## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
## Division 10—Health Care Plan
## Chapter 3—Public Entity Membership

## PROPOSED AMENDMENT

**22 CSR 10-3.070 Coordination of Benefits**. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the coordination of benefits (COB) in the Missouri Consolidated Health Care Plan.*

(2) Definitions. The following words and terms, when used in this rule, shall have the following meanings unless the context clearly indicates otherwise:

(A) Allowable expenses.

1. Allowable expense means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

2. Notwithstanding this definition, items of expense under coverage*[s]*, such as dental care, vision care, prescription drug, or hearing-aid programs, may be excluded from the definition of allowable expense. A plan which provides benefits only for any of these items of expense may limit its definition of allowable expenses to like items of expense.

3. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

4. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

5. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of allowable expense must include the corresponding expenses or services to which COB applies.

6. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of this reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

A. Only benefit reductions based upon provisions similar in purpose to those described previously and which are contained in the primary plan may be excluded from allowable expenses.

B. This provision shall not be used to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services;

(3) Order of Benefit Determination Rules.

(B) Rules. MCHCP determines its order of benefits using the first of the following rules which applies:

**1. Active/inactive employee. The benefits of the plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of the plan which covers that person as a laid off or retired employee (or as that employee's dependent);**

*[1.]***2.** Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; *[except that—if the person is also a Medicare beneficiary, and as a result of the rule established by the Title XVIII of the Social Security Act and implementing regulations, Medicare is—*

*A. Secondary to the plan covering the person as a dependent;*

*B. Primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent;*

*C. Primary if the person is eligible for Medicare due to disability; and*

*D. Primary after the first thirty (30) months if the person is eligible for Medicare due to end stage renal disease;]*

**3. Medicare.**

**A. If a member is an active employee and has Medicare, MCHCP is the primary plan for the active employee and his/her dependents. Medicare is the secondary plan except for members with end stage renal disease (ESRD) as defined in subparagraph (3)(B)3.C.**

**B. If a member is a retiree and has Medicare, Medicare is the primary plan for the retiree and his/her Medicare-eligible dependents. MCHCP is the secondary plan.**

**C. If a member or his/her dependents are eligible for Medicare solely because of ESRD, the member's MCHCP plan is primary to Medicare during the first thirty (30) months of Medicare eligibility for home peritoneal dialysis or home hemodialysis and thirty-three (33) months for in-center dialysis. After the thirty (30) or thirty-three (33) months, Medicare becomes primary, and claims are submitted first to Medicare, then to MCHCP for secondary coverage. The member is responsible for notifying MCHCP of his/her Medicare status;**

*[2.]***4.** Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different persons, called parents—

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;

*[3.]***5.** Dependent child/separated or divorced**, or never married**. If two (2) or more plans cover a person as a dependent child of divorced**,** *[or]* separated**, or never married** parents, benefits for the child are determined in this order—

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody of the child;

C. Then, the plan of the parent not having custody of the child; and

D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

*[4.]***6.** Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)*[2.]***4.**;

*[5.]***7.** Dependent child/parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits

with itself; *[and]*

**8. The plan that covers the member as a spouse is primary over the plan that covers the member as a dependent child; and**

*[6.]***9.** Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

*AUTHORITY: sections 103.059 and 103.089, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Rescinded and readopted: Filed July 1, 2010, effective Dec. 30, 2010. Amended: Filed Nov. 1, 2011.*

*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 Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. 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 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
## Division 10—Health Care Plan
## Chapter 3—Public Entity Membership

## PROPOSED AMENDMENT

**22 CSR 10-3.075 Review and Appeals Procedure**. The Missouri Consolidated Health Care Plan is amending sections (1)–(5); adding section (1); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

**(1) General Provision. The board of trustees has the right to suspend, revise, or remove eligibility and benefit requirements in the case of a disaster or emergency situation.**

*[(1)]***(2)** Claims Submissions and Initial Benefit Determinations.

(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously*[-]* approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously*[-]* approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, or a provider**,** or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based**,** with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

*[(2)]***(3)** General Appeal Provisions.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals

to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave *[rights]* **rise** to the appeal.

*[(3)]***(4)** Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage *[once]* **after** an individual has been covered under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical *[and pharmacy]* benefits administered by *[plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc.,]* **Coventry Health Care** in accordance with state law and regulations promulgated by DIFP *[and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010]*. **The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR and Express Scripts Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time).**

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the *[DIFP]* external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review *[by DIFP]* **except as specifically provided in 22 CSR 10-32.075(4)(A)4**.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will

be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 8086
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through *[Mercy Health Plans]* **Coventry Health Care**—

(a) First and second level appeals must be submitted in writing to—

*[Mercy Health Plans*
*Attn: Corporate Appeals*
*14528 S. Outer 40 Road, Suite 300*
*Chesterfield, MO 63017]*
**Coventry Health Care**
**Attn: Appeals Department**
**550 Maryville Centre, Ste. 300**
**St. Louis, MO 63141**

(b) Expedited appeals must be communicated by calling *[Mercy Health Plans]* **Coventry Health Care** telephone *[1-800-830-1918, ext. 2394]* **1-314-214-2394** or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
*[Clinical Appeals—MH3*
*6625 West 78th Street, BL0390]*
**Attn: Pharmacy Appeals—MH3**
**Mail Route 0390**
**6625 W. 78th St.**
Bloomington, MN 55439
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

**(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.**

**(II) The claimant can submit an external review request in writing to—**

**Office of Consumer Information and Oversight**
**Department of Health and Human Services**
**PO Box 791**
**Washington DC 20044**
**or by fax to 1-202-606-0036**
**or by email to disputedclaim@opm.gov**

**(III) The claimant may call the toll-free number 1-877-549-8152 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.**

**(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.**

**(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.**

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

*[(4)]***(5)** Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110

*[(5)]***(6)** In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.

(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date

of birth.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, *[the]* MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. **Plan changes are effective February 1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Wellness Program]* **Lifestyle Ladder** participation—MCHCP may deny all appeals regarding continuation of participation in the *[Wellness]* **Lifestyle Ladder** Program due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*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 Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. 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 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
## Division 10—Health Care Plan
## Chapter 3—Public Entity Membership

## PROPOSED AMENDMENT

**22 CSR 10-3.090 Pharmacy Benefit Summary**. The Missouri Consolidated Health Care Plan is deleting sections (2), (4), and (8); amending the purpose and sections (1), (5), and (7); adding sections (6)–(8); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP with HSA of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, [and] PPO 2000 Plan,* ***and HDHP with HSA*** *of the Missouri Consolidated Health Care Plan.*

(1) The pharmacy benefit provides coverage for prescription drugs**.** *[listed on the formulary, as described in the following:]* **Vitamins and nutrients coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.**

(A) *[Medications]* **PPO 600, PPO 1000, and PPO 2000 Prescription Drug Coverage**.

1. Retail—Network:

A. Generic: Eight-dollar ($8) copayment for up to a thirty (30)-day supply for **a** generic drug on the formulary**; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**;

B. Brand: Thirty-five-dollar ($35) copayment for up to a thirty (30)-day supply for **a** brand drug on the formulary**; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**;

**C. Non-formulary: One hundred-dollar ($100) copayment for up to a thirty (30)-day supply for a drug not on the formulary;**

*[C.]***D.** *[Mail order]* **Home delivery** program—

(I) *[Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for a twenty-dollar ($20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent ($87.50) copayment for a brand drug on the formulary.]* **Maintenance prescriptions may be filled through the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits.**

**(a) Generic: Twenty-dollar ($20) copayment for up to a ninety (90)-day supply for a generic drug on the formulary.**

**(b) Brand: Eighty-seven-dollar and fifty-cent ($87.50) copayment for up to a ninety (90)-day supply for a brand drug on the formulary.**

**(c) Non-formulary: Two hundred fifty-dollar ($250)**

**copayment for up to a ninety (90)-day supply for a drug not on the formulary; and**

(II) Specialty drugs covered only through network *[mail order]* **home delivery** for up to thirty (30) days. *[Copayments—]* **The first specialty prescription order may be filled through a retail pharmacy.**

(a) Generic: *[e]***Eight dollars ($8) for generic drug on the formulary list***[; and]***.**

(b) Brand: *[t]***Thirty-five dollars ($35) for brand drug on the formulary.**

**(c) Non-formulary: One hundred-dollar ($100) copayment for a drug not on the formulary; and**

**E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;**

**F. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment;**

**G. If the physician allows for generic substitution and the member chooses a brand name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug; and**

**H. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.**

2. *[Non-network pharmacies—]* **Retail—Non-network:** If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. *[S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment or coinsurance. All such claims must be filed within twelve (12) months of the incurred expense.]* **The pharmacy vendor will reimburse the cost of the drug based on the network discounted amount, less the applicable copayment.**

**A. Generic: Eight-dollar ($8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary.**

**B. Brand: Thirty-five-dollar ($35) copayment for up to a thirty (30)-day supply for a brand drug on the formulary.**

**C. Non-formulary: One hundred-dollar ($100) copayment for up to a thirty (30)-day supply for a drug not on the formulary.**

*[3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.]*

**(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.**

**1. Retail—Network:**

**A. Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; tobacco cessation prescriptions covered at 100%;**

**B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; tobacco cessation prescriptions covered at 100%;**

**C. Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary;**

**D. Home delivery program.**

**(I) Maintenance prescriptions may be filled through the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits.**

**(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.**

**(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.**

**(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary.**

**(II) Specialty drugs covered only through network home delivery for up to thirty (30) days.**

**(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.**

**(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; and**

**(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary; and**

**E. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.**

**2. Retail—Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. The pharmacy vendor will reimburse the cost of the drug based on the network discounted amount, less the applicable coinsurance.**

**A. Generic: Forty percent (40%) coinsurance after deductible for up to thirty (30)-day supply for a generic drug on the formulary.**

**B. Brand: Forty percent (40%) coinsurance after deductible for up to thirty (30)-day supply for a brand drug on the formulary.**

**C. Non-formulary: Fifty percent (50%) coinsurance after deductible for up to thirty (30)-day supply for a drug not on the formulary.**

*[(2) If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.]*

*[(3)]***(2)** Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;

2. Lowest applicable copayment is charged; and

3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;

2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.

*[(4) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.]*

*[(5)]***(3)** Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a

claim, members must—

(A) Complete the claim form; *[and]*

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include:

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply*[.]*; **and**

**(C) Members must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted price as determined by the vendor minus any applicable copayment. Members are responsible for any charge over the network discounted price and the applicable copayment.**

*[(6)]***(4)** Formulary—The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; or

(C) A drug is determined to have a safety issue.

*[(7)]***(5)** *[Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug.]* **Grandfathered Specialty Drugs—Prescription drugs grandfathered for members in 2011 because they had taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011, will continue to be covered at a thirty-five-dollar ($35) brand copayment level if enrolled in a PPO plan or at twenty percent (20%) coinsurance if enrolled in the HDHP plan.** Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

**(D) Attention-deficit hyperactivity disorder (ADHD);**

*[(D)]***(E)** Biologics for inflammatory conditions;

*[(E)]***(F)** Cancer drugs;

*[(F)]***(G)** Hemophilia drugs (*[F]***f**actor VIII and IX concentrates);

*[(G)]***(H)** Hepatitis drugs;

*[(H)]***(I)** Immunosuppressants (transplant anti-rejection agents);

*[(I)]***(J)** Insulin (basal);

*[(J)]***(K)** Low molecular weight heparins;

*[(K)]***(L)** Multiple sclerosis injectable drugs;

*[(L)]***(M)** Novel psychotropics (oral products and long-active injectables);

*[(M)]***(N)** Phosphate binders;

*[(N)]***(O)** Pulmonary hypertention drugs; and

*[(O)]***(P)** Somatostatin analogs.

*[(8) Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.]*

**(6) Medicare Part B Prescription Drugs—For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:**

**(A) Diabetes testing and maintenance supplies;**

**(B) Respiratory agents;**

**(C) Immunosuppressants; and**

**(D) Oral anti-cancer medications.**

**(7) Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the Food and Drug Administration and medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.**

**(8) Guidelines for Drug Use—If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those medications prescribed by an assigned physician approved by MCHCP.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions six hundred fifty-three thousand nine hundred sixty-three dollars ($653,963) in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities eight hundred ninety-one thousand forty-nine dollars ($891,049) 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 Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the* ***Missouri Register****. No public hearing is scheduled.*

# FISCAL NOTE
# PUBLIC COST

**I. Department Title: 22 - Missouri Consolidated Health Care Plan**
**Division Title: Division 10**
**Chapter Title: Chapter 3**

| | |
|---|---|
| **Rule Number and Name:** | **22 CSR 10-3.090 Pharmacy Benefit Summary** |
| **Type of Rulemaking:** | **Proposed Amendment** |

## II. SUMMARY OF FISCAL IMPACT

| Affected Agency or Political Subdivision | Estimated Cost of Compliance in the Aggregate |
|---|---|
| **Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003** | **$653,963** |

## III. WORKSHEET

Estimated cost is the projected portion of the premium attributable to prescription drug coverage for 2012, calculated as 50 percent of the Active Employee Only premium for all public entity employees who enroll for coverage under this plan for calendar year 2012.

