FY-92 PPA will be provided prior to the end of the state fiscal year for nonstate-operated ICF/MR facilities with a current provider agreement on file with the *[Division of Medical Services]* **MO HealthNet Division** as of October 1, 1991.

(I) For providers which qualify, the PPA shall be the lesser of—

(a) The provider's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjustment factor (PPAF) times the nonstate-operated intermediate care facility for the mentally retarded ceiling (ICFMRC) on October 1, 1991 (FPGF $\times$ PPD $\times$ PPAF $\times$ ICFMRC). For example: A provider having nine hundred twenty (920) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of twenty-eight thousand five hundred sixty-one (28,561) represents an FPGF of three and twenty-two hundredths percent (3.22%). So using the FPGF of 3.22% $\times$ 114,244 $\times$ 24.5% $\times$ $156.01 = $140,659; or

(b) The provider FPGF times one hundred forty-five percent (145%) of the amount credited to the intermediate care revenue collection center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

(II) FPGF—is determined by using each ICF/MR facility's paid days for the service dates in May 1991 through July 1991 as of September 20, 1991, divided by the sum of the paid days for the same service dates for all provider's qualifying as of the determination date of October 16, 1991.

(III) ICFMRC—is one hundred fifty-six dollars and one cent ($156.01) on October 1, 1991.

(IV) PPAF—is equal to twenty-four and five-tenths percent (24.5%) for Fiscal Year 1992 which includes an adjustment for economic trends.

(V) PPD—is the projection of one hundred fourteen thousand two hundred forty-four (114,244) patient days made on October 1, 1991, for the adjustment year;

5. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of eight dollars and eighty-six cents ($8.86) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/MR facilities; or

6. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of one dollar and sixty-six cents ($1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/MR facilities; and

(7) Allowable Cost Areas.

(C) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings**,** and equipment which are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight-line method of depreciation from the date initially put into service.

3. The basis of assets at the time placed in service shall be the lower of—

A. The book value of the provider;

B. Fair market value at the time of acquisition;

C. The recognized Internal Revenue Service (IRS) tax basis; and

D. In the case of the change in ownership, the cost basis of acquired assets of the owner of record on or after July 18, 1984, as of the effective date of the change of ownership; or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the *[Medicaid]* **MO HealthNet** program.

4. The basis of donated assets will be allowed to the extent of recognition of income resulting from the donation of the asset. Should a dispute arise between a provider and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the *[Medicaid]* **MO HealthNet** program and the facility in ratio to *[Medicaid recipient]* **MO HealthNet participant** reimbursable patient days to total patient days.

5. Allowable methods of depreciation shall be limited to the straight-line method. The depreciation method used for an asset under the *[Medicaid]* **MO HealthNet** program need not correspond to the method used by a provider for non-*[Medicaid]***MO HealthNet** purposes; however, useful life shall be in accordance with the American Hospital Association's Guidelines. Component part depreciation is optional and allowable under this plan.

6. Historical cost is the cost incurred by the provider in acquiring the asset and preparing it for use except as provided in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees and related legal fees. Where a provider has elected, for federal income tax purposes, to expense certain items such as interest and taxes during construction, the historical cost basis for *[Medicaid]* **MO HealthNet** depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this rule, any asset costing less than five hundred dollars ($500) or having a useful life of one (1) year or less, may be expensed and not capitalized at the option of the provider, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the *[Medicaid P]***MO HealthNet p**rogram.

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

8. For the purpose of determining allowance for depreciation, the cost basis of the asset shall be as prescribed in paragraph (7)(C)3.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if these capital expenditures fail to comply with any other federal or state law or regulation, such as CON.

10. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this plan.

(D) Interest and Finance Costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for those purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and capital improvements, and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost item, interest (including finance charges, prepaid costs**,** and discounts) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claims**,** and necessary and proper for the operation, maintenance**,** or acquisition of the provider's facilities.

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

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made, and provided further the department shall not reimburse for interest and finance charges any amount in excess of the prime rate current at the time the loan was obtained.

7. Interest on loans to providers by proprietors, partners**,** and any stockholders shall not be an allowable cost item because the loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity. If a facility operated by a religious order borrows from the order, interest paid to the order shall be an allowable cost.

8. If loans for capital indebtedness exceed the asset cost basis as defined in subsection (7)(C) of this rule, the interest associated with the portion of the loan(s) which exceed the asset cost basis as defined in subsection (7)(C) of this rule shall not be allowable.

9. Income from a provider's qualified retirement fund shall be excluded in consideration of the per diem rate.

10. A provider shall amortize finance charges, prepaid interest**,** and discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

11. Usual and customary costs, excluding finder's fees, incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

12. Usual and customary costs shall be limited to the lender's title and recording fees, appraisal fees, legal fees, escrow fees**,** and closing costs.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost item if the capital expenditure fails to comply with other federal or state law or rules such as CON.

(E) Rental and Leases.

1. Rental and leases of land, buildings, furnishings**,** and equipment are allowable cost areas provided that the rented items are necessary and not in essence a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those which are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those which are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and amounts, except in the case of related parties which is subject to other provisions of this rule, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to CON approval must have that approval before a rate is determined.

7. If rent or lease costs increase solely as a result of change in ownership, the resulting increase which exceeds the allowable capital cost of the owner of record as of July 18, 1984, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the *[Medicaid P]***MO HealthNet p**rogram, shall be a nonallowable cost.

(N) Utilization Review. Incurred cost for the performance of required utilization review for ICF/MR is an allowable cost area. The expenditures must be for the purpose of providing utilization review on behalf of Title XIX *[recipient]* **participant**. Utilization review costs incurred for Title XVIII and Title XIX must be apportioned on the basis of reimbursable *[recipient]* **participant** days recorded for each program during the reporting period.

(P) Nonreimbursable Costs.

1. Bad debts, charity**,** and courtesy allowances are deductions from revenue and are not to be included as allowable costs.

2. Those services that are specifically provided by Medicare and *[Medicaid]* **MO HealthNet** must be billed to those agencies.

3. Any costs incurred that are related to fund drives are not reimbursable.

4. Costs incurred for research purposes shall not be included as allowable costs.

5. The cost of services provided under the Title XX program, by contract or subcontract, is specifically excluded as an allowable item.

6. Attorney fees related to litigation involving state, local**,** or federal governmental entities and attorneys' fees which are not related to the provision of LTC services, such as litigation related to disputes between or among owners, operators**,** or administrators.

7. Costs, such as legal fees, accounting and administration costs, travel costs and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition of merger for which any payment has been previously made under the program.

(Q) Other Revenues. Other revenues, including those listed that follow and excluding amounts collected under paragraph (5)(A)8. will be deducted from the total allowable cost and must be shown separately in the cost report by use of a separate schedule if included in the gross revenue: income from telephone services; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time**,** and other discounts; purchase rebates and refunds; recovery on insured loss; parking lot revenues; vending machine commissions or profit; sales from drugs to other than *[recipients]* **participants**; income from investments of whatever type; and room reservation charges for temporary leave of absence days which are not covered

services under section (5) of this rule. Failure to separately account for any of the revenues specifically set out previously in this rule in a readily ascertainable manner shall result in termination from the program.

1. Interest income received from a funded depreciation account will not be deducted from allowable operating costs provided that interest is applied to the replacement of the asset being depreciated.

2. Cost centers or operations specified by the provider in paragraph (7)(R)3. of this rule shall not have their associated cost or revenues included in the covered costs or revenues of the facility.

3. Restricted and unrestricted funds.

A. Restricted funds as used in this rule mean those funds, cash or otherwise, including grants, gifts, taxes**,** and income from endowments, which must be used only for a specific purpose designated by the donor. Those restricted funds which are not transferred funds and are designated by the donor for paying operating costs will be offset from the total allowable expenses. If an administrative body has the authority to rerestrict restricted funds designated by the donor for paying operating costs, the funds will not be offset from total allowable expenses.

B. Unrestricted funds as used in this rule mean those funds, cash or otherwise, including grants, gifts, taxes**,** and income from endowments, that are given to a provider without restriction by the donor as to their use. These funds can be used in any manner desired by the provider. However, those unrestricted funds which are not transferred funds and are used for paying operating costs will be offset from total allowable expenses.

C. Transferred funds as used in this rule are those funds appropriated through a legislative or governmental administrative body's action, state or local, to a state or local government provider. The transfer can be state-to-state, state-to-local or local-to-local provider. These funds are not considered a grant or gift for reimbursement purposes, so having no effect on the provider's allowable cost under this plan.

(R) Apportionment of Costs to *[Medicaid Recipient]* **MO HealthNet Participant** Residents.

1. Provider's allowable cost areas shall be apportioned between *[Medicaid Program recipient]* **MO HealthNet program participant** residents and other patients so that the share borne by the *[Medicaid P]***MO HealthNet p**rogram is based upon actual services received by program *[recipients]* **participants**.

2. To accomplish this apportionment, the ratio of *[recipient]* **participant** residents' charges to total patient charges for the service of each ancillary department may be applied to the cost of this department. To this shall be added the cost of routine services for *[Medicaid Program recipient]* **MO HealthNet program participant** residents determined on the basis of a separate average cost per diem for general routine care areas or at the option of the provider on the basis of overall routine care area.

3. So that its charges may be allowable for use in apportioning costs under the program, each provider shall have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonable and consistently related to the cost of providing these services.

4. Average cost per diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

5. A patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (5) of this rule, the day of discharge being counted only when the patient was admitted the same day. A census log shall be maintained in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a *[recipient]* **participant** is away from the facility on a facility-sponsored group trip and remains under the supervision and care of facility personnel.

6. ICF/MR facilities that provide intermediate care services to *[Medicaid recipients]* **MO HealthNet participants** may establish distinct part cost centers in their facility provided that adequate accounting and statistical data required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share the common services and facilities**, such** as management services, dietary, housekeeping, building maintenance**,** and laundry.

7. In no case may a provider's allowable costs allocated to the *[Medicaid P]***MO HealthNet p**rogram include the cost of furnishing services to persons not covered under the *[Medicaid P]***MO HealthNet p**rogram.

(S) Return on Equity.

1. A return on a provider's net equity shall be an allowable cost area.

2. The amount of return on a provider's net equity shall not exceed twelve percent (12%).

3. An owner's net equity is comprised of investment capital and working capital. Investment capital includes the investment in building, property**,** and equipment (cost of land, mortgage payments toward principle**,** and equipment purchase less the accumulative depreciation). Working capital represents the amount of capital which is required to insure proper operation of the facility.

4. The return on owner's net equity shall be payable only to proprietary providers.

5. A provider's return on owner's net equity shall be apportioned to the *[Medicaid P]***MO HealthNet p**rogram on the basis of the provider's *[Medicaid P]***MO HealthNet p**rogram reimbursable *[recipient]* **participant** resident days of care to total resident days of care during the cost-reporting period. For the purpose of this calculation, total resident days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy during the cost year.

(8) Reporting Requirements.

(A) Annual Cost Report.

1. Each provider shall establish a twelve (12)-month fiscal period which is to be designated as the provider's fiscal year. An annual cost report for the fiscal year shall be submitted by the provider to the department on forms to be furnished for that purpose. The completed cost report shall be submitted by each provider the first day of the sixth month following the close of the fiscal period.

2. Unless adequate and current documentation in the following areas has been filed previously with the department, authenticated copies of the following documents must be submitted with the cost reports: authenticated copies of all leases related to the activities of the facility; all management contracts, all contracts with consultants; federal and state income tax returns for the fiscal year; and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.

3. Adequate documentation for all line items on the uniform cost reports must be maintained by the facility and must be submitted to the department upon request.

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

5. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership**,** or termination of participation in the *[Medicaid P]***MO HealthNet p**rogram, the division will withhold

all remaining payments from the selling provider until the cost report is filed. The fully completed cost report with all required attachments and documentation is due the first day of the sixth month after the date of change of control, ownership**,** or termination. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.

(10) Exceptions.

(A) For those *[Medicaid]***MO HealthNet**-eligible *[recipient]***participant**-patients who have concurrent Medicare Part A skilled nursing facilities benefits available, *[Missouri Medical Assistance Program]* **MO HealthNet** reimbursement for covered days of stay in a qualified facility will be based on the coinsurance as may be imposed under the Medicare Program.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided services of fewer than one thousand (1,000) patient days for Missouri Title XIX *[recipients]* **participants**, the reimbursement rate shall be the rate paid for comparable services and level-of-care by the state in which the provider is located; and

2. For providers which provide services of one thousand (1,000) or more patient days for Missouri Title XIX *[recipients]* **participants**, the reimbursement rate shall be the lower of—

A. The rate paid for comparable services and level-of-care by the state in which the provider is located; or

B. The rate calculated in sections (4) and (6) of this rule.

(11) Payment Assurance.

(B) Where third-party payment is involved, *[Medicaid]* **MO HealthNet** will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Service. Procedures for remitting third-party payments are provided in the *[Missouri Medical Assistance P]***MO HealthNet p**rogram provider manuals.

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

AUTHORITY: section[s 208.153,] 208.159 [and 208.201], RSMo 2000 ***and sections 208.153 and 208.201, RSMo Supp. 2007****. This rule was previously filed as 13 CSR 40-81.083. Original rule filed Aug. 13, 1982, effective Nov. 11, 1982. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed June 18, 2008, effective July 1, 2008, expires Dec. 28, 2008. Amended: Filed July 1, 2008.*

PUBLIC COST: This proposed amendment will cost public entities or political subdivisions approximately nine hundred eighty-seven thousand one hundred eighteen dollars ($987,118) annually until amended.

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

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

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Social Services
Division Title: MO HealthNet Division
Chapter Title: Nursing Home Program

Rule Number and Name:	13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/MR Services
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Social Services MO HealthNet Division	Annual estimated cost: $987,118 **

III. WORKSHEET

SFY 2009:

3% Trend

Estimated paid Days: SFY 2009	29,848
x Average Rate Increase	$5.86 *
Total Estimated Impact for 3%: SFY 2009	$174,715

13.95% Increase

Estimated Paid Days: SFY 2009	29,848
x Average Rate Increase	$27.22 *
Total Estimated Impact for 13.95%: SFY 2009	$812,402

Grand Total Impact SFY 2009 $987,118

IV. ASSUMPTIONS

Effective for dates of services billed for state fiscal year 2009, ICF/MR facilities Medicaid per-diem rates will be increased by three percent (3%) and thirteen and ninety-five hundredths percent (13.95%). The adjustment for each facility is calculated by multiplying 3% and 13.95% by the per diem rate paid on June 30, 2008. The total for the 3% and the 13.95% increase is then totaled for the grand total impact.

* The average rate increase is a weighted average of the facilities computed by adding the impact for all the facilities and dividing by the estimated days for all the facilities. The impact for each facility was determined by multiplying the estimated days for each facility by each facility's specific rate increase that reflected the 3% and the 13.95% increase.

** The $987,118 is the estimated cost for SFY 2009. After SFY 2009 this amount will become part of the core budget and continue annually until amended.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

PROPOSED AMENDMENT

13 CSR 70-10.080 Prospective Reimbursement Plan for HIV Nursing Facility Services. The division is amending sections (1), (2), (4), (10), and (13).

PURPOSE: This amendment provides for the following changes: section (1) was changed to update the division's name; section (2) was changed to clearly state the division's policy regarding how the division will implement its decisions during the appeal process; section (4) was changed to update the definition of division; section (10) was changed to add "incorporated by reference" language to the cost report and instructions; and section (13) was changed to move global per diem adjustments to 13 CSR 70-10.016.

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) Authority. This regulation is established pursuant to the authorization granted to the Department of Social Services (department), *[Division of Medical Services]* **MO HealthNet Division** (division), to promulgate rules and regulations.

(2) Purpose. This regulation establishes a methodology for determination of reimbursement rates for human immunodeficiency virus (HIV) nursing facilities, operated exclusively for persons with HIV that causes acquired immunodeficiency syndrome (AIDS). Subject to limitations prescribed elsewhere in this regulation, a facility's reimbursement rate shall be determined by the division as described in this regulation. Any reimbursement rate determined*[,]* by the division*[, that has been appealed in a timely manner shall not be final until there is a final decision.]* **shall be a final decision and will be implemented as set forth in the division's decision letter. The decisions of the division may be subject to review upon properly filing a complaint with the Administrative Hearing Commission (AHC). A nursing facility seeking review by the AHC must obtain a stay from the AHC to stop the division from implementing its final decision if the AHC determines the facility meets the criteria for a stay and so orders. If the facility appeals the division's decision, it is the responsibility of the nursing facility to notify any interested parties, including but not limited to hospice providers, that the rate being received is not a final rate and is subject to change.** Federal financial participation is available on expenditures for services provided within the scope of the Federal Medicaid Program and made under a court order in accordance with 42 CFR 431.250.

(4) Definitions.

(U) Division. Unless otherwise specified, division refers to the *[Division of Medical Services]* **MO HealthNet Division**, the division of the Department of Social Services charged with administration of Missouri's *[Medical Assistance (Medicaid)]* **MO HealthNet** Program.

(YY) Incorporation by Reference. This rule adopts and incorporates by reference the provisions of the—

1. **Financial and Statistical Report for Nursing Facilities (version MSIR-1 (3-95)) and the cost report instructions (revised 3/95) published by the** Missouri Department of Social Services, *[Division of Medical Services, Financial and Statistical Report for Nursing Facilities (Title XIX Cost Report)]* **MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, August 1, 2008. This rule does not incorporate any subsequent amendments or additions**;

2. *[Missouri Medicaid]* **MO HealthNet** Nursing Home Manual*[.]***, which is published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, August 1, 2008. This rule does not incorporate any subsequent amendments or additions.**

(10) Provider Reporting and Record Keeping Requirements.

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

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

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

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

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

5. Cost reports shall be submitted by the first day of the fourth month following the close of the fiscal period, unless an extension has been granted.

6. If requested in writing and postmarked prior to the first day of the fourth month following the close of the fiscal period, one (1) thirty (30)-day extension of the filing date may be granted.

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

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

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

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

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

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

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

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

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

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

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

M. Schedule of capital assets with corresponding debt.

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

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

(13) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed elsewhere in this regulation, a facility's reimbursement rate may be adjusted as described in this section **and 13 CSR 70-10.016**.

(A) Global Per Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments **as set forth in 13 CSR 70-10.016**. Global per diem rate adjustments shall be added to the specified cost component ceiling.

[1. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on September 1, 1997, shall be granted an increase to their per diem effective September 1, 1997, of one dollar and ninety-eight cents ($1.98) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the forty-cent (40¢) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by 8.67% to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator and assistant administrator.

2. FY-98 negotiated trend factor.

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1997, shall be granted an increase to their per diem effective October 1, 1997, of 3.4% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1. and the property insurance and property taxes detailed in paragraph (11)(D)3. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of this regulation.

3. FY-99 negotiated trend factor.

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1998, shall be granted an increase to their per diem effective October 1, 1998, of 2.1% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., the property insurance and property taxes detailed in paragraph (11)(D)3. of this regulation and the minimum wage adjustment detailed in paragraph (13)(A)1.; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1, 1998, shall have their increase determined by subsection (3)(S) of this regulation.

4. FY-2000 negotiated trend factor.

A. Facilities with either an interim rate or prospective rate in effect on July 1, 1999, shall be granted an increase to their per diem effective July 1, 1999, of 1.94% of the cost determined in subsections (11)(A), (11)(B), (11)(C), the property insurance and property taxes detailed in paragraph (11)(D)3. and the minimum wage adjustment detailed in paragraph (13)(A)1. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on July 1, 1999, shall have their increase determined by subsection (3)(S) of this regulation.

5. FY-2004 nursing facility operations adjustment.

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2003, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2003 through June 30, 2004 of four dollars and thirty-two cents ($4.32) for the cost of nursing facility operations. Effective for dates of service beginning July 1, 2004, the per diem adjustment shall be reduced to three dollars and seventy-eight cents ($3.78).

B. The operations adjustment shall be added to the facility's current rate as of June 30, 2003 and is effective for payment dates after August 1, 2003.

6. FY-2007 quality improvement adjustment.

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2006, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2006 of three dollars and seventeen cents ($3.17) to improve the quality of life for nursing facility residents.

B. The quality improvement adjustment shall be added to the facility's current rate as of June 30, 2006 and is effective for dates of service beginning July 1, 2006 and after.

7. FY-2007 trend adjustment.

A. Facilities with either an interim rate or a prospective rate in effect on February 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning February 1, 2007 of three dollars and zero cents ($3.00) to allow for a trend adjustment to ensure quality nursing facility services.

B. The trend adjustment shall be added to the facility's reimbursement rate as of January 31, 2007 and is effective for dates of service beginning February 1, 2007 for payment dates after March 1, 2007.

8. FY-2008 trend adjustment.

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2007 of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services.

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2007 and is effective for dates of service beginning July 1, 2007.]

*AUTHORITY: sections 208.153 and 208.201, RSMo [2000] **Supp. 2007** [and CCS for SCS for HCS for HB 1011, 93rd General Assembly]. Original rule filed Aug. 1, 1995, effective March 30, 1996. For intervening history, please consult the **Code of State Regulations**. Amended: Filed July 1, 2008.*

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

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

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

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—*[Division of Medical Services]* *MO HealthNet Division*
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending sections (1)–(8), (10), (12)–(15), and (17)–(21).

PURPOSE: This amendment provides for the MO HealthNet share of the Federal Reimbursement Allowance (FRA) assessment cost included in the Direct Medicaid payment to be allocated between a hospital's inpatient and outpatient services. This amendment also clarifies the calculation of the estimated MO HealthNet days to be used in determining the Direct Medicaid payment, and updates the trend indices used for inflating prior fiscal year data to the current state fiscal year. It also changes the name of the state's medical assistance program to MO HealthNet and revises the name of the program's administering agency to MO HealthNet Division to comply with state law. The amendment also changes reference to program recipients to participants.

(1) General Reimbursement Principles.

(A) For inpatient hospital services provided for an individual entitled to Medicare Part A inpatient hospital benefits and eligible for *[Medicaid]* **MO HealthNet**, reimbursement from the *[Missouri Medicaid P]***MO HealthNet p**rogram will be available only when *[Medicaid's]* **MO HealthNet's** applicable payment schedule amount exceeds the amount paid by Medicare. *[Medicaid's]* **MO HealthNet's** payment will be limited to the lower of the deductible and coinsurance amounts or the amount the *[Medicaid]* **MO HealthNet** applicable payment schedule amount exceeds the Medicare payments. For all other *[Medicaid recipients]* **MO HealthNet participants**, unless otherwise limited by rule, reimbursement will be based solely on the individual *[recipient's]* **participant's** days of care (within benefit limitations) multiplied by the individual hospital's Title XIX per diem rate. As described in paragraph (5)(D)2. of this rule, as part of each hospital's fiscal year-end cost settlement determination, a comparison of total *[Medicaid]***MO HealthNet**-covered aggregate charges and total *[Medicaid]* **MO HealthNet** payments will be made and any hospital whose aggregate *[Medicaid]* **MO HealthNet** per diem payments exceed aggregate *[Medicaid]* **MO HealthNet** charges will be subject to a retroactive adjustment.

(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]* **MO HealthNet** 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]* **MO HealthNet** and the cost of the uninsured unless otherwise permitted by federal law.

4. *[Medicaid]* **MO HealthNet** Add-Ons—*[Medicaid]* **MO HealthNet** Add-Ons are described in sections (13), (14), (15), (19)**,** and (21) and are in addition to *[Medicaid]* **MO HealthNet** 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.

(A) Allowable costs. Allowable costs are those related to covered *[Medicaid]* **MO HealthNet** services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the *[Missouri Medicaid]* **MO HealthNet** hospital provider manual and detailed on the desk-reviewed **Medicare**/Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary**,** and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item.

(G) Cost report. A cost report details, for purposes of both Medicare and *[Medicaid]* **MO HealthNet** reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report.

(I) 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 allowed but not mandated under federal regulation. These Safety Net and Uninsured Payment Add-Ons shall not exceed one hundred percent (100%) of the unreimbused cost for *[Medicaid]* **MO HealthNet** and the cost of the uninsured unless otherwise permitted by federal law.

(K) *[Medicaid]* **MO HealthNet** inpatient days. *[Medicaid]* **MO HealthNet** inpatient days are paid *[Medicaid]* **MO HealthNet** days for inpatient hospital services as reported by the Medicaid Management Information System (MMIS).

(L) Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR part**s** 405 **and 413**) as determined by the servicing fiscal intermediary based on yearly hospital cost reports.

(M) Nonreimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital;

2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;

3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and

4. Costs or services or costs and services specifically excluded or restricted in this plan or the *[Medicaid]* **MO HealthNet** hospital provider manual.

(O) Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital's *[Medicaid]* **MO HealthNet** per diem cost per day as determined in accordance with the general plan rate calculation from section (3) of this regulation using the base year cost report.

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

(A) The per diem rate shall be determined from the 1995 base year cost report in accordance with the following formula:

$$\text{Per Diem} = \frac{(\text{OC} * \text{TI})}{\text{MPD}} + \frac{\text{CMC}}{\text{MPDC}}$$

1. OC—The operating component is the hospital's total allowable cost (TAC) less CMC;

2. CMC—The capital and medical education component of the hospital's TAC;

3. MPD—Medicaid inpatient days;

4. MPDC-MPD—Medicaid patient days for capital costs as defined in paragraph (3)(A)3. with a minimum utilization of sixty percent (60%) as described in paragraph (5)(C)8.;

5. TI—Trend indices. The trend indices are applied to the OC of the per diem rate. The trend indices for SFY 1995 is used to adjust the OC to a common fiscal year end of June 30;

6. TAC—Allowable inpatient routine and special care unit expenses, ancillary expenses**,** and graduate medical education costs will be added to determine the hospital's total allowable cost (TAC);

7. The per diem shall not exceed the average *[Medicaid]* **MO HealthNet** inpatient charge per diem as determined from the base year cost report and adjusted by the TI; and

8. The per diem shall be adjusted for rate increases granted in accordance with subsection (5)(F) for allowable costs not included in the base year cost report.

(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%
N. SFY 2007—5.9%
O. SFY 2008—5.5%
P. SFY 2009—5.5%

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).

(4) Per Diem Rate—New Hospitals.

(A) Facilities Reimbursed by Medicare on a Per Diem Basis. In the absence of adequate cost data, a new facility's *[Medicaid]* **MO HealthNet** rate may be its most current Medicare rate on file for two (2) fiscal years following the facility's initial fiscal year as a new facility. The *[Medicaid]* **MO HealthNet** rate for this third fiscal year will be the lower of the most current Medicare rate on file by review date or the facility's *[Medicaid]* **MO HealthNet** rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The *[Medicaid]* **MO HealthNet** rate for the facility's fourth fiscal year will be determined in accordance with sections (1)–(3) of this plan.

(B) Facilities Reimbursed by Medicare on a DRG Basis. In the absence of adequate cost data, a new facility's *[Medicaid]* **MO HealthNet** rate may be ninety percent (90%) of the average-weighted, statewide per diem rate for two (2) fiscal years following the facility's initial fiscal year as a new facility. The *[Medicaid]* **MO HealthNet** rate for the third fiscal year will be the facility's *[Medicaid]* **MO HealthNet** rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The *[Medicaid]* **MO HealthNet** rate for the facility's fourth fiscal year will be determined in accordance with sections (1)–(3) of this plan.

(C) In addition to the *[Medicaid]* **MO HealthNet** rate determined by either subsection (4)(A) or (4)(B), the *[Medicaid]* **MO HealthNet** per diem rate for a new hospital licensed after February 1, 2007**,** shall include an adjustment for the hospital's estimated Direct Medicaid *[a]***A**dd-*[o]***O**n payment per patient day, as determined in subsection (15)(C), until the facility's fourth fiscal year. The *[Medicaid]* **MO HealthNet** rate for the facility's fourth fiscal year will be determined in accordance with sections (1)–(3) of this plan. The facility's Direct Medicaid *[a]***A**dd-*[o]***O**n adjustment will then no longer be included in the per diem rate but shall be calculated as a separate *[a]***A**dd-*[o]***O**n payment, as set forth in section (15).

(5) Administrative Actions.

(A) Cost Reports.

1. Each hospital participating in the *[Missouri Medical Assistance P]***MO HealthNet p**rogram shall submit a cost report in the manner prescribed by the state *[Medicaid]* **MO HealthNet** agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). A single extension, not to exceed thirty (30) days, may be granted upon the request of the hospital and the approval of the *[Missouri Division of Medical Services]* **MO HealthNet Division** when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and postmarked prior to the first day of the sixth month following the hospital's fiscal year end.

2. The change of control, ownership**,** or termination of or by a hospital of participation in the program requires that the hospital submit a cost report for the period ending with the date of change of control, ownership**,** or termination within five (5) calendar months after the close of the reporting period. No extensions in the submitting of cost reports shall be allowed when a termination of participation has occurred.

A. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership**,** or termination of participation in the *[Medicaid]* **MO HealthNet** program, the division will withhold all remaining payments from the selling provider until the cost report is filed. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.

B. If the director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership upon learning of a change of control or ownership, fifty thousand dollars ($50,000) of the next available *[Medicaid]* **MO HealthNet** payment, after learning of the change of control or ownership**,** will be withheld from the provider identified in the current *[Medicaid]* **MO HealthNet** participation agreement until a cost report is filed. If the *[Medicaid]* **MO HealthNet** payment is less than fifty thousand dollars ($50,000), the entire payment will be withheld. Once the cost report prepared in accordance with this regulation is received, the payment will be released to the provider identified in the current *[Medicaid]* **MO HealthNet** participation agreement.

C. The *[Division of Medical Services]* **MO HealthNet Division** may, at its discretion, delay the withholding of funds specified in subparagraphs (5)(A)2.A. and B. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the buying and selling provider may provide adequate assurances. The buying provider must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold fifty thousand dollars ($50,000) if the cost report is not timely filed.

3. All cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report, within the period prescribed in this subsection, may result in the impositions of sanctions as described in 13 CSR 70-3.030.

4. Amended cost reports or other supplemental. The division will notify hospital by letter when the desk review of its cost report is completed. Since*[,]* this data may be used in the calculation of per diem rates, direct payments, trended costs**,** or uninsured add-on payments, the hospital shall review the desk review data and the schedule of key data elements and submit amended or corrected data to the division within fifteen (15) days. Data received after the fifteen (15)-day deadline will not be considered by the division for per diem rates, direct payments, trended costs**,** or uninsured payments unless the hospital requests in writing and receives an extension to file additional information prior to the end of the fifteen (15)-day deadline.

(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]* **MO HealthNet** (excluding cross-over claims) respectively. Separate logs for inpatient and outpatient services should be maintained for *[Medicaid recipients]* **MO HealthNet participants** covered by managed care *[(MC+)]*. All records must be available upon request to representatives, employees**,** or contractors of the *[Missouri Medical Assistance P]***MO HealthNet p**rogram, 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]* **MO HealthNet** log for each fiscal year must be maintained by either date of service or date of payment by *[Medicaid]* **MO HealthNet** 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]* **MO HealthNet** 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]* **Participant** name and *[Medicaid]* **MO HealthNet** number;

(II) Dates of service;

(III) If inpatient claim, number of days paid for by *[Medicaid]* **MO HealthNet**, 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]* **MO HealthNet** payment rates by third-party payers shall not be included in the log);

(VIII) *[Medicaid]* **MO HealthNet** 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]* **MO HealthNet** or claims or charges paid from an established *[Medicaid]* **MO HealthNet** fee schedule. This would include 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]* **MO HealthNet** 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]* **MO HealthNet Division** 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]* **MO HealthNet Division** 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.

(C) New, Expanded**,** or Terminated Services. A hospital, at times, may offer to the public new or expanded inpatient services which may require Certificate of Need (CON) approval, or may permanently terminate a service.

1. A state hospital, i.e., one owned or operated by the board of curators as provided for in Chapter 172, RSMo, or one owned or operated by the Department of Mental Health, may offer new or expanded inpatient services to the public provided it receives legislative appropriations for the project. A state hospital may submit a request for inpatient rate reconsideration if the project meets or exceeds a cost threshold of one (1) million dollars for capital expenditures or one (1) million dollars for major medical equipment expenditures as described in 19 CSR 60-50.300.

2. Nonstate hospitals may also offer new or expanded inpatient services to the public, and incur costs associated with the additions or expansions which may qualify for inpatient rate reconsideration requests. Such projects may require a Certificate of Need (CON). Rate reconsideration requests for projects requiring CON review must include a copy of the CON program approval. Nonstate hospitals may request inpatient rate reconsiderations for projects not requiring review by the CON program, provided each project meets

or exceeds a cost threshold of one (1) million dollars for capital expenditures as described in 19 CSR 60-50.300.

3. A hospital (state or nonstate) will have six (6) months after the new or expanded service project is completed and the service is offered to the public to submit a request for inpatient rate reconsideration, along with a budget of the project's costs. The rate reconsideration request and budget will be subject to desk review and audit. Upon completion of the desk review and audit, the hospital's inpatient reimbursement rates may be adjusted, if indicated. Failure to submit a request for rate reconsideration and project budget within the six (6)-month period shall disqualify the hospital from receiving a rate increase prior to recognizing the increase through the trended cost calculation (direct Medicaid payments). Failure to submit a request shall not prohibit the division from reducing the rate in the case of a terminated service.

4. Failure to submit a budget concerning terminated services may result in the imposition of sanctions as described in 13 CSR 70-3.030.

5. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the *[Division of Medical Services']* **MO HealthNet Division's** final determination on rate reconsideration.

6. Any inpatient rate reconsideration request for new, expanded, or terminated services must be submitted in writing to the *[Division of Medical Services]* **MO HealthNet Division** and must specifically and clearly identify the issue and total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the adjustment is necessary, proper**,** and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60)-day period shall be grounds for denial of the request. If the state does not respond within the sixty (60)-day period, the request shall be deemed denied.

7. Rate adjustments due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense**,** and annual additional operating costs) multiplied by the ratio of total inpatient costs (less SNF and swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the agency as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days.

8. Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the days, including neonatal units, are less than sixty percent (60%), the sixty percent (60%) number plus newborn days will be used to determine the rate increase. This computation will apply to capital costs only.

9. Major medical equipment costs included in rate reconsideration requests shall not include costs to replace current major medical equipment if the replacement does not result in new or expanded inpatient services. The replacement of inoperative or obsolete major medical equipment, by itself, does not qualify for rate reconsideration, even if the new equipment costs at least one (1) million dollars.

(D) Audits.