## IV. ASSUMPTIONS

- Total enrollment under MCHCP Plans as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership in all MCHCP Plans remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Actual claim costs will vary based upon actual utilization of services.

# FISCAL NOTE
# PRIVATE COST

**I. Department Title: 22 - Missouri Consolidated Health Care Plan**
**Division Title: Division 10**
**Chapter Title: Chapter 3**

| | |
|---|---|
| **Rule Number and Title:** | **22 CSR 10-3.090 Pharmacy Benefit Summary** |
| **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: |
|---|---|---|
| **1,403 individuals enrolled in MCHCP public entity plans for CY 2012** | **Individuals enrolled in MCHCP public entity plans for CY 2012** | **$891,049** |

## III. WORKSHEET

Estimated cost is the projected portion of the premium attributable to prescription drug coverage for 2012, calculated as 50 percent of the Active Employee Only premium for all public entity subscribers' premium, plus 100 percent of the additional premium for other levels of coverage for all public entity employees who enroll for coverage under this plan for calendar year 2012.

## IV. ASSUMPTIONS

- Total enrollment in the MCHCP pharmacy plan as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the MCHCP pharmacy plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable.
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
## Division 10—Health Care Plan
## Chapter 3—Public Entity Membership

### PROPOSED RESCISSION

**22 CSR 10-3.092 Dental Benefit Summary**. This rule established the policy of the board of trustees in regard to the dental benefit summary for members of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to clarify the dental benefit is governed by a fully-insured plan.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded: Filed Nov. 1, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. 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 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
## Division 10—Health Care Plan
## Chapter 3—Public Entity Membership

### PROPOSED RULE

**22 CSR 10-3.092 Dental Coverage**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to dental coverage for members of the Missouri Consolidated Health Care Plan.*

(1) The plan administrator may offer dental coverage through a vendor.

(A) Dental plan design is defined by the vendor.

(B) Dental plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-3.020.

(C) Total dental premium costs for all coverage levels are fully paid by the member and/or public entity and collected by the plan administrator.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded and readopted: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions sixty thousand one hundred sixty dollars ($60,160) in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities four hundred thirty-five thousand seven hundred ninety-six dollars ($435,796) 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 Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE**
**PUBLIC COST**

**I. Department Title: 22 - Missouri Consolidated Health Care Plan**
**Division Title: Division 10**
**Chapter Title: Chapter 3**

| | |
|---|---|
| **Rule Number and Name:** | **22 CSR 10-3.092 Dental Benefit Summary** |
| **Type of Rulemaking:** | **Proposed Rule** |

## II. SUMMARY OF FISCAL IMPACT

| Affected Agency or Political Subdivision | Estimated Cost of Compliance in the Aggregate |
|---|---|
| **Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003** | **$60,160** |

## III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium for public entity employees who enroll for coverage under this plan for calendar year 2012.

## IV. ASSUMPTIONS

- Total enrollment under the all public entity plans as of August 1, 2011;
- Calendar year 2012 membership in the public entity dental plans remain relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity enrolled in the dental plan is contributing 50 percent toward the employee only monthly premium;
- Actual claim costs will vary based upon actual utilization of services.

# FISCAL NOTE
# PRIVATE COST

**I. Department Title: 22 – Missouri Consolidated Health Care Plan**
**Division Title: Division 10**
**Chapter Title: Chapter 3**

| | |
|---|---|
| **Rule Number and Title:** | **22 CSR 10-3.092 Dental Benefit Summary** |
| **Type of Rulemaking:** | **Proposed Rule** |

## 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: |
|---|---|---|
| **674 individuals enrolled in MCHCP Public Entity Dental Plan for CY 2012** | **Individuals enrolled in the MCHCP Public Entity Dental Plan for CY 2012** | **$435,796** |
| | | |
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| | | |

## III. WORKSHEET

Estimated cost is the annual cost for public entity subscribers' premium costs for dental coverage for calendar year 2012. The public entity must contribute at least fifty percent toward the employee only month premium for the dental plan. Dental coverage is limited to a $1,000 per person calendar year benefit.

## IV. ASSUMPTIONS

- Total enrollment in the public entity dental plans as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the public entity dental plans remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity enrolled in the dental plan is contributing 50 percent toward the employee only monthly premium;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
## Division 10—Health Care Plan
## Chapter 3—Public Entity Membership

### PROPOSED RESCISSION

**22 CSR 10-3.093 Vision Benefit Summary**. This rule established the policy of the board of trustees in regard to the vision benefit summary for members of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to clarify the vision benefit is governed by a fully-insured plan.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded: Filed Nov. 1, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. 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 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
## Division 10—Health Care Plan
## Chapter 3—Public Entity Membership

### PROPOSED RULE

**22 CSR 10-3.093 Vision Coverage**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to vision coverage for members of the Missouri Consolidated Health Care Plan.*

(1) The plan administrator may offer vision coverage through a vendor.

(A) Vision plan design is defined by the vendor.

(B) Vision plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-3.020.

(C) Total vision premium costs for all coverage levels are fully paid by the member and/or public entity and collected by the plan administrator.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded and readopted: Filed Nov. 1, 2011.*

*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 cost private entities one hundred twenty thousand five hundred fifty-five dollars ($120,555) 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 Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

# FISCAL NOTE
# PRIVATE COST

**I. Department Title: 22 – Missouri Consolidated Health Care Plan**
**Division Title: Division 10**
**Chapter Title: Chapter 3**

| | |
|---|---|
| **Rule Number and Title:** | **22 CSR 10-3.093 Vision Benefit Summary** |
| **Type of Rulemaking:** | **Proposed Rule** |

## 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: |
|---|---|---|
| **1,159 individuals enrolled in MCHCP Public Entity Vision Plan for CY 2012** | **Individuals enrolled in the MCHCP Public Entity Vision Plan for CY 2012** | **$120,555** |
| | | |
| | | |
| | | |

## III. WORKSHEET

Estimated cost is the annual cost for public entity subscribers' premium costs for the vision plan for calendar year 2012.

## IV. ASSUMPTIONS

- Total enrollment in the public entity vision plan as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the public entity vision plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
## Division 10—Health Care Plan
## Chapter 3—Public Entity Membership

## PROPOSED RULE

### 22 CSR 10-3.100 Fully-Insured Medical Plan Provisions

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the fully-insured plan provisions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.*

(1) A fully-insured medical plan is subject to applicable Department of Insurance, Financial Institutions and Professional Registration (DIFP) statutes and regulations. Members enrolled in a fully-insured medical plan will have rights and responsibilities as provided in those applicable statutes and regulations. If and to the extent there is a conflict between the plan and DIFP statutes and regulations, DIFP statutes and regulations shall prevail. Governing DIFP statutes and regulations include but are not limited to appeals, timelines, and payments.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Original rule filed Nov. 1, 2011.*

*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 Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. 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.*

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

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

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.001** Definitions and General Provisions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1741). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.011** Inspection Authority—Duties **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1741–1742). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received one (1) comment on this proposed amendment.

COMMENT: Charles Gohring, Missouri Department of Transportation, Motor Carrier Services, suggested language that would void the rule if it was determined to be in conflict with "any federal constitutional, statutory or regulatory provisions that would result in the loss of any federal funds to the state of Missouri."
RESPONSE: The commission did not recommend changes based on the comment and did not make any changes to the amendment.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.012** Registration—Training **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1742–1743). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received two (2) comments on this proposed amendment.

COMMENT #1: Charles Gohring, Missouri Department of Transportation, Motor Carrier Services, suggested language that would void the rule if it was determined to be in conflict with "any federal constitutional, statutory or regulatory provisions that would result in the loss of any federal funds to the state of Missouri."
RESPONSE: The commission did not recommend changes based on the comment and did not make any changes to the amendment.

COMMENT #2: Mr. Gohring also questioned whether common or contract motor carriers would be required to meet the registration and training provisions of Class I which might preempt federal hazardous materials regulations.
RESPONSE: Class I is designed for General LP gas operators, not common or contract carriers. The classification addresses the storage, sale, transportation, and distribution at retail-wholesale. The commission did not recommend changes based on the comment and did not make any changes to the amendment.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.013** Installation Requirements **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1743–1745). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received one (1) comment on this proposed amendment.

COMMENT: Charles Gohring, Missouri Department of Transportation, Motor Carrier Services, suggested language that would void the rule if it was determined to be in conflict with "any federal constitutional, statutory or regulatory provisions that would result in the loss of any federal funds to the state of Missouri."
RESPONSE: The commission did not recommend changes based on the comment and did not make any changes to the amendment.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.014** Storage **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1745–1746). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received one (1) comment on this proposed amendment.

COMMENT: Charles Gohring, Missouri Department of Transportation, Motor Carrier Services, suggested language that would void the rule if it was determined to be in conflict with "any federal constitutional, statutory or regulatory provisions that would result in the loss of any federal funds to the state of Missouri."
RESPONSE: The commission did not recommend changes based on the comment and did not make any changes to the amendment.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.015** Container, System, or Equipment Violations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1746). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.020** NFPA Manual No. 54, *National Fuel Gas Code* **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1746–1747). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.040** NFPA Manual No. 58, *Storage and Handling of Liquefied Petroleum Gases* **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1747). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received one (1) comment on this proposed amendment.

COMMENT: Charles Gohring, Missouri Department of Transportation, Motor Carrier Services, suggested language that would void the rule if it was determined to be in conflict with "any federal constitutional, statutory or regulatory provisions that would result in the loss of any federal funds to the state of Missouri."
RESPONSE: The commission did not recommend changes based on the comment and did not make any changes to the amendment.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission rescinds a rule as follows:

**2 CSR 90-10.060** NFPA Manual No. 59*, LP Gases at Utility Gas Plants* **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1748). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission rescinds a rule as follows:

**2 CSR 90-10.070** NFPA Manual No. 501A*, Manufactured Home Installations* **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1748). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.090** NFPA Manual No. 1192, Chapter 5*, Standard for Recreational Vehicles* **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1748). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 2—DEPARTMENT OF AGRICULTURE
## Division 90—Weights and Measures
## Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission adopts a rule as follows:

**2 CSR 90-10.120** Reporting of Odorized LP-Gas Release, Fire, or Explosion **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1748–1749). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 6—DEPARTMENT OF HIGHER EDUCATION
## Division 10—Commissioner of Higher Education
## Chapter 11—Nursing Education Incentive Program

### ORDER OF RULEMAKING

By the authority vested in the Department of Higher Education under section 335.203(5), RSMo, HB 233, First Regular Session, Ninety-sixth General Assembly, 2011, the department adopts a rule as follows:

6 CSR 10-11.010 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 15, 2011 (36 MoReg 1894–1895). The section with changes is reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Higher Education received nine (9) comments on the proposed rule.

Due to similar concerns in the following nine (9) comments, one (1) response can be found at the end of comment #9.
COMMENT #1: Zora Mulligan, Executive Director of the Missouri Community College Association, requested that language in the rule limiting eligible institutions of higher education to those offering the bachelor's degree or higher degrees be stricken to allow community colleges to be eligible to apply for grants in the program.
COMMENT #2: Pam McIntyre, President of St. Louis Community College—Westwood, objected to the rule's exclusion of community colleges from eligibility to apply for the program.
COMMENT #3: Marcia Pfeiffer, President of St. Louis Community College—Florissant Valley, objected to the rule's exclusion of community colleges from eligibility to apply for the program.
COMMENT #4: Steven Kurtz, President of Mineral Area College, objected to the rule's exclusion of community colleges from eligibility to apply for the program.
COMMENT #5: Jeff Jochems, President of Ozarks Technical Community College—Richwood Valley campus, objected to the rule's exclusion of community colleges from eligibility to apply for the program.
COMMENT #6: Marsha Drennon, President of State Fair Community College, objected to the rule's exclusion of community colleges from eligibility to apply for the program.
COMMENT #7: Neil Nuttall, President of North Central Missouri College, objected to the rule's exclusion of community colleges from eligibility to apply for the program.
COMMENT #8: Raymond Cummiskey, President of Jefferson College, objected to the rule's exclusion of community colleges from eligibility to apply for the program.

COMMENT #9: Cindy K. Hess, President of St. Louis Community College—Forest Park, objected to the rule's exclusion of community colleges from eligibility to apply for the program.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees that the rule imposes a restriction on potential applicants that is beyond the restrictions included in the enabling legislation. The rule has been changed to remove this restriction.

**6 CSR 10-11.010 Nursing Education Incentive Program**

(2) Institutional Criteria for Grant Awards. To be eligible to receive a Nursing Education Incentive Grant, the applicant must meet the following eligibility criteria:

(A) Be a Missouri institution of higher education (sponsoring institution) offering a program of professional nursing;

## Title 11—DEPARTMENT OF PUBLIC SAFETY
## Division 45—Missouri Gaming Commission
## Chapter 5—Conduct of Gaming

### ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission under section 313.805, RSMo Supp. 2010, the commission adopts a rule as follows:

11 CSR 45-5.194 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1615–1616). The section with changes is reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on this proposed rule on August 10, 2011. No one commented at the public hearing. Written comments were received from Bally and International Game Technology (IGT).

**Bally's comments—**
COMMENT #1: Bally's comment for 11 CSR 45-5.194(4)(B)—"Bally disagrees with an arbitrary percent limitation of 30%. Since the player can minimize the screen at any time the player should not be limited to size of screen for System Window."
RESPONSE: The commission has rules governing the clarity of information displayed on Electronic Gaming Device(s). The 30% rule was based on commission field observation. As stated in 11 CSR 45-7.040(2) and GLI 112.0–4.10.2, our jurisdiction requires the clarity of the screen and patron access to help screen menus.

COMMENT #2: An additional comment received on August 5, 2011, from Bally states: "With regard to the one concern that seems to remain after our discussion, will it be possible to at least change the regulation to add something like, unless the 'Commission approves otherwise;' unless of course it can be eliminated altogether which is our preference."
RESPONSE AND EXPLANATION OF CHANGE: The commission agrees with Bally's comment, therefore the rule has been revised to accommodate unforeseen technology.

COMMENT #3: 11 CSR 45-5.194(10)—While Bally is not currently submitting such a product to the Missouri Gaming Commission, it is our position that use of the Operator Content Delivery System (OCDS) for second chance to play games should not be prohibited in regulations providing that it complies with current regulations or that additional regulations and rules would be needed. We are in disagreement with this being established as policy.
RESPONSE: The OCDS rules have been established based on feedback from Missouri Class A Licensees. At this juncture, no one has expressed interest in implementing this technology beyond what has been annotated in 11 CSR 45-5.194. The expansion of 11 CSR 45-5.194 would give rise to policy concerns regarding repurposing of meters. To date, the commission is unaware of any meter schema that has been specifically designed to account for secondary gambling products. Additionally, permitting patrons to wager points would give rise to indirect consideration to a gambling game.

**IGT's comments—**
COMMENT #4: IGT requests clarification regarding 11 CSR 45-5.194(6)(D) to understand what is considered by "all critical memory" and how does this impact the communication to an "external device" if the integrity check were to fail following the established connection to an external device?
RESPONSE: "All critical memory" pertains to the memory within the system window rendering device which contains the data required for the device to function properly. The integrity check likely will happen upon boot-up of the system window rendering device since it must happen prior to any external communication. Should the integrity check fail, the system window rendering device shall not establish a communication link to an external device. If the system window rendering device is designed to perform an integrity check in addition to the boot-up integrity check, and the device fails the integrity check, any external communication should cease until the device can successfully pass the integrity check.

COMMENT #5: IGT suggests that 11 CSR 45-5.194(10) be expanded to allow the usage of a player's earned "Promotional Giveaway Credits" and "Player Reward Credits" for the opportunity for a player to wager the points for a chance to earn additional promotional awards rather than restrict the usage. The capability to convert "Promotional Giveaway Credits" and "Player Reward Credits" to either Non-Cashable Electronic Promotion (NCEP) or Cashable Electronic Promotion (CEP) for Electronic Gaming Machine (EGM) wagering as outlined in Missouri's Minimum Internal Control Standards Chapter U is allowed today. IGT contends that the ability to wager promotional awards at the system window is an extension of today's accepted NCEP/CEP wagering practices.
RESPONSE: The OCDS rules have been established based on feedback from Missouri Class A Licensees. At this juncture, no one has expressed interest in implementing this technology beyond what has been annotated in 11 CSR 45-5.194. IGT's recommendations would give rise to policy concerns regarding the wagering of promotional giveaway credits and player reward credits, as defined by Chapter 572, RSMo. Permitting patrons to wager giveaway credits and player reward credits would give rise to indirect consideration to a secondary non-tax, non-regulated gambling game.

**11 CSR 45-5.194 Operator Content Delivery Systems**

(4) A system window being displayed during game play shall not, unless otherwise approved in writing—

## Title 13—DEPARTMENT OF SOCIAL SERVICES
## Division 70—MO HealthNet Division
## Chapter 15—Hospital Program

### ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 208.152, 208.153, and 208.201, RSMo Supp. 2010, the division amends a rule as follows:

**13 CSR 70-15.010** Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1616–1619). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 13—DEPARTMENT OF SOCIAL SERVICES
## Division 70—MO HealthNet Division
## Chapter 15—Hospital Program

## ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 208.201 and 208.453, RSMo Supp. 2010, and section 208.455, RSMo 2000, the division amends a rule as follows:

**13 CSR 70-15.110** Federal Reimbursement Allowance (FRA) **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1840–1842). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The MO HealthNet Division (MHD) received two (2) comments from the Missouri Hospital Association.

COMMENT #1: A comment was received indicating that pending litigation in Cole County Circuit Court challenging the emergency regulations 13 CSR 70-15.010 and 13 CSR 70-15.220 generates significant uncertainty about the state's ability to make certain payments to hospitals that would have been funded by the increase in the FRA assessment from five and forty-five hundredths percent (5.45%) to five and ninety-five hundredths percent (5.95%). If the payments are delayed or blocked by the court's actions, the commentor believes it would be financially disruptive to Missouri hospitals to proceed with collecting the increased FRA. The commentor suggested the FRA assessment rate should be lowered from the proposed five and ninety-five hundredths percent (5.95%) to an amount necessary to fund payments associated with anticipated growth in service volume and ensure funding for payments made during the first quarter of SFY 2012. The commentor further suggested once the litigation is resolved the Department of Social Services could take action to raise the FRA assessment at that time. The commentor stated that to the extent the FRA revenues could be used as authorized by state and federal regulation to support payment streams that are not put at risk by the pending litigation, they would be pleased to discuss this.
RESPONSE: MHD has historically based the FRA assessment at a rate sufficient to cover the authorized projected payments for that state fiscal year (SFY). MHD determined that the FRA assessment rate sufficient to cover the projected payments for SFY 2012 including, but not limited, to those authorized by the emergency and proposed amendments to 13 CSR 70-15.010 and 13 CSR 70-15.220, is five and ninety-five hundredths percent (5.95%). While MHD understands the uncertainty felt by the hospital industry as a result of the aforementioned litigation, MHD is unable to reduce the FRA assessment below five and ninety-five hundredths percent (5.95%) at this time because it was determined to be the rate necessary to cover the projected payments for SFY 2012. Unless MHD is ordered by the court to change the hospital payments authorized in the emergency amendments to 13 CSR 70-15.010 or 13 CSR 70-15.220, the payments set forth in those amendments will continue, supporting the need for the FRA assessment rate of five and ninety-five hundredths percent (5.95%). MHD also does not have a basis to change the proposed amendment to 13 CSR 70-15.010 to revise hospital payments set forth in the amendment because no comments were received during the allotted comment period. Therefore, the hospital payments authorized under the proposed amendment to 13 CSR 70-15.010 will continue, supporting the need for the FRA assessment rate of five and ninety-five hundredths percent (5.95%). As stated above, MHD will continue to make hospital payments authorized by the various hospital regulations. However, if MHD is ordered by the court to stop hospital payments authorized in emergency amendments 13 CSR 70-15.010 and/or 13 CSR 70-15.220, MHD will reevaluate using the FRA revenues generated from the increase to fund authorized hospital payments that are not put at risk by the litigation. If the court orders payments to be reduced, MHD plans to either file an emergency amendment to reduce the tax to the amount needed to fund payments at the level ordered by the court or fund payments otherwise authorized. No changes have been made to the amendment as a result of this comment.

COMMENT #2: A comment was received indicating MHD might need to consider regulatory changes to address the unusual circumstances of incorporating Shriners Hospital for Children (Shriners) into the FRA program. Ordinarily, a hospital which does not have a fourth prior-year cost report would have its taxable revenue for purposes of the FRA defined using a formula based on the hospital's number of licensed beds. The commentor believes that due to the historic mission and specialized treatment of services of Shriners' hospital, this formula would generate an untoward result.
RESPONSE: MHD does not believe that a regulatory change is necessary to incorporate Shriners into the FRA program in a reasonable manner. MHD recognizes Shriners' unusual circumstances and believes it can determine a reasonable assessment under the current FRA rule. No changes have been made to the amendment as a result of this comment.

## Title 13—DEPARTMENT OF SOCIAL SERVICES
## Division 70—MO HealthNet Division
## Chapter 15—Hospital Program

## ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 208.152, 208.153, and 208.201, RSMo Supp. 2010, the division adopts a rule as follows:

13 CSR 70-15.220 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1620–1623). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The MO HealthNet Division (MHD) received several comments from Lashly & Baer, P.C.

COMMENT #1: A comment was received indicating that the methodology for calculating Disproportionate Share Hospital (DSH) payments was not contained in the proposed rule.
RESPONSE AND EXPLANATION OF CHANGE: MHD has amended sections (4), (5), and (7) to provide additional detail on how

Disproportionate Share Hospital Payments (DSH) payments are calculated.

COMMENT #2: A comment was received indicating the following terms referenced in subsection (1)(D) are not defined: uncompensated care costs, DSH limit, and DSH costs.
RESPONSE AND EXPLANATION OF CHANGE: MHD modified the term "DSH costs" for clarity and consistency and also amended the term "DSH limit" throughout the rule for consistency purposes. MHD amended subsection (1)(D), section (4), and added section (10) to define the terms used in the rule.

COMMENT #3: A comment was received indicating the statement in subsection (1)(D) "Hospital-specific DSH limit calculations must comply with federally-mandated DSH audit standards and definitions" is not accurate because the DSH limit calculations and DSH audit standards are separate requirements.
RESPONSE AND EXPLANATION OF CHANGE: MHD used this phrase to indicate that the estimated hospital-specific DSH limit must be calculated in a manner to ensure that DSH payments do not exceed the hospital-specific DSH limit using the federally-mandated DSH audit standards and definitions set forth in the federal DSH rules. MHD has amended subsection (1)(D) to clarify that the hospital-specific DSH limit calculations must comply with the federal DSH rules.

COMMENT #4: A comment was received indicating the title to section (4) "DSH Audit Payment Adjustment" is misleading because no audit or verification procedures for the payment adjustment are referenced in the rule.
RESPONSE AND EXPLANATION OF CHANGE: MHD used this term to indicate that the DSH payment adjustments are necessary to be in compliance with the federal DSH audit rules. The federal DSH audit rules and Centers for Medicare and Medicaid Services (CMS) guidance prescribe states to consider the findings from the 2005, 2006, and 2007 independent DSH audits when calculating uncompensated care cost estimates and associated DSH payments beginning with Medicaid State Plan rate year 2011. The results of those independent audits indicated that the DSH cost and payment methodology used by MHD would not comply with the hospital-specific DSH limit standards. Therefore, it was determined that a change in DSH cost and payment methodology was warranted. To reflect the methodology change for the state fiscal year (SFY) 2011 DSH payments, the adjustments set forth in this section are necessary. To avoid confusion, MHD has amended section (4) to remove the word "Audit" from the title.

COMMENT #5: A comment was received indicating the statement in subsection (4)(A) "payments…will be revised based on…DSH survey which uses federally-mandated DSH audit standards." implies the use of a survey complies with the federal DSH rule. The commentor believes the federal DSH rule makes no reference to using a "DSH Survey" to determine the DSH limit. The commentor goes on to say this statement is not accurate because there were no audit standards applied to the hospital-submitted DSH surveys and that those audit standards require testing and verification of the DSH limit calculations which the commentor believes MHD has not done.
RESPONSE AND EXPLANATION OF CHANGE: As indicated in a previous Comment and Response, MHD used the phrase "DSH survey which uses federally-mandated DSH audit standards" to indicate that the DSH calculations must be performed in accordance with the federal DSH rules. While the federal DSH rules do not explicitly state that a DSH survey must be used, the federal DSH rules require that the state's DSH payments must comply with the federal DSH rules, so MHD developed a state DSH survey to calculate interim DSH payments that are in compliance with the federal DSH rules. States are given considerable flexibility in developing DSH payment methodologies but are limited by the annual DSH allotment and the costs used to determine the hospital-specific DSH limits. MHD believes changing the current methodology and collecting the needed data through the use of the state DSH survey will allow it to determine interim DSH payments that comply with the federal DSH rules. A transition period was authorized by the federal DSH rules in that independent certified DSH audits for Medicaid State Plan rate years 2005–2010 would not be given weight except to the extent that the findings draw into question the reasonableness of the state's uncompensated care cost estimates used for calculating prospective DSH payments for Medicaid State Plan rate year 2011 and thereafter. The federal DSH rules and CMS guidance prescribe states to consider the findings from the 2005, 2006, and 2007 independent DSH audits when calculating uncompensated care cost estimates and associated DSH payments beginning with Medicaid State Plan rate year 2011. The results of those independent audits indicated that the DSH cost and payment methodology used by MHD would not comply with the hospital-specific DSH limit standards. Therefore, it was determined that a change in DSH cost and payment methodology was warranted. Given the age of the 2005, 2006, and 2007 independent DSH audit data the state determined it needed to use more recent data to make further adjustments to their SFY 2011 DSH payments. Since 2007, MHD has made cuts in Medicaid payments to hospitals resulting in larger hospital-specific DSH limits. Therefore, the MHD developed a DSH survey similar to the DSH survey utilized by the independent auditor during the federally-mandated annual independent DSH audit which is required by the federal DSH rules. The state DSH survey was designed to collect more recent cost and payment information on a hospital-specific basis. It also reflects the standards of calculating uncompensated care cost established by the federal DSH rules. Furthermore, on page 77908 of the December 19, 2008, *Federal Register*, CMS provided a response to a comment stating in part "Typically, States currently rely on unaudited surveys to estimate uncompensated care in eligible hospitals, and this regulation would simply require reconciliation based on statutory cost limits using a more accurate audit methodology." MHD believes this further supports its use of the state DSH survey as a data collection tool and that it is not not required to be audited. The federal DSH rules do not require the state to perform an audit of the data prior to the DSH payments being made. The federal DSH rules require an independent audit to be performed on actual DSH payments and costs three (3) years after the DSH payments are made. MHD has amended subsection (4)(A) to provide clarification. Furthermore, MHD discussed with CMS staff whether the use of a state DSH survey to determine interim DSH payments in compliance with the federal DSH rules would be allowable, and they indicated it would. CMS also approved the state's Medicaid State Plan amendment which provides for the use of the state DSH survey in calculating interim DSH payments.