1. A comprehensive hospital audit program shall be established in cooperation with the Missouri Medicare fiscal intermediary. Under the terms of the Common Audit Agreement, the Medicare intermediary shall perform the following:

A. Desk review all hospital cost reports;

B. Determine the scope and format for on-site audits;

C. Perform field audits when indicated in accordance with Title XIX principles; and

D. Submit to the state agency the final Title XVIII cost report with respect to each provider.

2. The state agency shall review audited **Medicare**/Medicaid*[-Medicare]* cost reports for each hospital's fiscal year in accordance with 13 CSR 70-15.040.

(E) Adjustments to Rates. The prospectively determined individual hospital's reimbursement rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. The adjustment shall be made retroactive to the date of the original rate. This adjustment shall not preclude the *[Medicaid agency]* **MO HealthNet Division** from imposing any sanctions authorized by any statute or rule;

2. When rate reconsideration is granted in accordance with subsection (5)(F);

3. When the Medicare per diem rate is changed by the servicing fiscal intermediary based on a new audit finding for the base year. This adjustment may be applied and effective no earlier than the first day of the month following notification by the *[Division of Medical Services]* **MO HealthNet Division**; or

4. When a hospital documents to the *[Division of Medical Services]* **MO HealthNet Division** a change in its status from nonprofit to proprietary, or from proprietary to nonprofit, its direct Medicaid payments for the state fiscal year will be adjusted to take into account any change in its *[Medicaid]* **MO HealthNet** inpatient allowable costs due to the change in its property taxes. The *[Medicaid]* **MO HealthNet** share of the change in property taxes will be calculated for the state fiscal year in which the change is reported by multiplying the increase or decrease in property taxes applicable to the current state fiscal year by the ratio of allowable *[Medicaid]* **MO HealthNet** inpatient hospital costs to total costs of the facility. (For example, if the property taxes are assessed starting January 1 for the calendar year, then one-half (1/2) of the calendar year property taxes will be used to calculate the additional inpatient direct Medicaid payments for the period of January 1 to June 30.)

(F) Rate Reconsideration.

1. Rate reconsideration may be requested under this subsection for changes in allowable cost which occur subsequent to the base period described in subsection (3)(A). The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the *[Division of Medical Services']* **MO HealthNet Division's** final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the *[Medicaid agency]* **MO HealthNet Division**:

A. New, expanded**,** or terminated services as detailed in subsection (5)(C);

B. When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war**,** or civil disturbance; and

C. Per diem rate adjustments for critical access hospitals.

(I) Critical access hospitals meeting either the federal definition or the Missouri expanded definition may request per diem rate adjustments in accordance with this subsection. The per diem rate increase will result in a corresponding reduction in the **direct** Medicaid *[direct]* payment.

(a) Hospitals which meet the federal definition as a critical access hospital will have a per diem rate equal to one hundred percent (100%) of their estimated *[Medicaid]* **MO HealthNet** cost per day as determined in section (15).

(b) Hospitals which meet the Missouri expanded definition as a critical access hospital will have a per diem rate equal to seventy-five percent (75%) of their estimated *[Medicaid]* **MO HealthNet** cost per day as determined in section (15). This includes new hospitals meeting the Missouri expanded definition as a critical access hospital whose interim *[Medicaid]* **MO HealthNet** rate was calculated in accordance with subsection (15)(C).

3. The following will not be subject to review under these procedures:

A. The use of Medicare standards and reimbursement principles;

B. The method for determining the trend factor;

C. The use of all-inclusive prospective reimbursement rates; and

D. Increased costs for the successor owner, management**,** or leaseholder that result from changes in ownership, management, control, operation**,** or leasehold interests by whatever form for any hospital previously certified at any time for participation in the *[Medicaid]* **MO HealthNet** program, except a review may be conducted when a hospital changes from nonprofit to proprietary or vice versa to recognize the change in its property taxes, see paragraph (5)(E)4.

4. As a condition of review, the *[Missouri Division of Medical Services]* **MO HealthNet Division** may require the hospital to submit to a comprehensive operational review. The review will be made at the discretion of the *[state Medicaid agency]* **MO HealthNet Division** and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the *[Missouri Division of Medical Services]* **MO HealthNet Division** and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally acceptable accounting principles. The hospital shall demonstrate the adjustment is necessary, proper**,** and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60)-day period shall be grounds for denial of the request. If the state does not respond within the sixty (60)-day period, the request shall be deemed denied.

(6) Disproportionate Share.

(A) Inpatient hospital providers may qualify as a Disproportionate Share Hospital (DSH) based on the following criteria. Hospitals shall qualify as Disproportionate Share Hospitals for a period of only one (1) state fiscal year and must requalify at the beginning of each state fiscal year to continue their disproportionate share classification—

1. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;

2. As determined from the fourth prior year desk-reviewed cost report, the facility must have either—

A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;

$$\text{MIUR} = \frac{\text{TMD}}{\text{TNID}}$$

or

B. A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(I) Total *[Medicaid]* **MO HealthNet** patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts**,** and the like) for patient services plus the CS; and

(II) The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party**,** or personal resources) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for *[medical assistance]* **MO HealthNet** under a state plan;

$$\text{LIUR} = \frac{\text{TMPR} + \text{CS}}{\text{TNR} + \text{CS}} + \frac{\text{CC–CS}}{\text{THC}}$$

3. As determined from the fourth prior year desk-reviewed cost report, the hospital—

A. Has an unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in paragraph (6)(A)2.; or

B. Ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursery and neonatal days by total nursery and neonatal days; or

C. Operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of nine percent (9%) reported or verified by the division from the fourth prior year cost report;

4. As determined from the fourth prior year desk-reviewed cost report—

A. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or

B. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or

C. The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo and the Missouri Rehabilitation Center created by Chapter 199, RSMo or their successors; or

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

5. As determined from the fourth prior year desk-reviewed cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.

(C) A hospital not meeting the requirements in subsection (6)(A), but has a Medicaid inpatient utilization percentage of at least one percent (1%) for Medicaid-eligible *[recipients]* **participants** may at the option of the state be deemed a Disproportionate Share Hospital (DSH). These facilities may receive only the DSH payments identified in section (18).

(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]* **MO HealthNet** and the cost of the uninsured. The hospital-specific DSH cap shall be computed by combining the estimated unreimbursed *[Medicaid]* **MO HealthNet** costs for each hospital, as calculated in section (15), with the hospital's corresponding estimated uninsured costs, as determined in section (18). 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 payments, other disproportionate share lump sum payments, direct Medicaid payments, and if necessary, as a reduced per diem. All DSH payments in the aggregate shall not exceed the federal DSH allotment within a state fiscal period.

(7) Outlier Adjustment for Children Under the Age of Six (6).

(A) Effective for admissions beginning on or after July 1, 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for *[Missouri Medicaid]***MO HealthNet**-eligible children under the age of six (6) will be made to hospitals meeting the disproportionate share requirements in subsection (6)(A) and, for *[Missouri Medicaid]***MO HealthNet**-eligible infants under the age of one (1), will be made to any other *[Missouri Medicaid]* **MO HealthNet** hospital except for specialty pediatric hospitals.

1. The following criteria must be met for the services to be eligible for outlier review:

A. The patient must be a *[Missouri Medicaid]***MO HealthNet**-eligible infant under the age of one (1) year, or for disproportionate share hospitals a *[Missouri Medicaid]***MO HealthNet**-eligible child under the age of six (6) years, for all dates of service presented for review;

B. Hospitals requesting outlier review for children one (1) year of age to children under six (6) years of age*[,]* must have qualified for disproportionate share status under section (6) of this plan for the state fiscal year corresponding with the fiscal year end of the cost report referred to in paragraph (7)(A)5.; and

C. One (1) of the following conditions must be satisfied:

(I) The total reimbursable charges for dates of service as described in paragraph (7)(A)3. must be at least one hundred fifty percent (150%) of the sum of total third-party liabilities and *[Medicaid]* **MO HealthNet** inpatient claim payments for that claim; or

(II) The dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days was reimbursed by *[Medicaid]* **MO HealthNet**.

2. Claims for all dates of service eligible for outlier review must—

A. Have been submitted to the *[Division of Medical Services]* **MO HealthNet Division** fiscal agent or the *[MC+]* **managed care** 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

B. Be submitted for outlier review with all documentation as required by the *[Division of Medical Services]* **MO HealthNet Division** no later than ninety (90) days from the last payment made by the fiscal agent or the *[MC+]* **managed care** health plan through the normal claims processing system for those dates of service.

3. Information for outlier reimbursement processing will be determined from claim charges and *[Medicaid]* **MO HealthNet** payment data, submitted to the *[Division of Medical Services]* **MO HealthNet Division** fiscal agent or *[MC+]* **managed care** health plan, by the hospital through normal claim submission. If the claim information is determined to be incomplete as submitted, the hospital may be asked to provide claim data directly to the *[Division of Medical Services]* **MO HealthNet Division** for outlier review.

4. The claims may be reviewed for—

A. Medical necessity at an inpatient hospital level-of-care;

B. Appropriateness of services provided in connection with the diagnosis;

C. Charges that are not permissible per the *[Division of Medical Services]* **MO HealthNet Division**; policies established in the institutional manual and hospital bulletins; and

D. If the hospital is asked to provide claim information, the hospital will need to provide an affidavit vouching to the accuracy of final payments by the *[Division of Medical Services, MC+]* **MO HealthNet Division, managed care** health plans and other third-party payors. The calculation of outlier payments will be based on the standard hospital payment defined in subparagraph (7)(A)6.B.

5. After the review, reimbursable costs for each claim will be determined using the following data from the most recent Medicaid hospital cost report filed by June 1 of each year:

A. Average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review;

B. Ancillary cost-to-charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review; and

C. No cost will be calculated for items such as malpractice insurance premiums, interns and residents, professional services**,** or return on equity.

6. Each state fiscal year, outlier adjustment payments for each hospital will be made for all claims submitted before March 1 of the preceding state fiscal year which satisfy all conditions in paragraphs (7)(A)1.–4. The payments will be determined for each hospital as follows:

A. Sum all reimbursable costs per paragraph (7)(A)5. for all applicable outlier claims to equal total reimbursable costs;

B. For those claims**,** subtract third-party payments and *[Medicaid]* **MO HealthNet** payments, which includes both per diem payments and Direct Medicaid Add-On payments, from total reimburseable costs to equal excess cost; and

C. Multiply excess costs by fifty percent (50%).

(B) Effective for admissions beginning on or after July 1, 1997, outlier adjustments shall also be made for *[Missouri Medicaid recipients]* **MO HealthNet participants** enrolled in *[MC+]* **managed care**. All criteria listed under subsection (7)(A) applies to *[MC+]* **managed care** outlier submissions.

(8) Payment Assurance.

(B) Where third-party payment is involved, *[Medicaid]* **MO HealthNet** will be the payor of last resort with the exception of state programs, such as Vocational Rehabilitation and the Missouri Crippled Children's Service. Procedures for remitting third-party payments are provided in the *[Missouri Medical Assistance P]***MO HealthNet p**rogram provider manuals.

(C) Regardless of changes of ownership, management, control, operation, **or** leasehold interests by whatever form for any hospital previously certified for participation in the *[Medicaid]* **MO HealthNet** program, the department will continue to make all the Title XIX payments directly to the entity with the hospital's current provider number and hold the entity with the current provider number responsible for all *[Medicaid]* **MO HealthNet** liabilities.

(10) Payment in Full. Participation in the program shall be limited to hospitals who accept as payment in full for covered services rendered to *[Medicaid recipients]* **MO HealthNet participants** the amount paid in accordance with the rules implementing the Hospital Reimbursement Program.

(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]* **participant** 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]* **MO HealthNet** 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. No *[Medicaid]* **MO HealthNet** payments will be made on behalf of any *[recipient]* **participant** 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. Each state fiscal year, to be effective July 1 of that state fiscal year, the division will calculate the trauma *[a]***A**dd-*[o]***O**n payments for qualifying hospitals as follows:

1. The case mix index for *[Medicaid]* **MO HealthNet** 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]* **MO HealthNet** 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.

(14) Trauma Outlier Payments.

(A) Outlier adjustments for trauma inpatient services involving exceptionally high cost for *[Missouri Medicaid]* **MO HealthNet-**eligible *[recipients]* **participants** 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]* **MO HealthNet Division** fiscal agent 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]* **MO HealthNet Division** 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]* **MO HealthNet-**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 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.

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

(15) Direct Medicaid Payments.

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

1. The increased *[Medicaid]* **MO HealthNet** costs resulting from the FRA assessment becoming an allowable cost on January 1, 1999;

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

3. The unreimbursed *[Medicaid]* **MO HealthNet** 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 increased cost per day results from lower utilization of inpatient hospital services by *[Medicaid recipients]* **MO HealthNet participants** now covered by a*[n MC+]* **managed care** 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]* **MO HealthNet** managed care region; and

6. The increased cost resulting from including out-of-state *[Medicaid]* **MO HealthNet** days in total projected *[Medicaid]* **MO HealthNet** days.

(B) Direct Medicaid payment will be computed as follows:

1. The *[Medicaid]* **MO HealthNet** share of the **inpatient** FRA assessment will be calculated by dividing the hospital's **inpatient** Medicaid patient days by **the** total **inpatient** hospital*['s]* patient days **from the hospital's base cost report** to arrive at the **inpatient** Medicaid utilization percentage. This percentage is then multiplied by the **inpatient** FRA assessment for the current SFY to arrive at the increased allowable *[Medicaid]* **MO HealthNet** costs*[;]* **for the inpatient FRA assessment. The MO HealthNet share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient MO HealthNet charges by the total outpatient hospital charges from the base cost report to arrive at the MO HealthNet utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the outpatient FRA assessment.**

2. The unreimbursed *[Medicaid]* **MO HealthNet** costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated *[Medicaid]* **MO HealthNet** patient days for the current SFY*[.]* **plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The estimated MO HealthNet patient days**

for the current SFY shall be the better of the sum of the Fee-for-Service (FFS) days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. The trended cost per day is calculated by trending the base year costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A). In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of *[Medicaid]* **MO HealthNet** residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospital's base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend**,** and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

B. For hospitals that meet the requirements in paragraphs (6)(A)1., (6)(A)2.**,** and (6)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year. For hospitals that meet the requirements in paragraphs (6)(A)1. and (6)(A)3. of this rule (first tier Disproportionate Share Hospitals), the base year operating costs may be the third or fourth prior year cost report. The *[Division of Medical Services]* **MO HealthNet Division** shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve (12)-month cost report and a partial year cost report, its base period cost report for that year will be the twelve (12)-month cost report.

C. The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment**,** and the poison control costs computed in paragraphs (15)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated *[Medicaid]* **MO HealthNet** patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of *[Medicaid]* **MO HealthNet** inpatient days the hospital will not provide as a result of the *[MC+ Health Plans]* **managed care health plans** limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated *[Medicaid]* **MO HealthNet** days for the current SFY to arrive at the *[Medicaid]* **MO HealthNet** utilization adjustment;

5. The poison control cost shall reimburse the hospital for the prorated *[Medicaid]* **MO HealthNet** managed care cost. It will be calculated by multiplying the estimated *[Medicaid]* **MO HealthNet** share of the poison control costs by the percentage of *[MC+ recipients]* **managed care participants** to total *[Medicaid recipients]* **MO HealthNet participants**; and

6. Prior to July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

(C) For new hospitals that do not have a base cost report, Direct Medicaid payments shall be estimated as follows:

1. Hospitals receiving Direct Medicaid payments shall be divided into quartiles based on total beds;

2. Direct Medicaid payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average Direct Medicaid payment per bed;

3. The number of beds for the new hospital without the base cost report shall be multiplied by the average Direct Medicaid payment per bed to determine the hospital's estimated Direct Medicaid payment for the current state fiscal year; and

4. For a new hospital licensed after February 1, 2007, estimated total Direct Medicaid payments for the current state fiscal year shall be divided by the estimated *[Medicaid]* **MO HealthNet** patient days for the new hospital's quartile to obtain the estimated Direct Medicaid adjustment per patient day. This adjustment per day shall be added to the new hospital's *[Medicaid]* **MO HealthNet** rate as determined in section (4), so that the hospital's Direct Medicaid payment per day is included in its per diem rate, rather than as a separate add-on payment. When the hospital's per diem rate is determined from its fourth prior year cost report in accordance with sections (1)–(3), the facility's Direct Medicaid payment will be calculated in accordance with subsection (15)(B) and reimbursed as an add-on payment rather than as part of the per diem rate. If the hospital is defined as a critical access hospital, its *[Medicaid]* **MO HealthNet** per diem rate and Direct Medicaid payment will be determined in accordance with subsection (5)(F).

(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]* **MO HealthNet** and the cost of the uninsured, unless otherwise permitted by federal law.

(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 *[a]***A**dd-*[o]***O**ns 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 *[u]***U**ninsured *[a]***A**dd-*[o]***O**n 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]* **MO HealthNet Division**;

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 **paragraph** (18)(D)1. 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 *[u]***U**ninsured *[a]***A**dd-*[o]***O**n payment by dividing the individual hospital's uninsured cost as determined from the three (3)-year average of the fourth, fifth, and sixth prior base-year cost reports by the total uninsured cost for all hospitals as determined from the three (3)-year average of the fourth, fifth, and sixth prior base-year cost reports, 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. The DSH cap for hospitals is the federal DSH allotment less the IMD allotment less other DSH expenditures.

B. Hospitals which qualify as safety net hospitals under subparagraphs (6)(A)4.B. and C. shall receive payment of one hundred percent (100%) of their proration. The percentage of proration payable to non-safety net hospitals shall be eighty-nine percent (89%), unless the hospital contributes through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO), in which case they shall receive ninety percent (90%);

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.

(E) Uninsured *[a]***A**dd-*[o]***O**n payments will coincide with the semimonthly claim payment schedule established by the *[Medicaid]* **MO HealthNet** fiscal agent. Each hospital's semimonthly add-on payment shall be the hospital's total cost of the uninsured as determined in subsection (18)(D), divided by the number of semimonthly pay dates available to the hospital in the state fiscal year.

(19) *[Medicaid]* **MO HealthNet** GME Add-On—A *[Medicaid]* **MO HealthNet** Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a *[Medicaid]* **MO HealthNet** managed care system *[such as MC+]* in accordance with this section.

(A) The *[Medicaid]* **MO HealthNet** GME Add-On for *[Medicaid clients]* **MO HealthNet participants** covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base year cost report shall be the fourth prior fiscal year (i.e., the base year for SFY 1999 is the FY 1995 cost report). The hospital per diem shall continue to include a component for GME related to *[Medicaid clients]* **MO HealthNet participants** not included in a managed care system.

1. Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital's *[Medicaid]* **MO HealthNet** population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars ($100,000), 2) forty percent (40%) of their *[Medicaid]* **MO HealthNet** days are related to *[Medicaid recipients]* **MO HealthNet participants** eligible for *[Medicaid]* **MO HealthNet** managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars ($30,000).

2. The annual GME Add-On shall be paid in quarterly installments.

(20) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and *[Medicaid]* **MO HealthNet** provider number shall have their *[Medicaid]* **MO HealthNet** reimbursement combined under the surviving hospital's (the hospital whose Medicare and *[Medicaid]* **MO HealthNet** provider number remains active) *[Medicaid]* **MO HealthNet** provider number.

(B) The per diem rate for merged hospitals shall be calculated—

1. For the remainder of the state fiscal year in which the merger occurred by multiplying each hospital's estimated *[Medicaid]* **MO HealthNet** paid days by its per diem rate, summing the estimated per diem payments and estimated *[Medicaid]* **MO HealthNet** paid days, and then dividing the total estimated per diem payments by the total estimated paid days to determine the weighted per diem rate. The effective date of the weighted per diem rate will be the date of the merger; and

2. For subsequent state fiscal years based on the combined desk-reviewed data after taking into account the different fiscal year ends of the cost reports.

(C) The **Direct** Medicaid *[Direct]* Payments and Uninsured Add-On shall be—

1. Combined under the surviving hospital's *[Medicaid]* **MO HealthNet** provider number for the remainder of the state fiscal year in which the merger occurred; and

2. Calculated for subsequent state fiscal years based on the combined data from the appropriate cost report for each facility.

(D) Merger of Children's Acute Care Hospital. When an acute care children's hospital merges with another acute care hospital, all the provisions in subsection (20)(A) shall apply, except the *[Medicaid]* **MO HealthNet** provider number for the children's hospital will remain active. The only payments made under the children's provider number will be the per diem and outpatient payments. The Direct Medicaid payments and Uninsured Add-On payments will be made under the *[Medicaid]* **MO HealthNet** number associated with the surviving Medicare provider number.

(21) Enhanced Graduate Medical Education (GME) Payment—An enhanced GME payment shall be made to any acute care hospital that provides graduate medical education (teaching hospital).

(B) The enhanced GME payment will be computed by first determining the percentage difference between the McGraw-Hill CPI index for hospital services and Medicare update factors applied to the per resident amounts from 1986 to the most recent SFY. For example, the percentage difference has been computed to be eighty-five and sixty-two*[-]* one-hundredth percent (85.62%) for SFY 2000. The percentage difference is then multiplied by the *[Medicaid]* **MO HealthNet** share of the aggregate approved amount reported on worksheet E-3 part IV of the Medicare cost report (HCFA 2552-96) for the fourth prior fiscal year and trended to the current state fiscal year. The resulting product is the enhanced GME payment.

AUTHORITY: sections ***208.152,*** *208.153,* ***[and]*** *208.201,* ***[RSMo 2000 and 208.152]*** *and 208.471, RSMo Supp.* ***[2006] 2007****. 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****. Emergency amendment filed June 18, 2008, effective July 1, 2008, expires Dec. 28, 2008. Amended: Filed July 1, 2008.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division,

615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person, or by courier within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—*[Division of Medical Services]* *MO HealthNet Division*
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA). The division is amending the division title and subsections (1)(A) and (1)(B) and is adding section (16).

PURPOSE: This amendment will establish the State Fiscal Year (SFY) 2009 Federal Reimbursement Allowance (FRA) assessment at 5.25% of each hospital's inpatient and outpatient adjusted net revenues for the fiscal year beginning July 1, 2008 and ending June 30, 2009. This amendment will also add a definition for FRA, revise the definitions for base year cost report and contractual allowances, clarify the description of FRA in succeeding state fiscal years, clarify the adjusted net revenues used to determine the FRA assessment on a quartile basis, update division title references to MO HealthNet Division, and update reference to the state's medical assistance program to MO HealthNet.

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

(A) Definitions.

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

2. Base cost report—Desk-reviewed Medicare/Medicaid cost report**.** *[for the latest hospital fiscal year ending during the calendar year. (For example, a provider has a cost report for the nine (9) months ending 9/30/95 and a cost report for the three (3) months ending 12/31/95.)]* **When a hospital has more than one (1) cost report with periods ending in the base year, the cost report covering a full twelve (12)-month period will be used. If none of the cost reports covers a full twelve (12)-months, the cost report with the latest period will be used.** If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report**,** to a twelve (12)-month period.

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

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

5. Department—Department of Social Services.

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

7. Division—*[Division of Medical Services]* **MO HealthNet Division**, Department of Social Services.

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

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

*[9.]***10.** Fiscal period—Twelve (12)-month reporting period determined by each hospital.

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

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

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

A. Obtain "Gross Total Charges" from Worksheet G-2, Line 25, Column 3, of the most recent cost report that is available for a hospital. Charges shall exclude revenues for physician services. Charges related to activities subject to the Missouri taxes assessed for outpatient retail pharmacies and nursing facility services shall also be excluded. "Gross Total Charges" will be reduced by the following:

(I) "Nursing Facility Charges" from Worksheet C, Part I, Line 35, Column 6.

(II) "Swing Bed Nursing Facility Charges" from Worksheet G-2, Line 5, Column 1.

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

(IV) "Distinct Part Ambulatory Surgical Center Charges" from Worksheet G2, Line 22, Column 2.

(V) "Ambulance Charges" from Worksheet C, Part I, Line 65, Column 7.

(VI) "Home Health Charges" from Worksheet G-2, Line 19, Column 2.

(VII) "Total Rural Health Clinic Charges" from Worksheet C, Part I, Column 7, Lines 63.50–63.59.

(VIII) "Other Non-Hospital Component Charges" from Worksheet G-2, Lines 6, 8, 21, 21.02, 23, and 24.

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

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

(I) Divide "Net Revenue" by "Gross Total Charges."

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

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

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

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

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

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

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

G. The trend indices listed in 13 CSR 70-15.010(3)(B) and the Missouri Specific Trend defined in 13 CSR 70-15.010 (15)(B)2.A. will be applied to the apportioned inpatient adjusted net revenue and outpatient adjusted net revenue in order to inflate or trend forward the adjusted net revenues from the base cost report fiscal year to the current state fiscal year to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment.

*[12.]***14.** Net operating revenue—Gross charges less bad debts, less charity care, and less contractual allowances times the trend indices listed in 13 CSR 70-15.010(3)(B).

*[13.]***15.** Other operating revenues—The other operating revenue is total other revenue less government appropriations, less donations**,** and less income from investments times the trend indices listed in 13 CSR 70-15.010(3)(B).

(B) Each hospital, except public hospitals which are operated primarily for the care and treatment of mental disorders and any hospital operated by the Department of Health **and Senior Services**, engaging in the business of providing inpatient health care in Missouri shall pay an FRA. The FRA shall be calculated by the Department of Social Services.

1. The FRA shall be sixty-three dollars and sixty-three cents ($63.63) per inpatient hospital day from the 1991 base cost report for Federal Fiscal Year 1994. *[The FRA shall be as described in sections (2), (3) and (4) f]***F**or succeeding periods*[.]***, the FRA shall be as described beginning with section (2) and going forward.**

2. If a hospital does not have a **fourth prior year** base cost report, *[total]* **inpatient and outpatient adjusted** net revenues *[less Medicaid net revenues]* shall be estimated as follows:

A. Hospitals required to pay the FRA shall be divided in quartiles based on total beds;

B. Average **inpatient and outpatient adjusted** net revenues *[less Medicaid net revenues]* shall be individually summed and divided by the total beds in the quartile to yield an average **inpatient and outpatient adjusted** net revenue *[less Medicaid net revenue]* per bed; and

C. Finally, the number of beds for the hospital without the base cost report shall be multiplied by the average **inpatient and outpatient adjusted** net revenue *[less Medicaid net revenue]* per bed.

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

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

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

(16) Federal Reimbursement Allowance (FRA) for State Fiscal Year (SFY) 2009. The FRA assessment for SFY 2009 shall be determined at the rate of five and twenty-five hundredths percent (5.25%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues from the hospital's 2006 Medicare/Medicaid cost report. The FRA assessment rate of 5.25% will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment for SFY 2009 is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

*AUTHORITY: sections 208.201, 208.453, and 208.455, RSMo [2000] **Supp. 2007**. 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 18, 2008, effective July 1, 2008, expires Dec. 28, 2008. Amended: Filed July 1, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies more than five hundred dollars ($500) in SFY 2009, which period covers the anticipated aggregate public cost of the amended rule.

PRIVATE COST: This proposed amendment is expected to cost private entities $821,699,802 in SFY 2009.

*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, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person or by courier within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. **Department Title:** Department of Social Services
Division Title: MO HealthNet Division
Chapter Title: Hospital Program

Rule Number and Title:	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 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:
136	**Hospitals**	**Annual estimated cost: $821,699,802**

III. WORKSHEET

The fiscal note is based on establishing the FRA assessment rate at 5.25% for SFY 2009 (July 1, 2008 through June 30, 2009).

IV. ASSUMPTIONS

The SFY 2009 FRA assessment rate of 5.25% for July 1, 2008 through June 30, 2009, is levied upon Missouri hospitals' inpatient net adjusted revenue of approximately $7,363,624,110. The FRA assessment rate of 5.25% is also levied upon Missouri hospitals' outpatient net adjusted revenue of approximately $5,261,209,347.

The 136 hospitals reported above include 38 hospitals that are owned or controlled by the state, counties, cities, or hospital districts. The impact on these hospitals is $111,248,884.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 8—Market Conduct Examination

PROPOSED AMENDMENT

20 CSR 100-8.040 Insurer Record Retention. The director is deleting subsection (3)(F).

PURPOSE: This amendment eliminates a duplicative and conflicting subsection within a new rule.

(3) Records to be Maintained. The following records shall be maintained:

(D) The Missouri complaint records required to be maintained under section 375.936(3), RSMo shall include a complaint log or register in addition to the actual written complaints. The complaint log or register shall show clearly the total number of complaints for a period of not less than the immediately preceding three (3) years, the classification of each complaint by line of insurance, the nature of each complaint, and the disposition of each complaint. The complaint log or register shall also contain a reference to the location of the file to which each complaint corresponds. If the insurer maintains the file in a computer format, the reference in the complaint log or register for locating such documentation shall be an identifier such as the policy number or other code. Such codes shall be provided to the examiners at the time of an examination; **and**

(E) The insurer shall retain declined underwriting files for a period of three (3) years from the date of declination. The term "declined underwriting file" shall mean all written or electronic records concerning a policy for which an application for insurance coverage has been completed and submitted to the insurer or its insurance producer but the insurer has made a determination not to issue a policy or not to add additional coverage when requested. A declined underwriting file shall include an application, any documentation substantiating the decision to decline an issuance of a policy, any binder issued without the insurer issuing a policy, any documentation substantiating the decision not to add additional coverage when requested**,** and, if required by law, any declination notification. Notes regarding requests for quotations which do not result in a completed application for coverage need not be maintained for purposes of this regulation*[; and]***.**

[(F) The insurer shall retain claim files for a period of three (3) years from the date of the claim determination. These files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of these events can be reconstructed. Documentary material which is pertinent to the investigation and/or denial of a claim shall be legibly date stamped with the date of receipt whether it is from an insured, his/her agent, a claimant, the department or any other insurer.]

AUTHORITY: sections 374.045 and 375.948, RSMo 2000. Original rule filed Nov. 1, 2007, effective July 30, 2008. Emergency amendment filed June 23, 2008, effective July 30, 2008, expires Feb. 26, 2009. Amended: Filed June 23, 2008.

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 until 5:00 p.m. on August 31, 2008. Written statements shall be sent to the Department of Insurance, Financial Institutions and Professional Registration, attention Tamara W. Kopp, PO Box 690, Jefferson City, MO 65102. No public hearing is scheduled.

SPECIAL NEEDS: If you have any special needs addressed by the Americans with Disabilities Act, please notify us at (573) 751-6798 or (573) 751-2619 at least five (5) working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 300—Market Conduct Examinations
Chapter 1—Sampling and Error Rates

PROPOSED RESCISSION

20 CSR 300-1.100 Unfair Claims Settlement Rates. This rule effectuated or aided in the interpretation of section 375.1007, RSMo regarding detection of frequency to indicate a business practice.

PURPOSE: This rule is being rescinded because as of July 30, 2008, the substance of the rule appears in rule 20 CSR 100-8.020 Sampling and Error Rates.

AUTHORITY: sections 374.045, RSMo Supp. 1996 and 375.1000–375.1018, RSMo 1994. This rule was previously filed as 4 CSR 190-10.060(1), (8), and (9). Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed June 23, 2008, effective July 30, 2008, expires Feb. 26, 2009. Rescinded: Filed June 23, 2008.*

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 until 5:00 p.m. on August 31, 2008. Written statements shall be sent to the Department of Insurance, Financial Institutions and Professional Registration, attention Tamara W. Kopp, PO Box 690, Jefferson City, MO 65102. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 300—Market Conduct Examinations
Chapter 1—Sampling and Error Rates

PROPOSED RESCISSION

20 CSR 300-1.200 Fraudulent or Bad Faith Conduct Rules. This rule set forth acts or practices which may constitute conducting business fraudulently or constitute not carrying out contracts in good faith within the scope of section 375.445, RSMo 1986 and set forth acts which may constitute misrepresentations and false advertising of insurance policies within the scope of section 375.936(6), RSMo 1986. The acts or practices prohibited by this regulation were not intended to be an exhaustive list of acts or practices prohibited by section 375.445 or 375.936(6), RSMo 1986.

PURPOSE: This rule is being rescinded because as of July 30, 2008, the substance of the rule appears in rule 20 CSR 100-8.020 Sampling and Error Rates.

AUTHORITY: sections 374.045, RSMo Supp. 1996. This rule was previously filed as 4 CSR 190-10.080. Original rule filed Aug. 4, 1986, effective Jan. 1, 1987. Amended: Filed Oct. 1, 1996, effective June 30, 1997. Emergency rescission filed June 23, 2008, effective July 30, 2008, expires Feb. 26, 2009. Rescinded: Filed June 23, 2008.

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 until 5:00 p.m. on August 31, 2008. Written statements shall be sent to the Department of Insurance, Financial Institutions and Professional Registration, attention Tamara W. Kopp, PO Box 690, Jefferson City, MO 65102. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 300—Market Conduct Examinations
Chapter 2—Record Retention for Market Conduct Examinations

PROPOSED RESCISSION

20 CSR 300-2.100 File and Record Documentation for Claims. This rule effectuated or aided in the interpretation of section 375.936(10), RSMo regarding retaining claim records.

PURPOSE: This rule is being rescinded because as of July 30, 2008, the substance of the rule appears in rules 20 CSR 100-8.010 Standards of Examination, 20 CSR 100-8.020 Sampling and Error Rates, and 20 CSR 100-8.040 Insurer Record Retention.

*AUTHORITY: sections 374.045 and 375.930–375.948, RSMo 1986. This rule was previously filed as 4 CSR 190-10.060(2). Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed June 23, 2008, effective July 30, 2008, expires Feb. 26, 2009. Rescinded: Filed June 23, 2008.*

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 until 5:00 p.m. on August 31, 2008. Written statements shall be sent to the Department of Insurance, Financial Institutions and Professional Registration, attention Tamara W. Kopp, PO Box 690, Jefferson City, MO 65102. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 300—Market Conduct Examinations
Chapter 2—Record Retention for Market Conduct Examinations

PROPOSED RESCISSION

20 CSR 300-2.200 Records Required for Purposes of Market Conduct Examinations. The regulation described the requirements for record keeping for insurance companies and related entities doing business in this state. This regulation was adopted pursuant to the provisions of section 374.045, RSMo 1986 and to implement sections 287.350, 354.190, 354.465, 374.190, 374.210, 375.158, 379.343, and 379.475, RSMo 1986, and sections 144.027, 354.149, 354.717, 375.022, 375.150, 375.151, 375.926, 375.932, 375.938, 375.1002, and 375.1009, RSMo Supp. 1991.

PURPOSE: This rule is being rescinded because as of July 30, 2008, the substance of the rule appears in rule 20 CSR 100-8.040 Insurer Record Retention.