COMMENT #6: A comment was received indicating the federal DSH rule requires that the DSH limit be determined in accordance with federal accounting standards and Medicare reasonable cost principles. The commentor stated that Medicare reasonable cost principles require that provider (FRA) taxes paid be reduced by (FRA) payments received that are associated with the assessed tax, such that reasonable costs are limited to the net tax expense. It is the commentor's understanding that the survey does not apply this principle and, therefore, does not comply with the federal DSH rule.
RESPONSE AND EXPLANATION OF CHANGE: MHD followed federal accounting standards and Medicare reasonable cost principles and followed guidance from CMS concerning the treatment of the provider (FRA) taxes when developing the survey and DSH payment methodologies. Furthermore, on page 77923 of the December 19, 2008, *Federal Register*, CMS provided a response to a comment on provider taxes stating "Existing Medicaid policy recognizes permissable health care taxes as an allowable cost for the purposes of Medicaid reimbursement. A portion of a permissable hospital tax may also be allocated to indigent care days as part of the hospital cost report step-down cost allocation process. Specifically, the portion of

a permissable health care related tax allocated to the cost of providing inpatient and outpatient hospital services to patients with no source of third party coverage may be included in the hospital-specific DSH limit." MHD added section (10) to provide clarification on the uncompensated care costs and Medicare cost reporting methodologies included in calculating the estimated hospital-specific DSH limit.

COMMENT #7: A comment was received indicating that subsection (4)(A) does not describe the state's calculations or methodology to determine the payment revisions based on the survey or the methodology for analyzing the 2011 state's DSH survey and limiting DSH payments to hospitals.
RESPONSE AND EXPLANATION OF CHANGE: MHD amended section (4) to provide additional detail on the state's calculations using the 2011 state DSH survey to calculate and revise DSH payments.

COMMENT #8: A comment was received indicating that subsection (4)(A) refers to a DSH survey but does not contain the requirement for hospitals to submit a DSH survey or the process to be followed by hospitals in completing the DSH survey.
RESPONSE AND EXPLANATION OF CHANGE: MHD added section (9) to provide guidance on the completion and submission of the DSH survey.

COMMENT #9: A comment was received indicating paragraph (4)(A)2. does not identify the process for recouping DSH payments that exceed the projected DSH limit nor explain the methodology for determining a hospital's projected DSH limit.
RESPONSE AND EXPLANATION OF CHANGE: MHD amended section (4) to identify the process for recouping DSH payments that exceeded the estimated hospital-specific DSH limit and amended sections (4) and (5) to provide additional detail on the methodology used for determining a hospital's estimated hospital-specific DSH limit.

COMMENT #10: A comment was received indicating the reference in subsection (4)(B) to redistribution of DSH payments based on the surveys does not comply with the federal DSH rule unless the reference to DSH audit is to the independent certified audit in 2014 of SFY 2011. The federal DSH rule provides for redistribution in connection with independent certified audits, not surveys.
RESPONSE AND EXPLANATION OF CHANGE: MHD believes the interim adjustments resulting in redistributions set forth in subsection (4)(B) do comply with the federal DSH rules. The federal DSH rules and CMS guidance prescribe states to consider the findings from the 2005, 2006, and 2007 independent DSH audits when calculating uncompensated care cost estimates and associated DSH payments for Medicaid State Plan rate year 2011. The results of those independent audits indicated that the DSH cost and payment methodology used by MHD would not comply with the hospital-specific DSH limit standards. Therefore, it was determined that a change in DSH cost and payment methodology was warranted. To reflect the methodology change for the SFY 2011 DSH payments, the adjustments set forth in this section are necessary. CMS also approved the state's Medicaid State Plan amendment which provides for the interim adjustments and redistribution of DSH payments based on a state DSH survey. MHD has amended section (4) to provide clarification on the redistribution process.

COMMENT #11: A comment was received indicating the SFY 2012 interim DSH payments found in subsection (5)(A) does not comply with the federal DSH rule due to the use of a survey rather than the independent certified audit.
RESPONSE: MHD believes the use of the state DSH survey complies with the federal DSH rules. States are given considerable flexibility in developing DSH payment methodologies but are limited by the annual DSH allotment and the costs used to determine the hospital-specific DSH limits. While the federal DSH rules do not explicitly state that a DSH survey must be used, the federal DSH rules require that the state's DSH payments must comply with the federal DSH rules. The federal DSH rules and CMS guidance prescribe states to consider the findings from the 2005, 2006, and 2007 independent DSH audits when calculating uncompensated care cost estimates and associated DSH payments for Medicaid State Plan rate year 2011. The results of those independent audits indicated that the DSH cost and payment methodology used by MHD would not comply with the hospital-specific DSH limit standards. Therefore, it was determined that a change in DSH cost and payment methodology was warranted. Given the age of independent DSH audit data the state was to consider, it was determined that the state needed to use more recent data to make further adjustments to their SFY 2011 DSH payments. Since 2007, MHD has made cuts in Medicaid payments to hospitals resulting in larger hospital-specific DSH limits. Therefore, the MHD developed a DSH survey similar to the DSH survey utilized by the independent auditor during the federally-mandated annual independent DSH audit which is in compliance with the federal DSH rules. The DSH survey was designed to collect more recent cost and payment information on a hospital-specific basis. It also reflects the standards of calculating uncompensated care cost established by the federal DSH rules. Furthermore, on page 77908 of the December 19, 2008, *Federal Register*, CMS provided a response to a comment stating in part "Typically, States currently rely on unaudited surveys to estimate uncompensated care in eligible hospitals, and this regulation would simply require reconciliation based on statutory cost limits using a more accurate audit methodology." CMS also approved the state's Medicaid State Plan amendment which provides for the use of the state DSH survey in calculating interim DSH payments. No changes have been made to the amendment as a result of this comment.

COMMENT #12: A comment was received indicating the SFY 2012 interim DSH payments found in subsection (5)(A) do not explain the methodology used to calculate interim 2012 DSH payments.
RESPONSE AND EXPLANATION OF CHANGE: MHD amended section (5) to provide additional detail regarding the methodology used to calculate interim DSH payments.

COMMENT #13: A comment was received indicating the SFY 2012 interim DSH payments found in subsection (5)(A) are not consistent with the process followed by the SFY 2011 DSH survey because the trends applied to SFY 2012 do not consider volume increases that were applied by hospitals in 2011.
RESPONSE: The state's 2011 DSH survey allowed hospitals to apply hospital-specific adjustments for both inflation/trend and volume changes to reflect each individual hospital's expected experience between the 2009 data and 2011. Since the SFY 2012 interim DSH payments were calculated by trending the 2011 DSH surveys, the individual hospital-specific adjustments were incorporated into the SFY 2012 interim DSH payments. No changes have been made to the amendment as a result of this comment.

COMMENT #14: A comment was received indicating the SFY 2012 interim DSH payments found in subsection (5)(A) do not comply with Medicare cost reimbursement principles as they relate to the handling of FRA taxes and FRA payments.
RESPONSE AND EXPLANATION OF CHANGE: MHD followed federal accounting standards and Medicare reasonable cost principles and followed guidance from CMS concerning the treatment of the provider (FRA) taxes when developing the survey and DSH payment methodologies. Furthermore, on page 77923 of the December 19, 2008, *Federal Register*, CMS provided a response to a comment on provider taxes stating "Existing Medicaid policy recognizes permissable health care taxes as an allowable cost for the purposes of Medicaid reimbursement. A portion of a permissable hospital tax may also be allocated to indigent care days as part of the hospital cost

report step-down cost allocation process. Specifically, the portion of a permissable health care related tax allocated to the cost of providing inpatient and outpatient hospital services to patients with no source of third party coverage may be included in the hospital-specific DSH limit." MHD added section (10) to provide clarification on the uncompensated care costs and Medicare cost reporting methodologies included in calculating the estimated hospital-specific DSH limit and interim DSH payments.

COMMENT #15: A comment was received indicating the terminology in subsection (7)(A) "Final DSH 'Adjustments'" should be changed to "recoupments" to be consistent with the terminology found in paragraph (4)(A)2.
RESPONSE: MHD does not believe this change is appropriate. The "Final DSH Adjustments" referenced in section (7) may result in either an overpayment subject to recoupment or an additional DSH payment depending on the results of the annual independent DSH audit. Paragraph (4)(A)2. uses the term "recouped" related to DSH payments that exceed the estimated hospital-specific DSH limit which are considered overpayments subject to recoupment. No changes have been made to the amendment as a result of this comment.

COMMENT #16: A comment was received questioning if the amount recouped by the interim adjustment under paragraph (4)(A)2. would be repaid to a hospital if the independent DSH audit in 2014 shows the the amount recouped as the interim adjustment was too much, and the hospital is determined to have been paid below its DSH limit for 2011.
RESPONSE: The amount recouped from a hospital as a result of the interim adjustment will not necessarily be repaid to a hospital even if the results of the independent DSH audit in 2014 reveals the hospital has been paid below its hospital-specific DSH limit. Any DSH redistributions resulting from the independent DSH audit in 2014 will be limited to the amount of DSH recouped at that time to ensure DSH payments do not exceed the annual federal DSH allotment. As set forth in the *Federal Register* Volume 73, No. 245/Friday, December 19, 2008, page 77915, "States are not required to make DSH payments to qualifying hospitals in an amount equal to the hospital-specific limit. The hospital-specific limit is not a DSH payment methodology, and States may impose stricter limits on costs that they will consider in determining payment." Page 77920 of the *Federal Register* also states "States do not have the flexibility to broaden or narrow the costs included in calculating the hospital-specific DSH limit, because the universe of costs is defined in the statute. States do have the flexibility to vary the level of DSH payment between individual hospitals as long as the payments are at or below the hospital-specific limit. And States are not required to make DSH payments that cover all costs included in calculating the hospital-specific DSH limit." No changes have been made to the amendment as a result of this comment.

COMMENT #17: A comment was received questioning if MHD will recoup and redistribute DSH payments if the 2014 independent DSH audits determine that a hospital was overpaid.
RESPONSE AND EXPLANATION OF CHANGE: MHD will recoup excess DSH payments if the 2014 independent DSH audit determines that a hospital was overpaid, as is required by federal law. MHD may redistribute DSH payments that have been recouped from hospitals that were overpaid to hospitals that were shown to be under their hospital-specific DSH limit in the 2014 independent DSH audit, up to the federal DSH allotment. The federal share of any DSH payments recouped in excess of the federal DSH allotment must be returned to the federal government. MHD has amended section (7) to provide additional detail to clarify final DSH adjustments.

COMMENT #18: A comment was received indicating nothing in subsection (7)(A) provides for recoupment and either repayment to the federal government or redistribution to other hospitals as part of the "Final DSH Adjustments." The intent is unclear and should be set forth in the rule.
RESPONSE AND EXPLANATION OF CHANGE: MHD will recoup excess DSH payments if the 2014 independent DSH audit determines that a hospital was overpaid, as is required by federal law. MHD may redistribute DSH payments that have been recouped from hospitals that were overpaid to hospitals that were shown to be under their hospital-specific DSH limit in the 2014 independent DSH audit, up to the federal DSH allotment. The federal share of any DSH payments recouped in excess of the federal DSH allotment must be returned to the federal government. MHD has amended section (7) to provide additional detail to clarify final DSH adjustments.

COMMENT #19: A comment was received indicating the terms "DSH audit standards" and "DSH audits" used in the proposed rule are not defined and are used inappropriately to describe a DSH survey process that applies no audit standards.
RESPONSE AND EXPLANATION OF CHANGE: MHD used the phrase "DSH audit standards" to reference that the DSH survey itself reflects the standards of calculating uncompensated care cost established by the federal DSH rules. States are given considerable flexibility in developing DSH payment methodologies but are limited by the annual DSH allotment and the costs used to determine the hospital-specific DSH limits. The federal DSH rules do not require the state to perform an audit of the data prior to the DSH payments being made. On page 77908 of the December 19, 2008, *Federal Register*, CMS provided a response to a comment stating in part "Typically, States currently rely on unaudited surveys to estimate uncompensated care in eligible hospitals, and this regulation would simply require reconciliation based on statutory cost limits using a more accurate audit methodology." MHD used the phrase "DSH audits" to reference the requirements in the federal DSH rules that an annual independent audit be performed on actual DSH payments and costs three years after the DSH payments are made. MHD has amended section (4) to provide clarification and added section (10) to define annual independent DSH audits.

COMMENT #20: A comment was received indicating the statement in subsection (7)(A) "DSH audits are completed three (3) years following the initial independent DSH audit." appears to mean that the "DSH audits" will be completed six (6) years after the state fiscal year (SFY) ends.
RESPONSE AND EXPLANATION OF CHANGE: MHD amended section (7) to clarify the timing of the final DSH adjustments.

COMMENT #21: A comment was received questioning the differences between the "DSH audits" performed by the MO HealthNet Division and the federally mandated independent audits.
RESPONSE AND EXPLANATION OF CHANGE: MHD does not perform DSH audits, but calculates interim DSH payments and adjustments based on the state DSH survey. The annual independent DSH audits are the annual independent DSH audits required in the federal DSH rules. MHD amended sections (4) and (7) to clarify the DSH audits are the federally-mandated annual independent DSH audits and added section (10) to define the term annual independent DSH audit.

**13 CSR 70-15.220 Disproportionate Share Hospital Payments**

*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) General Reimbursement Principles.

(D) Section 1923(g) of the Social Security Act (Act) limits the amount of DSH payments states can pay to each hospital and earn FFP. To be in compliance with the Act, DSH payments shall not exceed one hundred percent (100%) of the uncompensated care costs of providing hospital services to Medicaid and uninsured individuals. Hospital-specific DSH limit calculations must comply with the federal DSH rules (42 CFR 447, Subpart E and 42 CFR 455, Subpart D). If the disproportionate share payments exceed the hospital-specific DSH limit, the difference shall be deducted from disproportionate share payments or recouped from future payments.

(4) DSH Payment Adjustments.

(A) Beginning in Medicaid state plan year 2011, DSH payments made to hospitals will be revised based on the results of a 2011 state DSH survey. The revisions based on the 2011 state DSH survey will ensure state fiscal year (SFY) 2011 DSH payments are eligible for FFP through compliance with the federal DSH rules. These revisions are to serve as interim adjustments until the federally-mandated annual independent DSH audits are complete. Annual independent DSH audits are finalized three (3) years following the SFY year-end reflected in the audit. For example, the SFY 2011 DSH audit will be finalized in 2014. The interim adjustments shall be determined as follows:

1. 2011 estimated hospital-specific DSH limits were determined based upon the state's calculations using data provided in the 2011 state DSH survey, SFY 2011 Medicaid supplemental payments maintained by MHD, and data provided in the final 2007 independent DSH audit, if applicable. DSH payments will be limited to the hospital's estimated hospital-specific DSH limit. The state's calculations will be based on 2011 state DSH surveys received by MO HealthNet as of May 31, 2011. However, a corrected survey may be accepted if it is supported by documentation and the state determines the correction is appropriate and has a material impact on the survey results. The state's calculations are set forth below—

A. The 2011 estimated hospital-specific DSH limit is calculated as follows:

(I) 2011 estimated Medicaid net cost from the 2011 state DSH survey.

(II) Less actual SFY 2011 Medicaid supplemental payments.

(III) Equals 2011 estimated Medicaid uncompensated care cost.

(IV) Plus 2011 estimated uninsured uncompensated care cost from the 2011 state DSH survey.

(V) Equals 2011 estimated hospital-specific DSH limit;

B. The total 2011 estimated longfall/shortfall for each hospital is calculated as follows:

(I) 2011 estimated hospital-specific DSH limit.

(II) Less DSH payments paid by MHD during SFY 2011.

(III) Less out-of-state DSH payments received by the hospital during SFY 2011.

(IV) Equals total 2011 estimated longfall/shortfall;

C. The total 2011 estimated hospital DSH liability is an overpayment subject to recoupment which will be the SFY 2011 interim DSH payment adjustment for hospitals with an estimated longfall. The total 2011 estimated hospital DSH liability is the lessor of the:

(I) The 2011 estimated longfall; or

(II) DSH payments paid during SFY 2011;

D. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their SFY 2011 DSH payments adjusted based on combining the results of the 2011 state DSH surveys prorated monthly for the time period the merger was effective. If a 2011 estimated DSH liability is identified, the surviving hospital assumes the responsibility for the overpayment. The calculation for combining and prorating the 2011 state DSH surveys is set forth below—

(I) The estimated hospital DSH liability prior to the merger shall be calculated as follows:

(a) The calculations set forth in subparagraphs (4)(A)1.A., (4)(A)1.B., and (4)(A)1.C. will be calculated based on each separate hospital's 2011 state DSH survey, prorated monthly for the time period prior to the merger;

(II) The estimated hospital DSH liability beginning with the month the merger is effective shall be calculated as follows:

(a) The 2011 state DSH surveys for each hospital shall be added together to yield a combined 2011 state DSH survey and prorated monthly for the time period the merger was effective. The calculations set forth in subparagraphs (4)(A)1.A., (4)(A)1.B., and (4)(A)1.C. will be calculated for the combined 2011 state DSH survey;

(III) The total estimated hospital DSH liability for the merged entity will be the sum of the amounts determined in part (4)(A)1.D.(I) for each hospital plus the combined amount determined in part (4)(A)1.D.(II); and

E. Facilities not providing a 2011 state DSH survey shall have their SFY 2011 DSH payments revised using the most recent hospital-specific information provided to the state by the independent DSH auditor trended to the applicable SFY using the trend factor published in *Health Care Costs* by DRI/McGraw-Hill and listed in 13 CSR 70-15.010. A facility that was not included in the most recent hospital-specific information provided to the state by the independent DSH auditor shall have their entire SFY 2011 DSH payment recouped.

2. DSH payments paid during SFY 2011 that exceed the 2011 estimated hospital-specific DSH limits will be recouped from the hospitals to reduce their payments to their 2011 estimated hospital-specific DSH limit.

3. The amount of SFY 2011 DSH payments to be recouped from a hospital by the MO HealthNet Division will be limited in each state fiscal year to two percent (2%) of the hospital's taxable revenue set forth as follows. For recoupments made during SFY 2012 the recoupment amount will be limited to two percent (2%) of the hospital's SFY 2011 taxable revenue. Any balance remaining to be recouped during SFY 2013 will be limited to two percent (2%) of the hospital's SFY 2012 taxable revenue. Any balance remaining to be recouped will be incorporated in the final DSH adjustment, if applicable. The limitation on recoupment of DSH payments shall only apply to recoupments determined in accordance with section (4). No limitation on the recoupment of DSH payments shall apply if the hospital DSH liability is determined as a result of the final annual independent DSH audit set forth in section (7).

(B) Any payments that are recouped from hospitals as a result of the state's calculation in subsection (4)(A) will be redistributed to hospitals that are shown to have been paid less than their 2011 estimated hospital-specific DSH limits (i.e., estimated shortfall). These redistributions will occur proportionally based on each hospital's 2011 estimated shortfall to the total 2011 estimated shortfall, not to exceed each hospital's 2011 estimated hospital-specific DSH limit.

1. Redistribution payments to hospitals that have been paid less than their 2011 estimated hospital-specific DSH limit must occur after the recoupment of payments made to hospitals that have been paid in excess of their 2011 estimated hospital-specific DSH limits. The state may establish a hospital-specific recoupment plan. However, total industry redistribution payments may not exceed total industry recoupments collected to date.

2. If the Medicaid program's original DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their estimated hospital-specific DSH limit. These payments will occur proportionally based on each hospital's estimated shortfall to the total estimated shortfall, not to exceed each hospital's estimated hospital-specific DSH limit.

(5) Disproportionate Share Hospital (DSH) Interim Payments.

(A) Beginning with SFY 2012, interim DSH payments shall be

calculated on an annual basis as set forth below.

1. SFY 2012 interim DSH payments will be based on the state's calculations using data provided in the 2011 state DSH survey after applying the trend factor published in *Health Care Costs* by DRI/McGraw-Hill for the current fiscal year, estimated SFY 2012 Medicaid supplemental payments calculated by MHD in accordance with 13 CSR 70-15.010, and data provided in the final 2007 independent DSH audit, if applicable.

2. Beginning with SFY 2013, interim DSH payments will be based on the state's calculations using data provided in the state DSH survey for the applicable SFY, estimated Medicaid supplemental payments calculated by MHD in accordance with 13 CSR 70-15.010 for the applicable SFY, and data provided in the most recent final independent DSH audit, if applicable.

(B) The interim DSH payments will be calculated as follows:

1. The estimated hospital-specific DSH limit is calculated as follows:

A. Estimated Medicaid net cost from the state DSH survey.

B. Less estimated Medicaid supplemental payments calculated by MHD in accordance with 13 CSR 70-15.010.

C. Equals estimated Medicaid uncompensated care cost.

D. Plus estimated uninsured uncompensated care cost from the state DSH survey.

E. Equals estimated hospital-specific DSH limit.

2. The estimated uncompensated care costs potentially eligible for MHD interim DSH payments excludes out-of-state DSH payments and is calculated as follows:

A. Estimated hospital-specific DSH limit.

B. Less estimated out-of-state (OOS) DSH payments.

C. Equals estimated uncompensated care cost (UCC) net of OOS DSH payments.

3. Hospitals determined to have a negative estimated UCC net of OOS DSH payments (payments exceed costs) will not receive interim DSH payments because they are expected to exceed their estimated hospital-specific DSH limit unless they meet the requirement in subsection (5)(C).

4. Qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments (costs exceed payments) and hospitals that meet the requirements of subsection (5)(C) will receive interim DSH payments. The interim DSH payments are subject to the federal DSH allotment and the estimated hospital-specific DSH limits. The interim DSH payments will be calculated as follows:

A. Interim DSH payments to qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments will be calculated as follows:

(I) Up to one-hundred percent (100%) of the available federal DSH allotment will be allocated based on each hospital's positive estimated UCC net of OOS DSH payments to the total positive estimated UCC net of OOS DSH payments; and

(II) The allocated amount will then be reduced by one percent (1%) for hospitals that do not contribute 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) and Patient Safety Initiative; and

B. Interim DSH payments to federally-deemed hospitals are set forth in subsection (5)(C).

(C) Federally-deemed hospitals will receive the nominal DSH payment of five thousand dollars ($5,000) and the greater of their upper payment limit payment or their estimated interim DSH payment as calculated above in subsection (5)(B). Except for federally-deemed hospitals, hospitals may elect to receive an upper payment limit payment as defined in 13 CSR 70-15.230 in lieu of DSH payments.

(D) Disproportionate share payments will coincide with the semi-monthly claim payment schedule with the exception of the federally-deemed hospitals who will be paid the nominal DSH payment of five thousand dollars ($5,000) at the end of the SFY.

(E) New facilities will be paid based on the industry average estimated interim DSH payment as determined from subsection (5)(B) calculated as follows:

1. Hospitals receiving interim DSH payments shall be divided into quartiles based on total beds;

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

3. The number of beds for the new facility shall be multiplied by the average DSH payment per bed.

(F) Facilities not providing a state DSH survey for the applicable SFY will have interim DSH payments calculated using the most recent hospital-specific information provided to the state by the independent DSH auditor trended to the applicable SFY using the trend factor published in *Health Care Costs* by DRI/McGraw-Hill and listed in 13 CSR 70-15.010. A facility that was not included in the most recent hospital-specific information provided to the state by the independent DSH auditor shall not receive DSH payments for that SFY.

(G) Interim DSH Payments for Hospital Mergers.

1. Hospitals that merge prior to the beginning of the SFY. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their interim DSH payment determined based on adding each hospital's state DSH survey to yield a combined state DSH survey and applying the same calculations in subsection (5)(B).

2. Hospitals that merge after the beginning of the SFY. The interim DSH payments that have been determined separately for the hospitals will be added together and paid to the surviving hospital effective with the approval date of the merger.

(H) If the Medicaid program's original interim DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their estimated hospital-specific DSH limit. These payments will occur proportionally based on each hospital's estimated shortfall to the total estimated shortfall, not to exceed each hospital's estimated hospital-specific DSH limit.

(7) Final DSH Adjustments.

(A) Final DSH adjustments will be made after actual cost data is available and the annual independent DSH audit is completed. Annual independent DSH audits are completed three (3) years following the state fiscal year-end reflected in the audit. For example, final DSH adjustments for SFY 2011 DSH payments will be made following the completion of the annual independent DSH audit in 2014 (SFY 2015).

(B) Final DSH adjustments may result in a recoupment for some hospitals and additional DSH payments for other hospitals based on the results of the annual independent DSH audit as set forth below—

1. Hospital DSH liabilities are overpayments which will be recouped. If the annual independent DSH audit reflects that a facility has a hospital DSH liability, it is an overpayment to the hospital and is subject to recoupment;

2. Any overpayments that are recouped from hospitals as the result of the final DSH adjustment will be redistributed to hospitals that are shown to have a total shortfall. These redistributions will occur proportionally based on each hospital's total shortfall to the total shortfall, not to exceed each hospital-specific DSH limit;

3. Redistribution payments to hospitals that have a total shortfall must occur after the recoupment of hospital DSH liabilities. However, total industry redistribution payments may not exceed total industry recoupments collected to date;

4. If the amount of DSH payments to be recouped as a result of the final DSH adjustment is more than can be redistributed, the entire amount will be recouped, and the federal share will be returned to the federal government; and

5. If the Medicaid program's original interim DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their hospital-specific DSH limit as determined from the annual independent DSH audit. These payments will occur proportionally based

on each hospital's shortfall to the total shortfall, not to exceed each hospital's hospital-specific DSH limit.