*AUTHORITY: sections 144.027, 287.350, 354.190, 354.465, 354.717, 374.045, 374.190, 374.202, 374.205, 374.210, 375.013, 375.149, 375.150, 375.151, 375.932, 375.938, 375.948, 375.1002, 375.1009, 375.1018, 379.343, 379.475, and 536.016, RSMo 2000 and sections 375.012, 375.022, and 375.158, RSMo Supp. 2004. This rule was previously filed as 4 CSR 190-11.050. Original rule filed Dec. 20, 1974, effective Dec. 30, 1974. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed June 23, 2008, effective July 30, 2008, expires Feb. 26, 2009. Rescinded: Filed June 23, 2008.*

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 until 5:00 p.m. on August 31, 2008. Written statements shall be sent to the Department of Insurance, Financial Institutions and Professional Registration, attention Tamara W. Kopp, PO Box 690, Jefferson City, MO 65102. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 300—Market Conduct Examinations
Chapter 3—Policy Contents and Coverages

PROPOSED RESCISSION

20 CSR 300-3.100 Primary Coverage for Replacement Vehicle. The Circuit Court of Cole County, Missouri, issued a decision on June 20, 1995, declaring 20 CSR 300-3.100 to be void and of no force or effect. The Department of Insurance and the director of the department were permanently enjoined from enforcing this rule.

PURPOSE: This rule is being rescinded because the department is permanently enjoined from enforcing this rule.

AUTHORITY: sections 374.045, RSMo Supp. 1993 and 379.201, RSMo 1986. Original rule filed Jan. 10, 1994, effective Aug. 28,

1994. Rule declared void June 20, 1995. Rescinded: Filed June 23, 2008.

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 until 5:00 p.m. on August 31, 2008. Written statements shall be sent to the Department of Insurance, Financial Institutions and Professional Registration, attention Tamara W. Kopp, PO Box 690, Jefferson City, MO 65102. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2015—Acupuncturist Advisory Committee
Chapter 1—General Rules

PROPOSED AMENDMENT

20 CSR 2015-1.020 Acupuncturist Credentials, Name and Address Changes. The board is proposing to amend section (5).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 15 are being amended throughout the rule.

(5) A licensed acupuncturist shall use only those educational credentials in association with the license that have been earned at an acceptable educational institution as defined in *[4 CSR 15-4.020]* **20 CSR 2015-4.020** and that are related to acupuncture.

AUTHORITY: sections 324.481 and 324.487, RSMo 2000. This rule originally filed as 4 CSR 15-1.020. Original rule filed July 24, 2001, effective Feb. 28, 2002. Amended: Filed Feb. 15, 2005, effective Aug. 30, 2005. Moved to 20 CSR 2015-1.020, effective Aug. 28, 2006. Amended: Filed June 27, 2008.

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 Acupuncturist Advisory Committee, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-0735, or via email at acupunct@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2015—Acupuncturist Advisory Committee
Chapter 2—Acupuncturist Licensure Requirements

PROPOSED AMENDMENT

20 CSR 2015-2.010 Application for Licensure. The board is proposing to amend section (2).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 15 are being amended throughout the rule.

(2) The application shall be typewritten or printed in black ink, signed, notarized, and accompanied by all documents required by the advisory committee and the application fee as defined in *[4 CSR 15-1.030(3)(A)]* **20 CSR 2015-1.030(3)(A)**. Documentation required to be submitted with the application shall include, but is not limited to**,** the following:

(A) Two (2) sets of fingerprints and the applicable fee as defined in *[4 CSR 15-1.030(3)(C)]* **20 CSR 2015-1.030(3)(C)**;

AUTHORITY: sections 324.481, 324.487, and 324.493, RSMo 2000. This rule originally filed as 4 CSR 15-2.010. Original rule filed July 24, 2001, effective Feb. 28, 2002. Moved to 20 CSR 2015-2.010, effective Aug. 28, 2006. Amended: Filed June 27, 2008.

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 Acupuncturist Advisory Committee, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-0735, or via email at acupunct@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2015—Acupuncturist Advisory Committee
Chapter 2—Acupuncturist Licensure Requirements

PROPOSED AMENDMENT

20 CSR 2015-2.020 License Renewal, Restoration and Continuing Education. The board is proposing to amend section (4).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 15 are being amended throughout the rule.

(4) A person may submit an application to restore a license that has been expired for not more than two (2) years after the expiration date. The application shall be submitted in compliance with *[4 CSR 15-2.010]* **20 CSR 2015-2.010**, accompanied by the required fee, and shall include documentation of completing continuing education pursuant to *[4 CSR 15-2.020(3)]* **20 CSR 2015-2.020(3)**.

AUTHORITY: sections 324.481, 324.490, 324.493, and 324.496, RSMo 2000. This rule originally filed as 4 CSR 15-2.020. Original rule filed July 24, 2001, effective Feb. 28, 2002. Amended: Filed

March 15, 2004, effective Sept. 30, 2004. Moved to 20 CSR 2015-2.020, effective Aug. 28, 2006. Amended: Filed June 27, 2008.

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 Acupuncturist Advisory Committee, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-0735, or via email at acupunct@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2015—Acupuncturist Advisory Committee
Chapter 4—Supervision of Auricular Detox Technicians and Acupuncturist Trainees

PROPOSED AMENDMENT

20 CSR 2015-4.010 Supervision of Auricular Detox Technicians. The board is proposing to amend section (2).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 15 are being amended throughout the rule. This amendment also makes a grammatical correction.

(2) A licensed acupuncturist shall provide supervision of a technician. For the purpose of this rule, electronic communication is acceptable for supervision if the communication is visually and/or verbally interactive**,** and no more than fifty percent (50%) of the supervision shall be by electronic means.

(A) A licensed acupuncturist shall be available on-site or by telephone or pager when the *[detax]* **detox** technician is providing services as defined in *[4 CSR 15-4.010(1)]* **20 CSR 2015-4.010(1)**.

AUTHORITY: sections 324.475, 324.481, and 324.484, RSMo 2000. This rule originally filed as 4 CSR 15-4.010. Original rule filed July 24, 2001, effective Feb. 28, 2002. Moved to 20 CSR 2015-4.010, effective Aug. 28, 2006. Amended: Filed June 27, 2008.

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 Acupuncturist Advisory Committee, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-0735, or via email at acupunct@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2165—Board of Examiners for Hearing Instrument Specialists
Chapter 1—General Rules

PROPOSED AMENDMENT

20 CSR 2165-1.020 Fees. The board is proposing to amend section (1).

PURPOSE: House Bill 780 and Senate Bill 308 (2007) removed the requirement for audiologists to be dually licensed with the State Board of Registration for the Healing Arts. Pursuant to section 345.055.3, RSMo, the board shall set the amount of the fees which this chapter authorizes and requires by rules and regulations promulgated pursuant to section 536.021, RSMo. The fees shall be set at a level to produce revenue which shall not substantially exceed the cost and expense of administering this chapter. This amendment also implements an inactive license fee.

(1) The following fees are established by the Board of Examiners for Hearing Instrument Specialists and are payable in the form of a cashier's check, money order**,** or personal check:

(A) Hearing Instrument Specialist Application Fee	$*[150]***250**
(B) Hearing Instrument Specialist in Training Application Fee (Also known as temporary permit fee)	$*[150]***250**
(C) Exam Fee	
1. Written	$ *[95]***125**
2. Practical	$*[125]***150**
(F) Temporary Permit Extension	$ *[75]***175**
(G) License Renewal	
1. Active	$*[250]***400**
2. Inactive	**$200**

*AUTHORITY: sections 346.115.1(7) and (8), RSMo [Supp. 1998] **2000**. This rule originally filed as 4 CSR 165-1.020. Emergency rule filed March 18, 1996, effective March 28, 1996, expired Sept. 23, 1996. Emergency rule filed Oct. 28, 1996, effective Nov. 7, 1996, expired May 5, 1997. Original rule filed Oct. 16, 1996, effective May 30, 1997. For intervening history, please consult the **Code of State Regulations**. Amended: Filed July 1, 2008.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately eight thousand nine hundred forty dollars ($8,940) annually and approximately thirty-five thousand one hundred dollars ($35,100) 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 eight thousand nine hundred forty dollars ($8,940) and approximately thirty-five thousand one hundred dollars ($35,100) 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 Board of Examiners for Hearing Instrument Specialists, Attention: Dana Hoelscher, PO Box 1335, Jefferson City, MO 65102, via fax at (573) 526-3856, or via email at behis@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 20 - Department of Insurance, Financial Institutions, and Professional Registration

Division 2165 - Board of Examiners for Hearing Instrument Specialists

Chapter 1 - General Rules

Proposed Amendment - 20 CSR 2165-1.020 Fees

Prepared May 5, 2008 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Increase In Revenue	
Board of Examiners for Hearing Instrument Specialists	$8,940.00	Annually
	$35,100.00	Biennially

III. WORKSHEET

The division is statutorily obligated to enforce and administer the provisions of sections 346.007-346.250, RSMo. Pursuant to Section 346.115, RSMo, the division shall by rule and regulation set the amount of fees authorized by sections 346.007-346.250, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of sections 346.007-346.250, RSMo. The board estimates the projections calcuated in the Private Entity Fiscal Notes will be revenue for the board.

IV. ASSUMPTION

1. It is anticipated that the total revenue 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.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions, and Professional Registration
Division 2165 - Board of Examiners for Hearing Instrument Specialists
Chapter 1 - General Rules
Proposed Amendment - 20 CSR 2165-1.020 Fees
Prepared May 5, 2008 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Annual

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 will likely be affected:	Estimated annual increase in cost of compliance with the rule by affected entities:
26	Hearing Instrument Specialist Application Fee ($100 Increase)	$2,600
24	Hearing Instrument Specialist in Training Application Fee (Also known as temporary permit fee) ($100 Increase)	$2,400
33	Exam Fee - Written ($30 Increase)	$990
31	Exam Fee - Practical ($50 Increase)	$1,550
6	Temporary Permit Extension ($100 Increase)	$600
4	License Renewal - Inactive ($200 Increase)	$800
	Estimated Annual Increase in Cost of Compliance for the Life of the Rule	**$8,940**

Biennial

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 will likely be affected:	Estimated biennial increase in cost of compliance with the rule by affected entities:
234	License Renewal - Active ($150 Increase)	$35,100
	Estimated Biennal Increase in Cost of Compliance for the Life of the Rule	**$35,100**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The figures reported above are based on FY06-FY07 actuals and the board's five year projections.
2. The board has seen a 50% decrease in its licensees due to the passage of House Bill 780 and Senate Bill 308 in 2007, and could potentially see a further decrease during the next renewal period. The board can not calculate an expected growth rate at this time.
3. It is anticipated that the total increase in cost will recur or 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 division is statutorily obligated to enforce and administer the provisions of sections 346.007-346.250, RSMo. Pursuant to Section 346.115, RSMo, the division shall by rule and regulation set the amount of fees authorized by sections 346.007-346.250, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of sections 346.007-346.250, RSMo.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2165—Board of Examiners for Hearing Instrument Specialists
Chapter 1—General Rules

PROPOSED AMENDMENT

20 CSR 2165-1.030 Custodian of Public Records. The board is proposing to amend section (5).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 165 are being amended throughout the rule.

(5) The custodian shall maintain a file which will retain, for at least two (2) years, copies of all written requests for access to records and responses to requests. This file shall be maintained as a public record of the office open for inspection by any member of the general public during regular business hours as noted in *[4 CSR 165-1.030(2)]* **20 CSR 2165-1.030(2)**.

AUTHORITY: section 346.115.1(7), RSMo [Supp. 1996] 2000. This rule originally filed as 4 CSR 165-1.030. Original rule filed Oct. 16, 1996, effective May 30, 1997. Moved to 20 CSR 2165-1.030, effective Aug. 28, 2006. Amended: Filed June 27, 2008.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Examiners for Hearing Instrument Specialists, PO Box 1335, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at behis@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2165—Board of Examiners for Hearing Instrument Specialists
Chapter 2—Licensure Requirements

PROPOSED AMENDMENT

20 CSR 2165-2.010 Hearing Instrument Specialist in Training (Temporary Permits). The board is proposing to amend sections (1) through (4).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 165 are being amended throughout the rule.

(1) Any individual seeking to develop the skills and training necessary to obtain a license under section 346.075, RSMo, shall register supervision and apply for a temporary permit to engage in the practice of fitting hearing instruments as defined by section 346.010(11), RSMo. An application for registration of supervision shall be made on a form provided by the board and must be accompanied by the appropriate fee as prescribed in *[4 CSR 165-1.020]* **20 CSR 2165-1.020**. The application shall not be considered proper and final until qualifications of the supervisor match the criteria as prescribed in *[4 CSR 165-2.020]* **20 CSR 2165-2.020**.

(2) An approved temporary permit shall entitle the hearing instrument specialist in training to engage in the practice of fitting hearing instruments as defined by section 346.010(11), RSMo, for a period of one (1) year.

(A) If a person holding a permit has not passed the examination within the one (1)-year period, the hearing instrument specialist in training may renew the permit once for a period of six (6) months upon payment of the applicable fee as prescribed in *[4 CSR 165-1.020]* **20 CSR 2165-1.020**.

(3) The hearing instrument specialist in training shall accrue no less than one hundred (100) hours of supervision from a licensed hearing instrument specialist registered as a supervisor pursuant to *[4 CSR 165-2.020]* **20 CSR 2165-2.020** prior to becoming eligible for licensure by examination.

(4) If the hearing instrument specialist in training ceases to practice under an approved supervisor and/or changes supervision**,** s/he shall notify the board by filing a change of supervision form and paying the change of supervision fee as defined in *[4 CSR 165-1.020]* **20 CSR 2165-1.020**. The change of supervision is subject to review pursuant to *[4 CSR 165-2.010(2)]* **20 CSR 2165-2.010(2)**.

*AUTHORITY: sections 346.070, 346.075, 346.080, and 346.115.1(7), RSMo 2000. This rule originally filed as 4 CSR 165-2.010. Emergency rule filed March 18, 1996, effective March 28, 1996, expired Sept. 23, 1996. Emergency rule filed Oct. 28, 1996, effective Nov. 7, 1996, expired May 5, 1997. Original rule filed Oct. 16, 1996, effective May 30, 1997. For intervening history, please consult the **Code of State Regulations**. Amended: Filed June 27, 2008.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Examiners for Hearing Instrument Specialists, PO Box 1335, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at behis@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2165—Board of Examiners for Hearing Instrument Specialists
Chapter 2—Licensure Requirements

PROPOSED AMENDMENT

20 CSR 2165-2.020 Supervisors. The board is proposing to amend sections (1), (2), and (5).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 165 are being amended throughout the rule.

(1) A licensed hearing instrument specialist may obtain a certificate of authority as a registered supervisor by completing an application from the board and paying the required fee as defined in *[4 CSR 165-1.020]* **20 CSR 2165-1.020**.

(2) A registered supervisor of a hearing instrument specialist in training must be licensed in Missouri as a hearing instrument specialist for a minimum of two (2) years.

(B) Within twelve (12) months of the effective date of the proposed rule, as published in the *Code of State Regulations*, a licensed hearing instrument specialist shall pass the National Competency Examination (N.C.E.) administered by National Board for Certification in Hearing Instrument Sciences (NBC-HIS) in order to qualify as a registered supervisor.

1. *[4 CSR 165-2.020(2)(B)]* **20 CSR 2165-2.020(2)(B)** shall not apply to a licensed hearing instrument specialist licensed as an audiologist pursuant to Chapter 345, RSMo, and possessing a certificate of clinical competence or is completing the clinical fellowship year offered by the American Speech-Language-Hearing Association.

2. *[4 CSR 165-2.020(2)(B)]* **20 CSR 2165-2.020(2)(B)** shall not apply to a licensed hearing instrument specialist who has passed the N.C.E. administered by NBC-HIS prior to the effective date of this proposed rule.

(5) Within thirty (30) days of completion of registered supervision, pursuant to *[4 CSR 165-2.010(5)]* **20 CSR 2165-2.010(5)** the registered supervisor shall document the supervision and training on an attestation form provided by the board.

AUTHORITY: sections 346.075.2 and 346.115.1(7), RSMo [Supp. 1996] 2000. This rule originally filed as 4 CSR 165-2.020. Emergency rule filed March 18, 1996, effective March 28, 1996, expired Sept. 23, 1996. Emergency rule filed Oct. 28, 1996, effective Nov. 7, 1996, expired May 5, 1996. Original rule filed Oct. 16, 1996, effective May 30, 1997. Moved to 20 CSR 2165-2.020, effective Aug. 28, 2006. Amended: Filed June 27, 2008.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Examiners for Hearing Instrument Specialists, PO Box 1335, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at behis@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2165—Board of Examiners for Hearing Instrument Specialists
Chapter 2—Licensure Requirements

PROPOSED AMENDMENT

20 CSR 2165-2.050 Continuing Education Requirements. The board is proposing to amend section (1).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 165 are being amended throughout the rule.

(1) The following guidelines govern the attendance and approval of educational programs for license renewal:

(C) The licensee may submit the information outlined in *[4 CSR 165-2.050(1)(B)]* **20 CSR 2165-2.050(1)(B)** to the board for review and approval.