(9) State DSH Survey Reporting Requirements.

(A) Each hospital participating in the MO HealthNet program shall submit a state DSH survey prescribed by the state MO HealthNet agency and must be submitted by December 31st of each year. However, a corrected survey may be accepted if it is supported by documentation and the state determines the correction is appropriate and has a material impact on the survey results. The state DSH survey for each interim DSH payment period shall be completed based on the third prior year Medicare cost report and adjusted for inflationary trends and volume adjustments to the interim DSH payment period. For example, the state DSH survey that will be used to determine SFY 2013 interim DSH payments will be based on the state DSH survey completed using the 2010 Medicare cost report data adjusted by the hospital to 2013.

(10) Definitions.

(A) Annual independent DSH audit. The annual independent DSH audit is the annual independent certified audit of the state DSH payments as required by the federal DSH audit rule 42 CFR 455.301 through 42 CFR 455.304. The annual independent DSH audit also includes the reporting requirements of 42 CFR 447.299. The annual independent DSH audit may also be referred to as the federally-mandated annual independent DSH audit or independent federal DSH audit.

(B) Estimated Medicaid net cost. Estimated Medicaid net cost is the cost of providing inpatient and outpatient hospital services for all Medicaid eligible individuals including dual eligible and managed care participants less payments the hospital received for claims. The estimated Medicaid net cost is determined by using Medicare cost report costing methodologies described in this rule and is calculated using data reported on the the state DSH survey. Depending on the hospital's response to questions fourteen, fifteen, and sixteen of the state DSH survey the source of the Medicaid Out-of-State net cost, Medicaid Organ Acquisition net cost, and Medicaid/Medicare Crossover net cost will either be: the hospital's estimated data, an amount estimated by MHD based on the most recent annual independent DSH audit trended to the SFY the DSH payments relate to, or was determined by the hospital to be insignificant or zero. The estimated Medicaid net cost is the sum of the following estimated data:

1. In-state Medicaid inpatient net cost;
2. In-state Medicaid outpatient net cost;
3. Out-of-state Medicaid inpatient net cost;
4. Out-of-state Medicaid outpatient net cost;
5. Medicaid organ acquisition net cost; and
6. Medicaid/Medicare crossover net cost.

(C) Estimated uninsured net cost. Estimated uninsured net cost is the cost of providing inpatient and outpatient hospital services to individuals with no source of third party reimbursement for the inpatient and outpatient hospital services they receive. If the individual had health insurance, even if the third party insurer did not pay, those services are insured and cannot be included as uninsured costs. The costs are to be calculated using Medicare cost report costing methodologies described in this rule and should not include costs for services that were denied for any reason. The estimated uninsured net cost is calculated as the sum of the following estimated data reported on the state DSH survey.

1. Uninsured inpatient net cost.
2. Uninsured outpatient net cost.

(D) Estimated uninsured uncompensated care cost (UCC). The estimated uninsured uncompensated care cost is the estimated uninsured net cost less uninsured revenues and Section 1011 payments.

(E) Federal DSH allotment. The maximum amount of DSH a state can distribute each year, and receive federal financial participation (FFP) in the payments in accordance with 42 CFR 447.297 and 42 CFR 447.298.

(F) Hospital DSH liability. The hospital DSH liability is the amount of DSH overpayments subject to recoupment. It is the lessor of the total longfall or the DSH payments paid during the SFY. The source for this calculation is as follows:

1. Actual hospital DSH liability. The actual hospital DSH liability is determined from the final annual independent DSH audit; and

2. Estimated hospital DSH liability. The estimated hospital DSH liability is calculated by the state using data from the state DSH survey, Medicaid supplemental payments, and data provided in the most recent independent DSH audit, if applicable.

(G) Hospital-specific DSH limit. The hospital-specific DSH limit is the sum of the Medicaid uncompensated care cost plus the uninsured uncompensated care cost and is calculated each year. The source for this calculation is as follows:

1. Actual hospital-specific DSH limit. The actual hospital-specific DSH limit is determined from the final annual independent DSH audit; and

2. Estimated hospital-specific DSH limit. The estimated hospital-specific DSH limit is calculated by the state using data from the state DSH survey, Medicaid supplemental payments, and data provided in the most recent independent DSH audit, if applicable.

(H) Institution for Mental Diseases (IMD) DSH allotment. The IMD DSH allotment is a portion of the state-wide DSH allotment and is payable only to IMD hospitals.

(I) Inpatient and outpatient hospital services. For purposes of determining the estimated hospital-specific DSH limit and the actual hospital-specific DSH limit, the inpatient and outpatient hospital services are limited to inpatient and outpatient hospital services included in the approved Missouri Medicaid State Plan.

(J) Longfall. The longfall is the total amount a hospital has been paid (including all DSH payments) in excess of their hospital-specific DSH limit and is considered an overpayment subject to recoupment. The source for this calculation is as follows:

1. Actual longfall. The actual longfall is based on the annual independent DSH audit; and

2. Estimated longfall. The estimated longfall is calculated by the state using data from the state DSH survey, Medicaid supplemental payments, and data provided in the most recent independent DSH audit, if applicable.

(K) Medicaid state plan year. Medicaid state plan year coincides with the twelve (12)-month period for which a state calculates DSH payments. For Missouri, the Medicaid State Plan Year coincides with its state fiscal year (SFY) and is July 1 through June 30.

(L) Medicaid supplemental payments. For purposes of determining estimated hospital-specific DSH limits, the Medicaid supplemental payments include: Direct Medicaid Add-On, Graduate Medical Education (GME), Enhanced GME, Children's Outliers, Trauma Outliers, and any cost settlements. Upper payment limit (UPL) supplemental payments will be included in addition to the above Medicaid supplemental payments for purposes of determining the hospital-specific DSH limit in the annual independent DSH audit. Any supplemental payments made with state only funds are not required to be offset in determining the hospital-specific DSH limit.

(M) Medicare cost reporting methodologies. Medicaid and uninsured costs will be determined utilizing Medicare cost report (form 2552-96) methodologies. If the Medicare 2552-96 is superseded by an alternate Medicare developed cost reporting tool during a Medicaid state plan year, that tool must be used for the Medicaid state plan year. Based on these methodologies, the costs included in the DSH payment calculation will reflect the Medicaid and uninsured portion of total allowable costs from the Medicare cost report. Costs such as the Missouri Medicaid hospital provider tax (federal reimbursement allowance or FRA) are recognized as allowable costs for Medicaid and DSH program purposes and apportioned to Medicaid, uninsured, Medicare, and other payers following the cost finding

principles included in the costs report, applicable instructions, regulations, and governing statutes.

(N) New facility. A new hospital determined in accordance with 13 CSR 70-15.010 without a base year cost.

(O) Out-of-state DSH payments. DSH payments received by a Missouri hospital from a state other than Missouri.

(P) Section 1011 payments. Section 1011 payments are made to a hospital for costs incurred for the provision of specific services to specific aliens to the extent that the provider was not otherwise reimbursed for such services. Because a portion of the Section 1011 payments are made for uncompensated care costs that are also eligible under the hospital-specific DSH limit, a defined portion of the section 1011 payments must be recognized as an amount paid on behalf of those uninsured.

(Q) Shortfall. The shortfall is the hospital-specific DSH limit in excess of the total amount a hospital has been paid (including all DSH payments). The source for this calculation is as follows:

1. Actual shortfall. The actual shortfall is based on the annual independent DSH audit; and

2. Estimated shortfall. The estimated shortfall is calculated by the state using data from the state DSH survey, Medicaid supplemental payments, and data provided in the most recent independent DSH audit, if applicable.

(R) State DSH survey. The state DSH survey was designed to reflect the standards of calculating uncompensated care cost established by the federal DSH rules in determining hospital-specific DSH limits. The DSH survey is also similar to the DSH survey that is utilized by the independent auditor during the annual independent DSH audit performed in accordance with the federally-mandated DSH audit rules. The blank state DSH survey is referred to as the state DSH survey template. The following state DSH survey templates and instructions 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. This rule does not incorporate any subsequent amendments or additions.

1. Version 1 (9/10), also referred to as the 2011 state DSH survey, was used to calculate the SFY 2011 DSH payment adjustments set forth in section (4) and the SFY 2012 interim DSH payments set forth in section (5).

2. Version 2 (9/11) will be used to calculate interim DSH payments beginning with SFY 2013 as set forth in section (5). The survey shall be referred to as the SFY to which payments will relate. For example, the survey used to determine interim DSH payments for SFY 2013 will be referred to as the 2013 state DSH survey.

(S) Taxable revenue. Taxable revenue is the hospital's total inpatient adjusted net revenues plus outpatient adjusted net revenues determined in accordance with 13 CSR 70-15.110, paragraph (1)(A)13.

(T) Uncompensated care costs (UCC). The uncompensated care costs eligible for consideration in determining the hospital-specific DSH limit are calculated by reducing costs incurred in furnishing inpatient and outpatient hospital services to the Medicaid and uninsured populations, reduced by revenues received under Medicaid (not including DSH payments) and Section 1011 payments. The costs are to be calculated using Medicare cost report costing methodologies described in this rule and should not include costs for services that were denied for any reason. For purposes of this calculation the Medicaid and uninsured populations include:

1. The Medicaid population includes all Medicaid eligible individuals including dual eligible and managed care participants; and

2. The uninsured population includes individuals with no source of third-party reimbursement for the inpatient and outpatient services they receive. If the individual had health insurance, even if the third-party insurer did not pay, those services are insured and cannot be included as uninsured costs.

(U) Uninsured revenues. Payments received on a cash basis that are required to be offset against the uninsured cost to determine the uninsured net cost include any amounts received by the hospital, by or on behalf of, either self-pay or uninsured individuals during the SFY under audit.

## Title 13—DEPARTMENT OF SOCIAL SERVICES
## Division 70—MO HealthNet Division
## Chapter 15—Hospital Program

### ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 208.152, 208.153, and 208.201, RSMo Supp. 2010, the division adopts a rule as follows:

**13 CSR 70-15.230** Supplemental Upper Payment Limit Methodology **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1624–1625). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 16—RETIREMENT SYSTEMS
## Division 10—The Public School Retirement System of Missouri
## Chapter 4—Membership and Creditable Service

### ORDER OF RULEMAKING

By the authority vested in the board of trustees under section 169.020, RSMo Supp. 2010, the board of trustees amends a rule as follows:

**16 CSR 10-4.012** Payment for Reinstatement and Credit Purchases **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1852). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 16—RETIREMENT SYSTEMS
## Division 10—The Public School Retirement System of Missouri
## Chapter 4—Membership and Creditable Service

### ORDER OF RULEMAKING

By the authority vested in the board of trustees under section 169.020, RSMo Supp. 2010, the board of trustees amends a rule as follows:

**16 CSR 10-4.014** Reinstatement and Credit Purchases **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1852–1853). No changes have been made in the text

of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 16—RETIREMENT SYSTEMS
## Division 10—The Public School Retirement System of Missouri
## Chapter 6—The Public Education Employee Retirement System of Missouri

### ORDER OF RULEMAKING

By the authority vested in the board of trustees under section 169.610, RSMo Supp. 2010, the board of trustees amends a rule as follows:

**16 CSR 10-6.040** Membership Service Credit **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1853). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 16—RETIREMENT SYSTEMS
## Division 10—The Public School Retirement System of Missouri
## Chapter 6—The Public Education Employee Retirement System of Missouri

### ORDER OF RULEMAKING

By the authority vested in the board of trustees under section 169.610, RSMo Supp. 2010, the board of trustees amends a rule as follows:

**16 CSR 10-6.045** Reinstatement and Credit Purchases **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1853–1854). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
## Division 73—Missouri Board of Nursing Home Administrators
## Chapter 1—Organization and Description of Board

### ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-1.010** General Organization **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1626). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
## Division 73—Missouri Board of Nursing Home Administrators
## Chapter 2—General Rules

### ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

19 CSR 73-2.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1626–1627). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received three (3) comments on the proposed amendment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment and eight (8) comments were made.

COMMENT #1: Harvey M. Tettlebaum, attorney on behalf of the Missouri Health Care Association, noted that it is not clear from sections (1) and (8) if the board intends to require owners of facilities or who have an ownership of the facility to provide some management services to a licensed nursing home to be licensed as a "nursing home administrator" or whether the new definitions are merely intended to make clear that someone who is acting as an "administrator" of a nursing home must be licensed irrespective of whether he or she has an ownership interest in the nursing facility, manages the nursing facility in whole or in part, or supervises others who actually administer or manage the nursing facility.
RESPONSE: Sections (1) and (8) define that a licensed administrator is someone licensed by the board to administer, manage, or supervise a licensed long-term care facility, whether that person has an ownership of the facility and/or a person that shares administrative duties with others. No change will be made to the rule as a result of this comment.

COMMENT #2: Denise Clemonds, LeadingAge Missouri, appreciates the board including section (7), the definition of health care or aging-related experience.
RESPONSE: No change will be made to the rule as a result of this comment.

COMMENT #3: Denise Clemonds inquired if the board resolved the issue with the Department of Health and Senior Services, Section for Long Term Care Regulation regarding the RCF II regulation being "frozen" so the new licensure level can be used in the RCF II level of care.
RESPONSE: The Section for Long Term Care Regulation will be

amending 19 CSR 30-86.043 and 19 CSR 30-86.047 to be consistent with the board's proposed amendments. No change will be made to the rule as a result of this comment.

COMMENT #4: Tim Blattel, Missouri Assisted Living Association, requested that section (1), Administrator, be changed to a person that is currently licensed by the board as either a nursing home administrator or assisted living administrator who manages or supervises a long term care facility as such term is defined in section 344.010, RSMo.
RESPONSE: After considerable study and deliberation, the board concludes that section (1) is appropriate at this time. No change will be made to the rule as a result of this comment.

COMMENT #5: Tim Blattel requested that section (2), Clock hour, be changed from sixty (60) minutes to fifty (50) minutes.
RESPONSE: After considerable study and deliberation, the board concludes that section (2) is appropriate at this time. No change will be made to the rule as a result of this comment.

COMMENT #6: Tim Blattel requested that section (3), Continuing education, be changed to mean post-licensure education to maintain professional competency to practice administration of long-term care facilities, as defined in section 344.010, RSMo.
RESPONSE AND EXPLANATION OF CHANGE: The board concurs and will amend the language as suggested.

COMMENT #7: Tim Blattel questioned if all the references are necessary in section (5).
RESPONSE: The references are required by statute and cannot be changed without changes to the statute. No change will be made to the rule as a result of this comment.

COMMENT #8: Tim Blattel noted that section (8) can be deleted if the changes are made to section (1).
RESPONSE: After considerable study and deliberation, the board concludes that section (8) is appropriate at this time. No change will be made to the rule as a result of this comment.

COMMENT #9: Tim Blattel noted that section (10) can be deleted if the changes are made to section (1). Mr. Blattel noted that if section (10) is not deleted, then the language should be changed to clarify whether all RCFs are required to have a licensed administrator.
RESPONSE: After considerable study and deliberation, the board concludes that section (10) is appropriate at this time. No change will be made to the rule as a result of this comment.

COMMENT #10: Tim Blattel noted that previous section (5), Experience in health-care administration, was removed.
RESPONSE AND EXPLANATION OF CHANGE: After considerable review, the board concludes that the former section (5) definition was inadvertently deleted. Section (5) has been reinstated, renumbered to section (6), and the definitions have been renumbered throughout the rule.

COMMENT #11: Tim Blattel requested that "health care" be removed from subsection (11)(B) since the terminology could limit options for administrators to seek education in business management.
RESPONSE: After considerable study and deliberation, the board concludes that subsection (11)(B) is appropriate at this time. No change will be made to the rule as a result of this comment.

**19 CSR 73-2.010 Definitions**

(3) Continuing education means post-licensure education to maintain professional competency to practice administration of long-term care facilities, as defined in section 344.010, RSMo.

(6) Experience in health-care administration shall mean having management responsibility, which shall include the on-site supervision of at least three (3) staff persons in a licensed long-term care or acute-care facility or a licensed mental health facility, or a department of one of these facilities.

(7) Health care facility shall mean a licensed long-term care facility, licensed acute-care facility, or licensed inpatient mental health facility.

(8) Health care or aging-related experience shall mean full-time equivalency experience in a licensed home health agency, licensed hospice agency, licensed acute-care or long-term care facility, licensed adult day care program, or licensed mental health facility.

(9) Nursing Home Administrator shall mean an administrator, as defined in section (1), that administers, manages, or supervises a long-term care facility, as defined in section 344.010, RSMo.

(10) Resident shall mean a person residing in a long-term care facility, as defined in section 344.010, RSMo.

(11) Residential Care and Assisted Living Administrator shall mean an administrator, as defined in section (1), that administers, manages, or supervises an assisted living facility or residential care facility, as defined in Chapter 198, RSMo. This includes residential care facilities that were licensed as a residential care facility II on or before August 27, 2006, and that continue to meet the licensure standards for a residential care facility II in effect on August 27, 2006.

(12) Training agency shall mean—
(A) An accredited educational institution; or
(B) A statewide or national membership agency, association, professional society or organization in the fields of health care or health care management approved by the board to provide courses of instruction and training.

## Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
## Division 73—Missouri Board of Nursing Home Administrators
## Chapter 2—General Rules

## ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.015** Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1627–1628). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment on the proposed amendment during the public comment period.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted that nothing directly in the rule addresses an increase of fifty dollars ($50.00) plus five dollars and ninety cents ($5.90) processing fee as indicated on the fiscal note.
RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars ($500) whether the rule addresses it or not. No change will made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**
**Division 73—Missouri Board of Nursing Home Administrators**
**Chapter 2—General Rules**

## ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.020** Procedures and Requirements for Licensure of Nursing Home Administrators **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1629–1630). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment on the proposed amendment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment and two (2) comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted nothing directly in the rule addresses the increase of fifty-five dollars ($55.00) as indicated on the fiscal note.
RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars ($500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

COMMENT #2: Tim Blattel, Missouri Assisted Living Association, requested changing the language in paragraph (2)(E)1. to include health care or aging-related experience since section (5) was removed from 19 CSR 73-2.010.
RESPONSE: This comment is outside of the purview of the amendment change; however, the board amended 19 CSR 73-2.010 to reinstate section (5). No change will be made to the rule as a result of this comment.

COMMENT #3: Cindy Wrigley, Missouri Association of Nursing Home Administrators, requested the board to continue considering experience as a top priority when considering qualifications for approval to sit for the exam.
RESPONSE: This comment is outside of the purview of the amendment change; therefore, it cannot be addressed. Additionally, experience is set by statute and cannot be changed without changes to the statute. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**
**Division 73—Missouri Board of Nursing Home Administrators**
**Chapter 2—General Rules**

## ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board adopts a rule as follows:

19 CSR 73-2.022 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1631–1632). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received two (2) comments on the proposed rule during the public comment period. In addition, a public hearing on this proposed rule was held August 4, 2011. At the public hearing, the board staff explained the proposed rule, and six (6) comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted that the reference to the rule, 19 CSR 73-2.020(2)(E)1.–2., should read as 19 CSR 73-2.022(2)(E)1.–2. in section (4).
RESPONSE AND EXPLANATION OF CHANGE: The board concurs and will make the change.

COMMENT #2: Denise Clemonds noted that nothing directly in this rule addresses an increase of fifty dollars ($50.00) plus a five dollars and ninety cents ($5.90) processing fee as indicated on the fiscal note.
RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars ($500) whether the rule addresses it or not. No change will made to the rule as a result of this comment.

COMMENT #3: Tim Blattel, Missouri Assisted Living Association, noted that rather than having separate standards by which an individual's criminal history is evaluated, they suggest copying the requirements as outlined in 19 CSR 30-86 for long-term care facilities.
RESPONSE: The standards are set by statute, Chapter 344, RSMo, and cannot be changed without changes to the statute. No change will made to the rule as a result of this comment.

COMMENT #4: Tim Blattel suggested changes to the experience qualification in paragraph (2)(E)1. to add another option in experience qualification of five (5) years hotel or general management experience and successful completion of the required 24-hour course on community-based assessments in assisted living facilities.
RESPONSE: After considerable study and deliberation, the board concludes that paragraph (2)(E)1. is appropriate at this time. Additional study of experience and education will be ongoing. No change will be made to the rule as a result of this comment.

COMMENT #5: Tim Blattel suggested changes to the experience qualification in subparagraphs (2)(E)2.A. and B. by changing the experience language to "health-care or aging-related experience including management and supervisory responsibility."
RESPONSE: After considerable study and deliberation, the board concludes that subparagraphs (2)(E)2.A. and B. are appropriate at this time. Additional study of experience and education will be ongoing. No change will be made to the rule as a result of this comment.

COMMENT #6: Tim Blattel suggested changes to section (3) to include applicants that are eligible to take the exams upon board approval and pay the fees if the applicant completed the five (5) criteria in section (2).
RESPONSE: After considerable study and deliberation, the board concludes that section (3) is appropriate at this time. No change will be made to the rule as a result of this comment.

COMMENT #7: Tim Blattel suggested changes to section (4) to allow the applicant to withdraw the application or submit additional information.
RESPONSE AND EXPLANATION OF CHANGE: After considerable study and deliberation, the board concludes that section (4) is appropriate. However, to provide clarification, the board will amend section (4) by reordering subsections (4)(A) and (B).

COMMENT #8: Tim Blattel suggested including another option for applicants that have failed to meet the criteria to successfully complete a one thousand (1,000)-hour internship with an administrator of an assisted living facility.
RESPONSE: The options for applicants are outlined in section (4). The internship criteria are addressed in 19 CSR 73-2.031. No change will be made to the rule as a result of this comment.

**19 CSR 73-2.022 Procedures and Requirements for Licensure of Residential Care and Assisted Living Administrators**

(4) If the board determines the applicant has failed to meet one (1) of the criteria outlined in 19 CSR 73-2.022(2)(E)1.–2., the applicant—

(A) May submit additional information for reevaluation if done so no later than two (2) weeks prior to the next board meeting. The applicant will be given notice of the next board meeting date; or

(B) Must complete the course of instruction and training approved by the board pursuant to 19 CSR 73-2.031. The planned curriculum, including a description of each planned course, must be submitted to the board in writing for PRIOR review and approval. Failure to do so within six (6) months following notification of the board's decision will cause reapplication to become necessary for any future consideration.

## Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
## Division 73—Missouri Board of Nursing Home Administrators
## Chapter 2—General Rules

## ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

19 CSR 73-2.025 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1633–1634). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received three (3) comments on the proposed amendment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and two (2) comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, requested the language in subsection (2)(E) to remain as is with performance as a licensed administrator for one (1) year instead of three (3) years.
RESPONSE: After study and deliberation, the board concludes that subsection (2)(E) is appropriate at this time. Additional study on reciprocity will be ongoing. No change will be made to the rule as a result of this comment.

COMMENT #2: Denise Clemonds noted that section (7) addresses the regulation 19 CSR 73-2.020 and needs to include 19 CSR 73-2.022.
RESPONSE AND EXPLANATION OF CHANGE: The board concurs and will amend the language to include 19 CSR 73-2.022.

COMMENT #3: Denise Clemonds noted that nothing directly in this rule addresses an increase of fifty dollars ($50.00) plus a five dollars and ninety cents ($5.90) processing fee as indicated on the fiscal note.
RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars ($500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

COMMENT #4: Tim Blattel, Missouri Assisted Living Association, noted rather than having separate standards by which an individual's criminal history is evaluated, they suggest copying the requirements as outlined in 19 CSR 30-86 for long-term care facilities.
RESPONSE: The standards are set by statute and cannot be changed without changes to the statute. No change will made to the rule as a result of this comment.

COMMENT # 5: Tim Blattel recommended changes to the language in section (7) to include an applicant has the option to withdraw the application or may submit additional information.
RESPONSE: After considerable study and deliberation, the board concludes that section (7) is appropriate at this time. No changes will be made to the rule as a result of this comment.

**19 CSR 73-2.025 Licensure by Reciprocity**

(7) If the applicant is unable to meet the requirements of subsection (2)(E) of this rule, but meets all other requirements of section (2), the candidate shall be considered an applicant for initial licensure pursuant to the appropriate rule 19 CSR 73-2.020(2)(E) or 19 CSR 73-2.022(2)(E). If the results of that evaluation show that the applicant meets the criteria, the board shall accept the applicant's passing of the national examination in another state if it was taken within three (3) years of the applicant's submission for licensure in Missouri. The applicant then must meet the requirements of section (6) of this rule by successfully completing and passing the state examination. If the applicant does not meet the criteria, the applicant will be required to complete a prescribed course of instruction and training as outlined in 19 CSR 73-2.031.

## Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
## Division 73—Missouri Board of Nursing Home Administrators
## Chapter 2—General Rules

## ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

19 CSR 73-2.031 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1635). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received two (2) comments on the proposed amendment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and three (3) comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, requested the requirement of beds in subsection (5)(D) be changed from sixty (60) to thirty (30).
RESPONSE AND EXPLANATION OF CHANGE: The board agrees with this and will amend subsection (5)(D). In addition, subsection (5)(C) will be amended to reflect thirty (30) beds for consistency.

COMMENT #2: Denise Clemonds noted in section (10) that the completion of the internship for the residential care and assisted living administrator license should be completed in its entirety in an assisted living facility or residential care facility II with thirty (30) or more beds.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees with this and will amend the language.

COMMENT #3: Tim Blattel, Missouri Assisted Living Association, noted that this rule should only be for the nursing home administrator license and the internship requirements for the residential care and assisted living administrator license should be outlined in 19 CSR 73-2.022.
RESPONSE: After study and deliberation, the board concludes that the proposed language is appropriate at this time. No change will be made to the rule as a result of this comment.