*AUTHORITY: section 346.115.1(7), RSMo 2000. This rule originally filed as 4 CSR 165-2.050. Original rule filed Oct. 16, 1996, effective May 30, 1997. For intervening history, please consult the **Code of State Regulations**. Amended: Filed June 27, 2008.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Examiners for Hearing Instrument Specialists, PO Box 1335, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at behis@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2165—Board of Examiners for Hearing Instrument Specialists
Chapter 2—Licensure Requirements

PROPOSED AMENDMENT

20 CSR 2165-2.060 License Renewal. The board is proposing to amend section (6) and add section (9).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 165 are being amended throughout the rule. This amendment also adds an inactive license status.

(6) When an organization owns or leases all or a portion of the audiometers utilized by the hearing instrument specialist employed, the organization must submit annual receipt of calibration as required

in *[4 CSR 165-2.060(3)]* **20 CSR 2165-2.060(3)**. A hearing instrument specialist employed with such an organization who utilizes only this equipment may reference this annual receipt as evidence of compliance with his/her annual calibration requirements.

(9) Inactive License.

(A) A hearing instrument specialist may choose to place his/her license on an inactive status by signing an affidavit stating that s/he will not engage in the practice or be involved in any aspect, administrative or otherwise, of the practice of fitting hearing instruments in Missouri, which would include serving as a supervisor of a hearing instrument specialist in training and submitting that affidavit with the renewal application and the appropriate fee to the board office. The license issued to all these applicants shall be stamped "inactive."

(B) In order for a hearing instrument specialist to activate an inactive license, the licensee shall submit to the board office—

1. The renewal application;

2. The balance of the active renewal fee. No fee will be prorated;

3. Evidence that the licensee has completed the required continuing education credits in accordance with 20 CSR 2165-2.060(5) for each renewal cycle that the license is inactive. These required approved continuing education credits shall not exceed a total of fifty (50) hours. These hours must have been obtained during the preceding twenty-four (24) months from the date of application for restoration to active status;

4. Annual calibration receipt;

5. The license stamped "inactive"; and

6. Registered supervisors must submit proof of current board certification.

(C) The board will issue an inactive license, which shall be effective until the next regular renewal date. No penalty fee shall apply.

AUTHORITY: sections 346.095 and 346.115.1(7), RSMo 2000. This rule originally filed as 4 CSR 165-2.060. Emergency rule filed Oct. 28, 1996, effective Nov. 7, 1996, expired May 5, 1997. Original rule filed Nov. 6, 1996, effective May 30, 1997. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 27, 2008.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Examiners for Hearing Instrument Specialists, Attention: Dana Hoelscher, PO Box 1335, Jefferson City, MO 65102, via fax at (573) 526-3856, or via email at behis@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2165—Board of Examiners for Hearing Instrument Specialists
Chapter 3—Code of Ethics

PROPOSED AMENDMENT

20 CSR 2165-3.010 General Obligations of the Licensee. The board is proposing to amend sections (3) and (4).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 165 are being amended throughout the rule.

(3) It shall be unethical for a hearing instrument specialist in training to misrepresent or mislead, directly or by implication, prospective purchasers into the erroneous belief that the hearing instrument specialist in training is licensed as a hearing instrument specialist by the state of Missouri by—

(A) Omitting "hearing instrument specialist in training" or its equivalent as defined in *[4 CSR 160-2.030]* **20 CSR 2165-2.030** from business cards, advertising, or any other industry document bearing his/her name; or

(4) It shall be unethical for a registered supervisor of a hearing instrument specialist in training to—

(A) Fail to provide the required training and supervision according to *[4 CSR 165-2.010]* **20 CSR 2165-2.010** to a hearing instrument specialist in training; or

*AUTHORITY: section 346.115.1(7), RSMo [(Cum. Supp. 1996)] **2000**. This rule originally filed as 4 CSR 165-3.010. Emergency rule filed Oct. 18, 1996, effective Nov. 1, 1996, expired April 29, 1997. Original rule filed Nov. 6, 1996, effective May 30, 1997. Moved to 20 CSR 2165-3.010, effective Aug. 28, 2006. Amended: Filed June 27, 2008.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Examiners for Hearing Instrument Specialists, PO Box 1335, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at behis@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2197—Board of Therapeutic Massage
Chapter 1—General Rules

PROPOSED AMENDMENT

20 CSR 2197-1.010 Definitions. The board is proposing to amend the original purpose statement.

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 197 are being amended throughout the rule.

*PURPOSE: This rule defines terms used in [4 CSR 197] **20 CSR 2197**.*

*AUTHORITY: sections 324.245, 324.257, and 324.265, RSMo Supp. [1999] **2007**. This rule originally filed as 4 CSR 197-1.010. Original rule filed Feb. 25, 2000, effective Sept. 30, 2000. Moved to 20 CSR 2197-1.010, effective Aug. 28, 2006. Amended: Filed June 27, 2008.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Therapeutic Massage, Loree Kessler, Executive Director, PO Box 1335, Jefferson City, MO 65102, by faxing comments to (573) 751-0735, or by emailing comments to massther@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2197—Board of Therapeutic Massage
Chapter 5—Massage Therapy Business Requirements

PROPOSED AMENDMENT

20 CSR 2197-5.040 Massage Therapy Business License Renewal. The board is proposing to amend section (4).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 197 are being amended throughout the rule.

(4) The license of a massage therapy business that is not renewed by the expiration date shall lapse and become not current. A massage therapy business license that has lapsed may be renewed by completing the renewal form and paying the required renewal and late fees as defined in *[4 CSR 197-1.040(3)(B)1.]* **20 CSR 2197-1.040(3)(B)1.** within thirty (30) days of the expiration date. A massage therapy business shall not offer massage therapy until filing the renewal form and paying the required fees.

AUTHORITY: sections 324.245, 324.257, and 324.262, RSMo Supp. 2007 and sections 324.250, 324.255, and 324.260, RSMo 2000. This rule originally filed as 4 CSR 197-5.040. Original rule filed Feb. 25, 2000, effective Sept. 30, 2000. Amended: Filed Nov. 26, 2003, effective June 30, 2004. Moved to 20 CSR 2197-5.040, effective Aug. 28, 2006. Amended: Filed Aug. 21, 2007, effective March 30, 2008. Amended: Filed June 27, 2008.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Therapeutic Massage, Loree Kessler, Executive Director, PO Box 1335, Jefferson City, MO 65102, by faxing comments to (573) 751-0735, or by emailing comments to massther@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2200—State Board of Nursing
Chapter 4—General Rules

PROPOSED AMENDMENT

20 CSR 2200-4.010 Fees. The board is proposing to amend subsection (1)(J).

PURPOSE: The board is statutorily obligated to enforce and administer the provisions of Chapter 335, RSMo. Pursuant to section 335.036.2., RSMo, the board shall by rule and regulation set the amount of fees authorized by Chapter 335, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of sections 331.010–331.115, RSMo. Therefore, the board is proposing to reduce their renewal fees.

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

(J) Biennial Renewal Fee—

1. RN—Effective January 1, 2003	$ 80
A. Effective January 1, 2009	**$ 60**
2. LPN—Effective January 1, 2003	$ 72
A. January 1, 2008 to December 31, 2008	$ 37
B. Effective January 1, 2009	$ *[72]***52**

3. License renewal for a professional nurse shall be biennial; occurring on odd-numbered years and the license shall expire on April 30 of each odd-numbered year. License renewal for a practical nurse shall be biennial; occurring on even-numbered years and the license shall expire on May 31 of each even-numbered year. Renewal shall be for a twenty-four (24)-month period except in instances when renewal for a greater or lesser number of months is caused by acts or policies of the Missouri State Board of Nursing. Renewal applications (see 20 CSR 2200-4.020) shall be mailed every even-numbered year by the Missouri State Board of Nursing to all LPNs currently licensed and every odd-numbered year to all RNs currently licensed;

4. Renewal fees for each biennial renewal period as outlined in this subparagraph shall be accepted by the Missouri State Board of Nursing only if accompanied by an appropriately completed renewal application:

A. RNs (odd-numbered years):	
(I) Effective January 1, 2003	$80
B. LPNs (even-numbered years):	
(I) Effective January 1, 2003	$72
(II) January 1, 2008 through December 31, 2008	$37
(III) Effective January 1, 2009	$72

5. All fees established for licensure or licensure renewal of nurses incorporate an educational surcharge in the amount of one dollar ($1) per year for practical nurses and five dollars ($5) per year for professional nurses. These funds are deposited in the professional and practical nursing student loan and nurse repayment fund;

AUTHORITY: section 335.036, RSMo Supp. 2007 and section 335.046, RSMo 2000. This rule originally filed as 4 CSR 200-4.010.

Emergency rule filed Aug. 13, 1981, effective Aug. 23, 1981, expired Dec. 11, 1981. Original rule filed Aug. 13, 1981, effective Nov. 12, 1981. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 2, 2008.*

PUBLIC COST: This proposed amendment will reduce the State Board of Nursing Fund approximately two (2) million dollars biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will save private entities approximately two (2) million dollars 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 Nursing, Lori Scheidt, Executive Director, PO Box 656, Jefferson City, MO 65102, by fax at (573) 751-0075, or via email at nursing@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 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2200 - State Board of Nursing
Chapter 4 - General Rules
Proposed Amendment - 20 CSR 2200-4.010 Fees
Prepared March 17, 2008 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Loss of Revenue	
State Board of Nursing		$2,000,000.00
	Total Loss of Revenue Biennially for the Life of the Rule	$2,000,000.00

III. WORKSHEET

The board estimates the projections calcuated in the Private Entity Fiscal Notes will be total loss of revenue for the board.

IV. ASSUMPTION

1. The division is statutorily obligated to enforce and administer the provisions of sections 335.011-324.257, RSMo. Pursuant to Section 335.036, RSMo, the board shall set the amount of the fees which this chapter authorizes and requires by rules and regulations. The fees shall be set at a level to produce revenue which shall not substantially exceed the cost and expense of administering this chapter.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration

Division 2200 - State Board of Nursing

Chapter 4 - General Rules

Proposed Amendment - 20 CSR 2200-4.010 Fees

Prepared March 17, 2008 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 savings for compliance with the amendment by affected entities:
80,000	Register Nurse (Renewal Fee @ $20 decrease)	$1,600,000
20,000	License Practical Nurse (Renewal Fee @ $20 decrease)	$400,000
	Estimated Biennial Cost Savings for the Life of the Rule	**$2,000,000**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The figures reported above are based on FY07 actuals.
2. It is anticipated that the total saving 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 division is statutorily obligated to enforce and administer the provisions of sections 335.011-324.257, RSMo. Pursuant to Section 335.036, RSMo, the board shall set the amount of the fees which this chapter authorizes and requires by rules and regulations. The fees shall be set at a level to produce revenue which shall not substantially exceed the cost and expense of administering this chapter.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2200—State Board of Nursing
Chapter 4—General Rules

PROPOSED AMENDMENT

20 CSR 2200-4.020 Requirements for Licensure. The board is proposing to amend sections (4), (5), and (8), delete section (9) and renumber the remaining sections.

PURPOSE: This amendment further clarifies the requirements for licensure for foreign educated applicants.

(4) Passing Score.

(A) The standard score of three hundred fifty (350) in each subject of the State Board Test Pool Examination for Registered Nurses shall be the Missouri passing score beginning with series **nine hundred forty-nine (**949**)** through series **two hundred eighty-two (**282**)**. Candidates writing the licensing examination prior to the date series **nine hundred forty-nine (**949**)** was given shall have no grade below sixty-five percent (65%) and shall have attained an average score of seventy percent (70%). Beginning July 1982, the standardized scoring system to be used with the National Council Licensure Examination for Registered Nurses will have a passing score of sixteen hundred (1600). Beginning February 1989, to be eligible for licensure, a candidate must achieve a pass designation on the National Council Licensure Examination for Registered Nurses.

(5) Licensure by Endorsement in Missouri—Registered Nurses (RNs) and Licensed Practical Nurses (LPNs).

(A) A professional/practical nurse licensed in another state or territory of the United States *[or Canada]* shall be entitled to licensure provided qualifications are equivalent to the requirements of Missouri at the time of original licensure. This equivalency shall be defined as—

1. Evidence of completion and graduation from an accredited program of professional/practical nursing **if educated in a state of the United States; a course-by-course evaluation report received directly from a credentials evaluation service approved by the board or a Commission on Graduates of Foreign Nursing Schools (CGFNS) certificate if the initial nursing education was earned in a territory, Canada or another country**;

2. Attainment of a passing standard score or pass designation as determined by the Missouri State Board of Nursing on the licensing examination or attainment of an acceptable grade in areas comparable to those required in Missouri at the time licensure was secured in the state of original licensure;

3. Evidence of completion of the applicable secondary education set forth in section 335.046, RSMo requirements or the equivalent as determined by the State Department of Education;

4. Applicants who are not citizens of the United States who have completed programs in schools of professional/practical nursing in states which require citizenship for licensure may take the National Council Licensure Examination for professional/practical nurses in Missouri if they meet all of Missouri's requirements; and

5. If an individual was licensed by waiver as a practical/vocational nurse in another state, territory or foreign country prior to July 1, 1955, and the individual meets the requirements for licensure as a practical nurse in Missouri which were in effect at the time the individual was licensed in the other jurisdiction, she/he is eligible for licensure in Missouri as an LPN. If an individual is licensed by waiver in another state after July 1, 1955, she/he does not qualify for licensure by waiver in Missouri as a practical nurse.

(8) Intercountry Licensure by Examination in Missouri—RN and LPN.

(A) Application Procedure.

1. A professional/practical nurse *[licensed]* **educated** outside **a state** of the United States *[or Canada]* shall be entitled to apply to take the examination for licensure if, in the opinion of the Missouri State Board of Nursing, current requirements for licensure in Missouri are met.

2. An applicant must request*[, in writing,]* an Application for Professional/Practical Nurse Licensure by Examination. The request shall include the applicant's full name, current mailing address and country of original licensure. The application shall be properly executed by the applicant in black ink and shall be included in the documents submitted to the Missouri State Board of Nursing for evaluation with the required credentials. All original documents shall be returned to the applicant. Credentials in a foreign language shall be translated into English, the translation shall be signed by the translator and the signature shall be notarized by a notary public. The translation shall be attached to the credentials in a foreign language when submitted to the Missouri State Board of Nursing.

3. The required credentials for practical nurse applicants are—

A. A course-by-course evaluation report received directly from a foreign credentials evaluation service approved by the board;

B. A photostatic copy of birth certificate (if a copy of birth certificate is not available, copy of baptismal certificate, passport or notarized statement from an authorized agency will be accepted as verification of name, date of birth and place of birth);

C. Photostatic copy of marriage license/certificate (if applicable);

D. Evidence of English-language proficiency by any of the following:

(I) Test of English as a Foreign Language (TOEFL) www.toefl.org with a passing score of **five hundred forty (**540**)** on the paper examination or a passing score of **two hundred seven (**207**)** for the computerized examination **or a passing score of seventy-six (76) on the Internet-based exam**; or

(II) Test of English for International Communication (TOEIC) www.toeic.com with a passing score of **seven hundred twenty-five (**725**)**; or

(III) International English Language Testing System (IELTS) www.ielts.org with a passing score in the academic module of **six and one-half (**6.5**)** and the Spoken Band score of **seven (**7**)**;

E. Test of Spoken English (TSE®) Certificate indicating that the applicant has obtained a minimum overall score of fifty (50);

F. Photostatic copy of original license issued by the licensing agency where original licensure/registration was secured by examination; and

G. The completed application must be accompanied by one (1) two-inch by two-inch (2"× 2") portrait/photograph of the applicant, and proof of submission of fingerprints to the Missouri State Highway Patrol's approved vendor for both a Missouri State Highway Patrol and Federal Bureau of Investigation fingerprint background check. Proof shall consist of any documentation acceptable to the board. Any fees due for fingerprint background checks shall be paid by the applicant directly to the Missouri State Highway Patrol or its approved vendor, and the required application fee. All fees are nonrefundable.

4. The required credentials for professional nurse applicants are—

A. A course-by-course evaluation report received directly from a credentials evaluation service approved by the board **or Commission on Graduates of Foreign Nursing Schools (CGFNS) certificate** and evidence of English-language proficiency. Any of the following is considered evidence of English-language proficiency:

(I) Test of English as a Foreign Language (TOEFL) www.toefl.org with a passing score of **five hundred forty (**540**)** on the paper examination or a passing score of **two hundred seven (**207**)** for the computerized examination **or a passing score of seventy-six (76) on the Internet-based exam**; or

(II) Test of English for International Communication

(TOEIC) www.toeic.com with a passing score of **seven hundred twenty-five (**725**)**; or

(III) International English Language Testing System (IELTS) www.ielts.org with a passing score in the academic module of **six and one-half (**6.5**)** and the Spoken Band score of **seven (**7**)**.

B. A photostatic copy of birth certificate (if a copy of birth certificate is not available, a copy of baptismal certificate, passport or notarized statement from authorized agency will be accepted as verification of name, date of birth and place of birth);

C. Photostatic copy of original license or certificate issued by the licensing agency where original licensure/registration was secured by examination;

D. Photostatic copy of marriage license/certificate (if applicable); and

E. The completed examination application with the required examination fee, one (1) two-inch by two-inch (2" × 2") portrait/photograph of the applicant, and proof of submission of fingerprints to the Missouri State Highway Patrol's approved vendor for both a Missouri State Highway Patrol and Federal Bureau of Investigation fingerprint background check. Proof shall consist of any documentation acceptable to the board. Any fees due for fingerprint background check shall be paid by the application directly to the Missouri State Highway Patrol or its approved vendor. All the credentials shall be submitted to the Missouri State Board of Nursing.

[(9) Guidelines for Evaluating Intercountry Transcripts.

(A) An applicant who has secured original licensure outside of the United States and has been licensed by examination in another state, territory or Canada may be licensed in Missouri if the applicant qualifies for licensure by endorsement from that state, territory or Canada under section (4). Each applicant under this section must cause a photostatic copy of a nursing transcript to be provided to the board office, except that RN applicants instead may cause the CGFNS to submit directly to the board office a CGFNS certificate or a course-by-course evaluation report received directly from a credentials evaluation service approved by the board and evidence of English-language proficiency. Any of the following is considered evidence of English-language proficiency:

1. Test of English as a Foreign Language (TOEFL) www.toefl.org with a passing score of 540 on the paper examination or a passing score of 207 for the computerized examination; or

2. Test of English for International Communication (TOEIC) www.toeic.com with a passing score of 725; or

3. International English Language Testing System (IELTS) www.ielts.org with a passing score in the academic module of 6.5 and the Spoken Band score of 7.

(B) Guidelines for evaluating intercountry transcripts for professional/practical nurse applicants are the minimum standards for accredited schools in Missouri in effect at the time the candidate originally became licensed by examination in another state, territory or Canada or at the time of application.]

*[(10)]***(9)**Licensure Renewal.

(A) Renewal periods shall be for one (1), two (2), or three (3) years as determined by the board.

(B) The required fee shall be submitted prior to the date the license lapses.

(C) In answer to requests for information regarding an individual's licensure, the staff of the board will verify status and other information as deemed appropriate by the executive director.

*[(11)]***(10)** Inactive Licenses.

(A) Any nurse possessing a current license to practice nursing in Missouri may place that license on inactive status by filing a written and signed request for inactive status with the board. This request may be accomplished, but need not be, by signing the request for inactive status which appears on the nurse's application for license renewal and returning that application to the board prior to the date the license has lapsed.

(B) Individuals wishing to reactivate licenses after being carried as inactive shall request a Petition for Renewal from the Missouri State Board of Nursing. Fees shall be accepted only if accompanied by a completed Petition for Renewal. Back fees shall not be required for the years the licensee's records were carried as inactive. The Petition for Renewal shall show, under oath or affirmation of the nurse, a statement—

1. That the nurse is not presently practicing nursing in Missouri; and

2. As to whether the nurse did practice nursing while the license was inactive and, if so, how long and where. If the nurse was practicing nursing in Missouri at the time his/her license was inactive, he/she also must submit a notarized statement indicating that he/she ceased working as soon as he/she realized that the license was inactive. In addition, the nurse must cause his/her employer to submit a statement on the employer's letterhead stationery or a notarized statement indicating that the nurse ceased working as soon as he/she realized that the license was inactive.

(C) No person shall practice nursing or hold him/herself out as a nurse in Missouri while his/her license is inactive.

(D) A nurse who petitions for renewal of an inactive license who answers yes to one (1) or more of the questions on the petition which relate to possible grounds for denial of renewal under section 335.066, RSMo, shall submit copies of appropriate documents related to that answer, as requested by the board, before his/her petition will be considered complete. The copies shall be certified if they are records of a court or administrative government agency. If a nurse requesting reinstatement of his/her inactive license is denied by the State Board of Nursing based upon the fact that the nurse is subject to disciplinary action under any provisions of Chapter 335, RSMo, the nurse shall be notified of the statutory right to file a complaint with the Administrative Hearing Commission.

(E) A nurse whose license is inactive for three (3) years or more shall file the petition, documents and fees required in subsection (11)(B). In addition, the nurse may be required to appear before the board personally and demonstrate evidence of current nursing knowledge and may be required to successfully complete an oral or written examination, or both, provided by the board or to present proof of regular licensed nursing practice in other states during that time period.

*[(12)]***(11)** Lapsed Licenses, When—Procedures for Reinstatement.

(A) Pursuant to sections 335.056 and 335.061, RSMo, a license issued by the State Board of Nursing to an RN or LPN is lapsed if the nurse fails to renew that license in a timely fashion. A license renewal is timely if the nurse mails a completed application for renewal, accompanied by the requisite fee, in a properly stamped and addressed envelope, postmarked no later than the expiration date of the nurse's current license. No person shall practice nursing or hold him/herself out as a nurse in Missouri while his/her license is registered with the State Board of Nursing as being lapsed.

(B) A nurse whose license has lapsed in Missouri for fewer than thirty (30) days may obtain renewal of that license by mailing the requisite fee to the proper address and postmarked no later than the thirtieth day of lapse. Satisfactory explanation of the lapse will be presumed. The State Board of Nursing, in its discretion, may not renew the license of any nurse who is subject to disciplinary action under Chapter 335, RSMo, but the board shall advise the nurse of the statutory right to file a complaint with the Administrative Hearing Commission.

(C) A nurse whose license has lapsed in Missouri for thirty (30) days or more, but fewer than three (3) years, must petition the State Board of Nursing for renewal of the license on a form furnished by

the board. Accompanying the petition shall be a late renewal fee and the fee for the current renewal period as outlined in 20 CSR 2200-4.010. If the nurse has practiced nursing in Missouri while the license was lapsed, in order to renew, the licensee must pay the lapsed fee, the renewal fee for each year he/she practiced nursing in Missouri and the fee for the current renewal period. This petition shall show under oath or affirmation of the nurse—

1. A statement that the nurse is not presently practicing nursing in Missouri;

2. A statement as to whether the nurse did practice nursing while the license was lapsed and, if so, how long and where; and

3. If the nurse was practicing nursing in Missouri at the time his/her license was lapsed, he/she must submit a notarized statement indicating that he/she ceased working as soon as he/she realized that the license was lapsed. In addition, the nurse must cause his/her employer to submit a statement on the employer's letterhead stationery or a notarized statement indicating that the nurse ceased working as soon as he/she realized that the license was lapsed.

(D) A nurse whose license is lapsed for three (3) years or more shall file the same petition, documents and fees required in subsection (12)(C). In addition, the nurse may be required to appear before the board personally and demonstrate evidence of current nursing knowledge and may be required to successfully complete an examination provided by the board or by proof of regular licensed nursing practice in other states during that time period.

(E) Upon satisfactory completion of the requirements specified in subsections (12)(B)–(D) which are pertinent to that nurse, the board reserves the right to refuse to reinstate the lapsed license of any nurse, including one who is subject to disciplinary action under any provisions of Chapter 335, RSMo, which includes disciplinary action for practicing nursing without a license while that license is lapsed. A nurse who is petitioning for renewal of a lapsed license who answers yes to one (1) or more of the questions on the petition which relate to possible grounds for denial of renewal under section 335.066, RSMo, shall submit copies of appropriate documents, as requested by the board, related to that answer before his/her petition will be considered complete. The copies shall be certified if they are records of a court or administrative government agency. If a lapsed license is not reinstated, the board shall notify the nurse of the fact and the statutory right to file a complaint with the Administrative Hearing Commission.

(F) If any provision of this rule is declared invalid by a court or agency of competent jurisdiction, the balance of this rule shall remain in full force and effect, severable from the invalid portion.

*[(13)]***(12)** Duplicate Licenses. A duplicate license, marked duplicate, may be issued in the event the original becomes lost or destroyed, or if the licensee requests a duplicate license due to a name change. The licensee must notify the Missouri State Board of Nursing and a form will be forwarded for completion and notarization. A fee will be charged for the duplicate.

*[(14)]***(13)** Change of Name, Address, or Both.

(A) Original License. The original license may not be altered in any way; it must remain in the name under which it was issued.

(B) Current License.

1. If a change of name has occurred since the issuance of the current license, the licensee must notify the board of the name change in writing. If a duplicate license reflecting the name change is desired, the current license and required fee must be submitted to the board office.

2. If a change of address has occurred since the issuance of the current license, the licensee must notify the board of the address change. No duplicate license will be issued solely to reflect an address change. Each licensee must notify the board of any change in the licensee's mailing address prior to the expiration date of the licensee's current license.

3. Requests for the current license to be sent to a place other than the regular mailing address shall be forwarded to the executive director.

*[(15)]***(14)** Retired License Status.

(A) An applicant for renewal of a nurse license who is retired from the profession may apply for a retired license status by completing a form provided by the board.

(B) Retired from the profession means that the licensee does not intend to practice nursing for monetary compensation for at least two (2) years; such person may provide volunteer services.

(C) A licensee may qualify for retired license status provided the licensee:

1. Is retired from the profession;

2. Holds a current, unrestricted, and undisciplined nurse license; and

3. Submits the required form.

(D) Retired license renewal for a professional nurse shall be biennial; occurring on odd-numbered years and the license shall expire on April 30 of each odd-numbered year. Retired license renewal for a practical nurse shall be biennial; occurring on even-numbered years and the license shall expire on May 31 of each even-numbered year.

(E) Individuals wishing to reactivate licenses after being carried as retired shall request a petition for renewal from the board. Fees shall be accepted only if accompanied by a completed petition for renewal. Back fees shall not be required for the years the licensee's records were carried as retired. The petition for renewal shall show, under oath or affirmation of the nurse, a statement:

1. That the nurse is not presently practicing nursing in Missouri for monetary compensation; and

2. As to whether the nurse did practice nursing for monetary compensation while the license was retired and, if so, how long and where. If the nurse was practicing nursing for monetary compensation in Missouri at the time his/her license was retired, s/he also must submit a notarized statement indicating employment dates, employer names and addresses, and an explanation of why the nurse practiced for compensation while the license was retired. In addition, the nurse must cause his/her employer to submit a statement on the employer's letterhead stationery or a notarized statement indicating that the nurse ceased working as soon as s/he realized that the license was retired.

(F) A nurse who petitions for renewal of a retired license, who answers yes to one (1) or more of the questions on the petition which relate to possible grounds for denial of renewal under section 335.066, RSMo, shall submit copies of appropriate documents related to that answer, as requested by the board, before his/her petition will be considered complete. The copies shall be certified if they are records of a court or administrative government agency. If a nurse requesting reinstatement of his/her retired license is denied by the State Board of Nursing based upon the fact that the nurse is subject to disciplinary action under any provisions of Chapter 335, RSMo, the nurse shall be notified of the statutory right to file a complaint with the Administrative Hearing Commission.

AUTHORITY: section 335.036(2) and (7), ***RSMo Supp. 2007 and sections*** *335.046 and 335.051, RSMo 2000. This rule originally filed as 4 CSR 200-4.020. Original rule filed Oct. 14, 1981, effective Jan. 14, 1982. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed June 2, 2008.*

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 State Board of Nursing, Lori Scheidt, Executive Director, PO Box 656, Jefferson City, MO 65102, by fax at (573) 751-0075 or via email at nursing@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2200—State Board of Nursing
Chapter 4—General Rules

PROPOSED AMENDMENT

20 CSR 2200-4.100 Advanced Practice Nurse. The board is proposing to amend section (6).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 200 are being amended throughout the rule.

(6) Certifying Body Criteria.

(A) In order to be a certifying body acceptable to the *[Missouri]* State Board of Nursing for advanced practice nurse status, the certifying body must meet the following criteria—

1. Be national in the scope of its credentialing;
2. Have no requirement for an applicant to be a member of any organization;
3. Have formal requirements that are consistent with the requirements of *[4 CSR 200-4.100]* **20 CSR 2200-4.100** Advanced Practice Nurse rule;
4. Have an application process and credential review that includes documentation that the applicant's advanced nursing education, which included theory and practice, is in the advanced practice nursing clinical specialty area being considered for certification;
5. Use psychometrically sound and secure examination instruments based on the scope of practice of the advanced practice nursing clinical specialty area;
6. Issue certification based on passing examination and meeting all other certification requirements;
7. Provide for periodic recertification/maintenance options which include review of qualifications and continued competence; and
8. Have an evaluation process to provide quality assurance in its certification, recertification, and continuing competency components.

AUTHORITY: sections 335.016(2)[, RSMo Supp. 2006] and 335.036, RSMo [2000] ***Supp. 2007****. This rule originally filed as 4 CSR 200-4.100. Original rule filed Nov. 15, 1991, effective March 9, 1992. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed June 27, 2008.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Nursing, PO Box 656, Jefferson City, MO 65102, by facsimile at 573-751-0075, or via email at nursing@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2200—State Board of Nursing
Chapter 4—General Rules

PROPOSED AMENDMENT

20 CSR 2200-4.200 Collaborative Practice. The board is proposing to amend section (2).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 200 are being amended throughout the rule.

(2) Geographic Areas.

(C) An advanced practice nurse who desires to enter into a collaborative practice arrangement to provide health care services that include the diagnosis and treatment of acutely or chronically ill or injured persons at a location where the collaborating physician is not continuously present shall practice at the same location with the collaborating physician for a period of at least one (1) calendar month before the collaborating advanced practice nurse practices at a location where the collaborating physician is not present. The provision of the above specified health care services pursuant to a collaborative practice arrangement shall be limited to only an advanced practice nurse. This provision applies to all collaborative practice arrangements between a physician and an advanced practice nurse unless a waiver is obtained as provided in *[4 CSR 200-4.200(2)(D)]* **20 CSR 2200-4.200(2)(D)**.

(D) If an advanced practice nurse has been continuously providing health care services pursuant to a collaborative practice arrangement with the same physician for at least one (1) year and the collaborating physician terminates the collaborative practice arrangement with less than thirty (30) days notice for reasons unrelated to the advanced practice nurse, *[4 CSR 200-4.200(2)(C)]* **20 CSR 2200-4.200(2)(C)** may be waived by the board of nursing and the board of healing arts if the requirement for one (1) calendar month same-site collaboration would result in health care services at the location where the advanced practice nurse practices being discontinued or reduced. The request for the waiver with supporting documentation shall be submitted to the board of nursing or the board of healing arts by the advanced practice nurse or the collaborating physician and shall specify all information necessary for the board of nursing and the board of healing arts to evaluate the request including, but not limited to, the date and reasons for the termination of the collaborative practice arrangement, number of patients affected and plan for a new collaborative practice arrangement.

AUTHORITY: sections 334.104.3[, RSMo Supp. 2002] and 335.036, RSMo [2000] ***Supp. 2007****. This rule originally filed as 4 CSR 200-4.200. Original rule filed Jan. 29, 1996, effective Sept. 30, 1996. Amended: Filed April 1, 1998, effective Oct. 30, 1998. Amended: Filed Oct. 30, 2002, effective June 30, 2003. Moved to 20 CSR 2200-4.200, effective Aug. 28, 2006. Amended: Filed June 27, 2008.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Nursing, PO Box 656, Jefferson City, MO 65102, by facsimile at 573-751-0075, or via email at nursing@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2200—State Board of Nursing
Chapter 6—Intravenous Infusion Treatment Administration

PROPOSED AMENDMENT

20 CSR 2200-6.020 Definitions. The board is proposing to amend section (27).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 200 are being amended throughout the rule.

(27) Qualified practical nurses—for the purpose of this chapter, this term includes:

(A) Graduate practical nurses practicing in Missouri within the time frame as defined in *[4 CSR 200-4.020(3)]* **20 CSR 2200-4.020(3)**;

AUTHORITY: section[s] 335.017, ***RSMo 2000*** *and* ***section*** *335.036, RSMo [2000]* ***Supp. 2007****. This rule originally filed as 4 CSR 200-6.020. Original rule filed Sept. 1, 2005, effective April 30, 2006. Moved to 20 CSR 2200-6.020, effective Aug. 28, 2006. Amended: Filed June 27, 2008.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Nursing, PO Box 656, Jefferson City, MO 65102, by facsimile at 573-751-0075, or via email at nursing@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2200—State Board of Nursing
Chapter 6—Intravenous Infusion Treatment Administration

PROPOSED AMENDMENT

20 CSR 2200-6.060 Requirements for Intravenous Therapy Administration Certification. The board is proposing to amend sections (1) through (6).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 200 are being amended throughout the rule.

(1) A practical nurse who is currently licensed to practice in Missouri and who is not Intravenous (IV)-Certified in Missouri can obtain IV-Certification upon the successful completion of a board approved venous access and intravenous infusion treatment modalities course.

(B) Upon receipt of the verification of IV-Certification letter from the board, the licensed practical nurse may engage in practical nursing care acts involving venous access and intravenous infusion treatment modalities as specified in the provisions of section 335.016, RSMo, *[4 CSR 200-5.010]* **20 CSR 2200-5.010**, and this chapter.

(2) A practical nurse who is currently licensed to practice in another state or territory of the United States, who is an applicant for licensure by endorsement in Missouri and has been issued a temporary permit to practice in Missouri and is not IV-Certified in another state or territory can obtain IV-Certification upon successful completion of a board approved venous access and intravenous infusion treatment modalities course.

(B) Upon receipt of the Verification of IV-Certification letter from the board, the individual may engage in practical nursing care acts involving venous access and intravenous infusion treatment modalities as specified in the provisions of section 335.016, RSMo, *[4 CSR 200-5.010]* **20 CSR 2200-5.010**, and this chapter.

(3) A practical nurse who is currently licensed to practice in another state or territory of the United States, who is an applicant for licensure by endorsement in Missouri and has been issued a temporary permit to practice in Missouri, and is IV-Certified in another state or territory of the United States, or who has completed a venous access and intravenous infusion treatment modalities course in another state or territory of the United States, can obtain IV-Certification in Missouri by:

(D) Upon receipt of the Verification of IV-Certification letter from the board, the individual may engage in practical nursing care acts involving venous access and intravenous infusion treatment modalities as specified in the provisions of section 335.016, RSMo, *[4 CSR 200-5.010]* **20 CSR 2200-5.010**, and this chapter;

(4) Individuals who graduated from a board approved practical nursing program after February 28, 1999 are exempt from taking a separate venous access and intravenous infusion treatment modalities course to become IV-Certified.

(A) A graduate of such a practical nursing program may perform the functions and duties related to venous access and intravenous infusion treatment modalities as delineated in *[4 CSR 200-6.030]* **20 CSR 2200-6.030** until s/he has received the results of the first licensure examination taken by the nurse or until ninety (90) days after graduation, whichever first occurs.

(5) Graduate practical nurses as specified in **sub**sections *[4 CSR 200-6.040(2)(C) and (D)]* **20 CSR 2200-6.040(2)(C) and (D)** of this chapter who are seeking licensure by examination in Missouri and for whom the board has received confirmation of successful completion of an approved venous access and intravenous infusion treatment modalities course must meet all licensure requirements before a license stating LPN IV-Certified can be issued.

(6) If a qualified licensed practical nurse requests a license stating LPN IV-Certified prior to the next licensure renewal cycle, the procedure for obtaining a duplicate license as stated in *[4 CSR 200-4.020(14)]* **20 CSR 2200-4.020(14)** shall be followed.

*AUTHORITY: section[s] 335.017, **RSMo 2000** and **section** 335.036, RSMo [2000] **Supp. 2007**. This rule originally filed as 4 CSR 200-6.060. Original rule filed Sept. 1, 2005, effective April 30, 2006. Moved to 20 CSR 2200-6.060, effective Aug. 28, 2006. Amended: Filed June 27, 2008.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Nursing, PO Box 656, Jefferson City, MO 65102, by facsimile at 573-751-0075, or via email at nursing@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2233—State Committee of Marital and Family Therapists
Chapter 1—General Rules

PROPOSED AMENDMENT

20 CSR 2233-1.020 Policy for Release of Public Records. The board is proposing to amend section (4).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 233 are being amended throughout the rule.

(4) The division may charge a reasonable fee pursuant to *[4 CSR 233-1.040(1)(G) and (K)]* **20 CSR 2233-1.040(1)(G) and (K)** for the cost for inspecting and copying the records. Charges and payments of the fees shall be based on the following:

*AUTHORITY: section 337.727.1(10), RSMo [Supp. 1997] **2000**. This rule originally filed as 4 CSR 233-1.020. Original rule filed Dec. 31, 1997, effective July 30, 1998. Moved to 20 CSR 2233-1.020, effective Aug. 28, 2006. Amended: Filed June 27, 2008.*

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 State Committee of Marital and Family Therapists, Loree Kessler, Executive Director, PO Box 1335, Jefferson City, MO 65102, by faxing comments to (573) 751-0735, or by emailing comments to maritalfam@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2233—State Committee of Marital and Family Therapists
Chapter 3—Ethical Standards

PROPOSED AMENDMENT

20 CSR 2233-3.010 General Principles. The board is proposing to amend subsection (7)(I).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 233 are being amended throughout the rule.

(7) The therapist providing marital and family therapy as defined in section 337.700(7), RSMo *[Cum. Supp. 1997]* shall maintain client records that include:

(I) Informed consent as defined in *[4 CSR 233-3.020(1)(A)–(H)]* **20 CSR 2233-3.020(1)(A)–(H)**.

*AUTHORITY: sections 337.727.1(6) and (10) and 337.730.2(15), RSMo [Supp. 1997] **2000**. This rule originally filed as 4 CSR 233-3.010. Original rule filed Dec. 31, 1997, effective July 30, 1998. Moved to 20 CSR 2233-3.010, effective Aug. 28, 2006. Amended: Filed June 27, 2008.*

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 State Committee of Marital and Family Therapists, Loree Kessler, Executive Director, PO Box 1335, Jefferson City, MO 65102, by faxing comments to (573) 751-0735, or by emailing comments to maritalfam@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2245—Real Estate Appraisers
Chapter 3—Applications for Certification and Licensure

PROPOSED AMENDMENT

20 CSR 2245-3.005 Trainee Real Estate Appraiser Registration. The board is proposing to amend paragraph (5)(B)1.

PURPOSE: This amendment updates the version of the USPAP that the board utilizes.

(5) Training.

(B) The supervising appraiser(s) shall be responsible for the training, guidance, and direct supervision of the registrant by:

1. Accepting responsibility for the appraisal report by signing and certifying that the report complies with the *Uniform Standards of Professional Appraisal Practice[,]* (USPAP)**,** *[2006]* **2008** Edition. The USPAP, *[2006]* **2008** Edition, is incorporated herein by reference and can be obtained from The Appraisal Foundation, 1155 15th Street NW, Suite 1111, Washington, DC 20005, by calling (202) 347-7722**,** or at www.appraisalfoundation.org.

2. Reviewing and signing the appraisal report(s) for which the registrant has provided appraisal services; and

3. Personally inspecting each appraised property with the registrant until the supervising appraiser determines the registrant trainee is competent, in accordance with the competency rule of USPAP.

AUTHORITY: section 339.509(8), RSMo 2000. Original rule filed Nov. 21, 2006, effective July 30, 2007. Amended: Filed Nov. 15, 2007, effective May 30, 2008. Amended: Filed June 27, 2008.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Real Estate Appraisers Commission, Vanessa Beauchamp, Executive Director, PO Box 1335, Jefferson City, MO 65102, by faxing comments to (573) 751-0038, or by emailing comments to reacom@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2270—Missouri Veterinary Medical Board
Chapter 1—General Rules

PROPOSED AMENDMENT

20 CSR 2270-1.040 Name and Address Changes. The board is proposing to amend section (2).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 270 are being amended throughout the rule.

(2) A licensee/registrant whose name is changed, within sixty (60) days of the effective change, shall—

(B) Pay the name change fee prescribed in *[4 CSR 270-1.021]* **20 CSR 2270-1.021**;

AUTHORITY: section 340.210, RSMo [Supp. 1993] 2000. This rule originally filed as 4 CSR 270-1.040. Original rule filed Nov. 4, 1992, effective July 8, 1993. Moved to 20 CSR 2270-1.040, effective Aug. 28, 2006. Amended: Filed June 27, 2008.

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 Veterinary Medical Board, PO Box 633, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at vets@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2270—Missouri Veterinary Medical Board
Chapter 1—General Rules

PROPOSED AMENDMENT

20 CSR 2270-1.050 Renewal Procedures. The board is proposing to amend sections (2) through (5).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 270 are being amended throughout the rule.

(2) Renewal of an Active or Inactive License/Certificate of Registration.

(A) In order for a veterinarian to renew an active or inactive license, the licensee shall submit the following to the board office prior to the expiration date of the license:

1. A completed and signed renewal application, which shall certify that the licensee has completed the required number of approved continuing education credits in accordance with *[4 CSR 270-4.042]* **20 CSR 2270-4.042**; and

2. The appropriate renewal fee.

(B) In order for a veterinary technician to renew the active or inactive certificate of registration, the licensee shall submit the following to the board office prior to the expiration date of the registration:

1. A completed and signed renewal application, which has been signed by the supervising veterinarian and certifies that the licensee has completed the required number of approved continuing education credits in accordance with *[4 CSR 270-4.050]* **20 CSR 2270-4.050**; and

2. The appropriate renewal fee.

(3) Restoration of a Noncurrent License/Certificate of Registration.

(A) Any veterinarian whose license has been declared noncurrent under section 340.262, RSMo and who wishes to restore the license shall make application to the board by submitting the following within two (2) years of the license renewal date:

1. An application for renewal of licensure;

2. The current renewal fee and all delinquent renewal fees as set forth in *[4 CSR 270-1.021]* **20 CSR 2270-1.021**;

3. The penalty fee as set forth in *[4 CSR 270-1.021]* **20 CSR 2270-1.021**; and

4. Certification of completion of the required number of approved continuing education credits in accordance with *[4 CSR 270-4.042]* **20 CSR 2270-4.042**.

(4) Inactive License/Certificate of Registration.

(B) In order for a veterinarian to activate an inactive license, the licensee shall submit to the board office:

1. The renewal application**,** which shall certify that the licensee

has completed the required continuing education credits in accordance with *[4 CSR 270-4.042]* **20 CSR 2270-4.042**;

2. The balance of the active renewal fee; and

3. The license stamped "Inactive."

(C) In order for a veterinary technician to activate an inactive registration, the licensee shall submit to the board office:

1. The renewal application which shall certify that the licensee has completed the required continuing education credits in accordance with *[4 CSR 270-4.050]* **20 CSR 2270-4.050**;

2. The balance of the active renewal fee;

3. The license stamped "Inactive"; and

4. Verification of current employment under the supervision of a licensed veterinarian.

(5) Retired License/Certificate of Registration.

(B) If a retired veterinarian decides to again practice veterinary medicine, s/he must submit to the board office a completed renewal application which shall certify that the licensee has completed the required continuing education credits in accordance with *[4 CSR 270-4.042]* **20 CSR 2270-4.042** and the current renewal fee. The board will issue an active license which shall be effective until the next regular renewal date. No penalty fee shall apply. If it has been more than two (2) years since the retirement affidavit was submitted, evidence of ten (10) hours of continuing education for each year of retirement must be submitted with the renewal application. The board reserves the right pursuant to section 340.268, RSMo to direct any such applicant to take an examination(s) to reactivate his/her license.

(C) If a retired veterinary technician decides to again practice veterinary medicine, s/he shall submit to the board office a completed renewal application along with the current renewal fee. The renewal application shall verify current employment under the supervision of a licensed veterinarian and certify completion of the required number of approved continuing education credits in accordance with *[4 CSR 270-4.050]* **20 CSR 2270-4.050**. The board will issue an active registration which shall be effective until the next regular renewal date. No penalty fee shall apply. The board reserves the right pursuant to section 340.268, RSMo to direct any such applicant to take an examination(s) to reactivate his/her registration.

AUTHORITY: sections 340.210 340.258, 340.314, 340.322, 340.324, and 340.326, RSMo 2000 and ***sections*** *340.262, 340.312, and 340.320, RSMo Supp. [2005]* ***2007****. This rule originally filed as 4 CSR 270-1.050. Original rule filed Nov. 4, 1992, effective July 8, 1993. Amended: Filed April 14, 1994, effective Sept. 30, 1994. Rescinded and readopted: Filed April 13, 2001, effective Oct. 30, 2001. Amended: Filed Dec. 1, 2005, effective June 30, 2006. Moved to 20 CSR 2270-1.050, effective Aug. 28, 2006. Amended: Filed Aug. 11, 2006, effective Jan. 30, 2007. Amended: Filed June 27, 2008.*

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 Veterinary Medical Board, PO Box 633, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at vets@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2270—Missouri Veterinary Medical Board
Chapter 1—General Rules

PROPOSED AMENDMENT

20 CSR 2270-1.060 Public Records. The board is proposing to amend section (3).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 270 are being amended throughout the rule.

(3) When a party requests copies of the records, the board may collect the appropriate fee for costs for inspecting and copying the records and may require payment of the fee prior to making the records available (see *[4 CSR 270-1.021]* **20 CSR 2270-1.021**).

AUTHORITY: section 340.210, RSMo [Supp. 1992,] ***2000 and sections*** *610.023 and 610.026, RSMo Supp. [1987]* ***2007****. This rule was originally filed as 4 CSR 270-1.030. This rule previously filed as 4 CSR 270-1.060. Original rule filed Aug. 5, 1991, effective Feb. 6, 1992. Amended: Filed Nov. 4, 1992, effective July 8, 1993. Moved to 20 CSR 2270-1.060, effective Aug. 28, 2006. Amended: Filed June 27, 2008.*

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 Veterinary Medical Board, PO Box 633, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at vets@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2270—Missouri Veterinary Medical Board
Chapter 2—Licensure Requirements for Veterinarians

PROPOSED AMENDMENT

20 CSR 2270-2.051 Licensure (Exception). The board is proposing to amend section (1).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 270 are being amended throughout the rule.

(1) Faculty members at an American Veterinary Medical Association (AVMA)-accredited college or university who are AVMA board-certified but did not graduate from an AVMA-accredited college of

veterinary medicine may apply to the board for a veterinary license under the following conditions:

(A) Achieving a passing score as defined in *[4 CSR 270-2.031]* **20 CSR 2270-2.031** on the North American Veterinary Licensing Examination (NAVLE) and Missouri State Board examinations; and

AUTHORITY: sections 340.210, 340.216, and 340.230, RSMo 2000. This rule originally filed as 4 CSR 270-2.051. Original rule filed Nov. 4, 1992, effective July 8, 1993. Amended: Filed April 1, 2003, effective Sept. 30, 2003. Moved to 20 CSR 2270-2.051, effective Aug. 28, 2006. Amended: Filed June 27, 2008.

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 Veterinary Medical Board, PO Box 633, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at vets@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2270—Missouri Veterinary Medical Board
Chapter 2—Licensure Requirements for Veterinarians

PROPOSED AMENDMENT

20 CSR 2270-2.060 Reciprocity. The board is proposing to amend section (3).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 270 are being amended throughout the rule.

(3) The applicant shall—

(A) Complete an application form provided by the board (see *[4 CSR 270-1.031]* **20 CSR 2270-1.031**) which shall include a complete listing of all locations of all previous places of practice and licensure in chronological order;

(C) Request the licensing authority in each state in which the applicant has ever been licensed to submit a Verification Request Form (see *[4 CSR 270-1.031]* **20 CSR 2270-1.031**) which is available from the board;

AUTHORITY: sections 340.210 and 340.238, RSMo 2000 and section 340.234, RSMo Supp. 2007. This rule originally filed as 4 CSR 270-2.060. Original rule filed Nov. 4, 1992, effective July 8, 1993. Amended: Filed Oct. 10, 1995, effective April 30, 1996. Amended: Filed July 31, 2000, effective Jan. 30, 2001. Moved to 20 CSR 2270-2.060, effective Aug. 28, 2006. Amended: Filed Oct. 30, 2007, effective April 30, 2008. Amended: Filed June 27, 2008.

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 Veterinary Medical Board, PO Box 633, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at vets@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2270—Missouri Veterinary Medical Board
Chapter 3—Registration Requirements for Veterinary Technicians

PROPOSED AMENDMENT

20 CSR 2270-3.030 Reciprocity. The board is proposing to amend section (2).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 270 are being amended throughout the rule.

(2) The applicant shall—

(D) Request the national testing service to send evidence that the applicant has taken the Veterinary Technician National Examination (VTNE) and received a passing score as defined in *[4 CSR 270-3.020]* **20 CSR 2270-3.020**.

*AUTHORITY: sections 340.210[, 340.234,] **and** 340.238, [and 340.306,] RSMo 2000 **and sections 340.234 and 340.306, RSMo Supp. 2007**. This rule originally filed as 4 CSR 270-3.030. Original rule filed Nov. 4, 1992, effective July 8, 1993. Amended: Filed March 10, 1995, effective Sept. 30, 1995. Amended: Filed April 13, 2001, effective Oct. 30, 2001. Moved to 20 CSR 2270-3.030, effective Aug. 28, 2006. Amended: Filed June 27, 2008.*

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 Veterinary Medical Board, PO Box 633, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at vets@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2270—Missouri Veterinary Medical Board
Chapter 5—Veterinary Facilities Permits

PROPOSED AMENDMENT

20 CSR *[270/2270-5.021* **Veterinary Facility Self-Inspection Procedures**. The board is proposing to amend section (2).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 270 are being amended throughout the rule.

(2) The self-inspection form (see *[4 CSR 270-5.011]* **20 CSR 2270-5.011**) is available from the executive director, Missouri Veterinary Medical Board, P*[.]*O*[.]* Box 633, Jefferson City, MO 65102.

*AUTHORITY: sections 340.210 and 340.264, RSMo [Supp. 1992] **2000**. This rule originally filed as 4 CSR 270-5.021. Original rule filed Nov. 4, 1992, effective July 8, 1993. Moved to 20 CSR 2270-5.021, effective Aug. 28, 2006. Amended: Filed June 27, 2008.*

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 Veterinary Medical Board, PO Box 633, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at vets@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2270—Missouri Veterinary Medical Board
Chapter 5—Veterinary Facilities Permits

PROPOSED AMENDMENT

20 CSR 2270-5.041 Temporary Continuance of Veterinary Practice Upon Death of Owner. The board is proposing to amend section (2).

PURPOSE: Pursuant to Executive Order 06-04, the Division of Professional Registration was transferred from the Department of Economic Development, Title 4, to the Department of Insurance, Financial Institutions and Professional Registration, Title 20. Therefore, references to 4 CSR 270 are being amended throughout the rule.

(2) The unlicensed owner shall provide the Veterinary Medical Board with written notice of the veterinarian in charge in accordance with *[4 CSR 270-5.011(6)]* **20 CSR 2270-5.011(6)**. The thirty (30)-day time period may be extended upon written petition to the board.

AUTHORITY: sections 340.210 and 340.264, RSMo 2000. This rule originally filed as 4 CSR 270-5.041. Original rule filed March 10, 1995, effective Sept. 30, 1995. Moved to 20 CSR 2270-5.041, effective Aug. 28, 2006. Amended: Filed Oct. 30, 2007, effective April 30, 2008. Amended: Filed June 27, 2008.

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 Veterinary Medical Board, PO Box 633, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at vets@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.*