COMMENT #4: Tim Blattel suggested changing "shall" to "may" in section (1).
RESPONSE: After study and deliberation, the board concludes that section (1) is appropriate at this time. No change will be made to the rule as a result of this comment.

COMMENT #5: Tim Blattel suggested removing "duly" in subsection (5)(C) and section (10).
RESPONSE: After study and deliberation, the board concludes that subsection (5)(C) and section (10) are appropriate at this time. No change will be made to the rule as a result of this comment.

**19 CSR 73-2.031 Prescribed Course of Instruction and Training**

(5) Internships as required by section (1) shall be under the direct supervision of a licensed administrator approved and designated as a preceptor by the Missouri Board of Nursing Home Administrators. An administrator may be approved and designated as a preceptor for a period of two (2) years, if s/he—

(C) Is currently serving as the administrator of a duly licensed intermediate care facility (ICF), skilled nursing facility (SNF), assisted living facility (ALF), or any Residential Care Facility (RCF) that was licensed as a residential care II on or before August 27, 2006, that continues to meet the licensure standards for a residential care facility II in effect on August 27, 2006, with thirty (30) or more beds;

(D) Is an administrator of an ICF, SNF, ALF, or RCF (as described above) with thirty (30) or more beds, which is in substantial compliance with the rules governing long-term care facilities; and

(10) A portion of an internship for a nursing home administrator applicant may be completed in a duly licensed ALF or RCF (as described above) with thirty (30) or more beds if the intern desires such experience. The residential care and assisted living administrator applicant may complete its entire portion of an internship in a duly licensed ALF or RCF (as described above) with thirty (30) or more beds. The maximum hours of nursing home administrator internship that may be served in such an ALF or RCF (as described above) are designated as follows. Nursing home administrator applicants may complete up to—

## Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
## Division 73—Missouri Board of Nursing Home Administrators
## Chapter 2—General Rules

### ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under sections 344.040 and 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.050** Renewal of Licenses **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1635–1638). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment on the proposed amendment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and three (3) comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted that nothing in this rule addresses an increase of fifty dollars ($50.00) plus four dollars and forty-three cents ($4.43) processing fee for the two (2)-year license and the twenty-five dollar ($25.00) plus two dollar and twenty-five cents ($2.25) processing fee for the one (1)-year license as indicated on the fiscal note.
RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars ($500) whether the rule addresses it or not. No change will made to the rule as a result of this comment.

COMMENT #2: Tim Blattel, Missouri Assisted Living Association, recommended changing the forty (40) clock hours to be board-approved or NAB approved in subsection (2)(A).
RESPONSE: The board addressed the approval by NAB in the paragraph (3)(A)3. No change will be made to the rule as a result of this comment.

COMMENT #3: Tim Blattel and Cindy Wrigley, Missouri Association of Nursing Home Administrators, recommended removing the patient care requirement on the clock hours in subsection (2)(A).
RESPONSE: After study and deliberation, the board concludes that subsection (2)(A) is appropriate at this time. Additional study on clock hour requirements will be ongoing. No change will be made to the rule as a result of this comment.

COMMENT #4: Tim Blattel recommended moving the language from subsection (4)(A) requiring the maximum of twenty (20) of the forty (40) clock hours can be online to (2)(A) for clarification.
RESPONSE: After study and deliberation, the board concludes that subsection (4)(A) is appropriate at this time. No change will be made to the rule as a result of this comment.

## Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
## Division 73—Missouri Board of Nursing Home Administrators
## Chapter 2—General Rules

### ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.051** Retired Licensure Status **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1639). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**
**Division 73—Missouri Board of Nursing Home Administrators**
**Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.053** Inactive Licensure Status **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1639–1641). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and no comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted nothing directly in this rule addresses an increase in the licensing fee plus the processing fee for the inactive license and inactive license renewal.
RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars ($500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**
**Division 73—Missouri Board of Nursing Home Administrators**
**Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under sections 344.040 and 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.055** Renewal of Expired License **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1642–1643). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and no comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted nothing directly in this rule addresses an increase of fifty dollars ($50.00) plus the five dollars and sixteen cents ($5.16) processing fee for late license renewals.
RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars ($500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**
**Division 73—Missouri Board of Nursing Home Administrators**
**Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under sections 344.030 and 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.070** Examination **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1644–1645). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and one (1) comment was made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted nothing directly in this rule addresses an increase of fifty-five dollars ($55.00).
RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars ($500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

COMMENT #2: Tim Blattel, Missouri Assisted Living Association, inquired if both exams have one hundred and thirteen (113) questions.
RESPONSE: No, the number one hundred and thirteen (113) referenced in section (6) refers to the passing score for the national examination. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**
**Division 73—Missouri Board of Nursing Home Administrators**
**Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under sections 344.030 and 344.070, RSMo Supp.

2010, the board amends a rule as follows:

**19 CSR 73-2.080** Temporary Emergency Licenses **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1646). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received no comments during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and one (1) comment was made.

COMMENT #1: Tim Blattel, Missouri Assisted Living Association, requested clarification on the date and event identification in subsection (1)(E) and why the change from submitting a copy.
RESPONSE: The date and event identification are the identifiers for the facility's statement of deficiencies document. The facility will be able to reference these identifiers in lieu of mailing a hard copy of the statement of deficiencies document. No change will be made to the rule as a result of this comment.

## Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
## Division 73—Missouri Board of Nursing Home Administrators
## Chapter 2—General Rules

### ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.085** Public Complaints **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1646–1647). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
## Division 73—Missouri Board of Nursing Home Administrators
## Chapter 2—General Rules

### ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.120** Duplicate License **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1647). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
## Division 73—Missouri Board of Nursing Home Administrators
## Chapter 2—General Rules

### ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.130** Notice of Change of Address **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1647–1648). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received no comments during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and one (1) comment was made.

COMMENT #1: Tim Blattel, Missouri Assisted Living Association, recommended changing the language to "may" rather than "shall" in section (1).
RESPONSE: After study and deliberation, the board concludes that section (1) is appropriate at this time. Additional study on change of contact information will be ongoing. No change will be made to the rule as a result of this comment.

## Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
## Division 2010—Missouri State Board of Accountancy
## Chapter 2—General Rules

### ORDER OF RULEMAKING

By the authority vested in the Missouri State Board of Accountancy under sections 326.262, 326.271, 326.277, 326.280, 326.283, 326.286, and 326.289, RSMo Supp. 2010, the board amends a rule as follows:

**20 CSR 2010-2.160** Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1854–1857). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

## Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
## Division 2245—Real Estate Appraisers
## Chapter 6—Educational Requirements

### ORDER OF RULEMAKING

By the authority vested in the Missouri Real Estate Appraisers commission under section 339.509, RSMo 2000, and section 339.517, RSMo Supp. 2010, the commission amends a rule as follows:

20 CSR 2245-6.015 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1755–1756). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: One (1) comment was received on the proposed amendment as summarized below.

COMMENT #1: Upon further review of the amendment, the commission determined that by specifying that the courses listed in paragraph (2)(A)2. can be accepted as on-line qualifying education it would effectively exclude the courses listed in paragraph (2)(B)2. as on-line qualifying education. Consequently, this would allow general real estate appraisers to obtain the courses on-line, while prohibiting residential real estate appraisers to obtain the exact same courses on-line.
RESPONSE AND EXPLANATION OF CHANGE: The commission would like to clarify that the courses to be accepted should include those listed in paragraphs (2)(A)2. and (2)(B)2. by adding (2)(B)2. to the amended language.

**20 CSR 2245-6.015 Examination and Education Requirements**

(2) Qualifying Education. The Missouri Real Estate Appraisers Commission does not accept on-line qualifying education with the exception of the courses listed in paragraphs (2)(A)2. and (2)(B)2. and the "Appraisal Subject Matter Electives" as noted below.

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

## Title 7—DEPARTMENT OF TRANSPORTATION
## Division 10—Missouri Highways and Transportation Commission
## Chapter 25—Motor Carrier Operations

## IN ADDITION

### 7 CSR 10-25.010 Skill Performance Evaluation Certificates for Commercial Drivers

### PUBLIC NOTICE

Public Notice and Request for Comments on Applications for Issuance of Skill Performance Evaluation Certificates to Intrastate Commercial Drivers with Diabetes Mellitus or Impaired Vision

**SUMMARY:** This notice publishes MoDOT's receipt of applications for the issuance of Skill Performance Evaluation (SPE) Certificates, from individuals who do not meet the physical qualification requirements in the Federal Motor Carrier Safety Regulations for drivers of commercial motor vehicles in Missouri intrastate commerce, because of impaired vision, or an established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control. If granted, the SPE Certificates will authorize these individuals to qualify as drivers of commercial motor vehicles (CMVs), in intrastate commerce only, without meeting the vision standard prescribed in 49 CFR 391.41(b)(10), if applicable, or the diabetes standard prescribed in 49 CFR 391.41(b)(3).

**DATES:** Comments must be received at the address stated below, on or before January 3, 2012.

**ADDRESSES:** You may submit comments concerning an applicant, identified by the application number stated below, by any of the following methods:
• *Email:* Kathy.Hatfield@modot.mo.gov
• *Mail:* PO Box 893, Jefferson City, MO 65102-0893
• *Hand Delivery:* 1320 Creek Trail Drive, Jefferson City, MO 65109
• *Instructions:* All comments submitted must include the agency name and application number for this public notice. For detailed instructions on submitting comments, see the Public Participation heading of the Supplementary Information section of this notice. All comments received will be open and available for public inspection and MoDOT may publish those comments by any available means.

### COMMENTS RECEIVED BECOME MoDOT PUBLIC RECORD

• By submitting any comments to MoDOT, the person authorizes MoDOT to publish those comments by any available means.
• *Docket:* For access to the department's file, to read background documents or comments received, 1320 Creek Trail Drive, Jefferson City, MO 65109, between 7:30 a.m. and 4:00 p.m., CT, Monday through Friday, except state holidays.

**FOR FURTHER INFORMATION CONTACT:** Ms. Kathy Hatfield, Motor Carrier Specialist, (573) 522-9001, MoDOT Motor Carrier Services Division, PO Box 893, Jefferson City, MO 65102-0893. Office hours are from 7:30 a.m. to 4:00 p.m., CT, Monday through Friday, except state holidays.

**SUPPLEMENTARY INFORMATION:**

**Public Participation**
If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard.

**Background**
The individuals listed in this notice have recently filed applications requesting MoDOT to issue SPE Certificates to exempt them from the physical qualification requirements relating to vision in 49 CFR 391.41(b)(10), or to diabetes in 49 CFR 391.41(b)(3), which otherwise apply to drivers of CMVs in Missouri intrastate commerce.

Under section 622.555, RSMo Supp. 2010, MoDOT may issue a Skill Performance Evaluation Certificate, for not more than a two (2)-year period, if it finds that the applicant has the ability, while operating CMVs, to maintain a level of safety that is equivalent to or greater than the driver qualification standards of 49 CFR 391.41. Upon application, MoDOT may renew an exemption upon expiration.

Accordingly, the agency will evaluate the qualifications of each applicant to determine whether issuing a SPE Certificate will comply with the statutory requirements and will achieve the required level of safety. If granted, the SPE Certificate is only applicable to intrastate transportation wholly within Missouri.

**Qualifications of Applicants**

**Application #MP110719029**

Applicant's Name & Age: Melvin Goldstein, 64

Relevant Physical Condition: Mr. Goldstein's best corrected visual acuity is 20/30 Snellen in his right eye and 20/30 Snellen in his left eye. He was diagnosed with insulin treated diabetes mellitus in 1985.

Relevant Driving Experience: Employed for a company located in St. Louis, MO, he currently drives a seven to fifteen (7–15) passenger vehicle and has approximately thirteen (13) years commercial driving experience. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in May 2011, his endocrinologist certified, "In my medical opinion, Mr. Goldstein's diabetes deficiency is stable, he is capable of performing the driving tasks required to operate a commercial motor vehicle, and his condition will not adversely affect his ability to operate a commercial motor vehicle safely."

Traffic Accidents and Violations: No accidents or violations within the past three (3) years.

**Application #MP090424017**

Renewal Applicant's Name & Age: Rodger D. Jarvis, 60

Relevant Physical Condition: Mr. Jarvis's best-corrected visual acuity in his right eye is 20/25 Snellen and in his left eye is 3/200 Snellen. He had cataract surgery as an infant.

Relevant Driving Experience: Mr. Jarvis is currently employed as a driver for a coin company. He has approximately three (3) years of commercial motor vehicle driving experience. He currently has a Class E license. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in August 2011, his optometrist certified, "In my medical opinion, Mr. Jarvis's visual deficiency is stable, he is capable of performing the driving tasks required to operate a commercial motor vehicle, and his condition will not adversely affect his ability to operate a commercial motor vehicle safely."

Traffic Accidents and Violations: No accidents or violations on record.

**Application #MP070323014**

Renewal Applicant's Name & Age: Robert Ogle Jr., 52

Relevant Physical Condition: Mr. Ogle's best-corrected visual acuity in his left eye is 20/20 Snellen and he is blind in his right eye.

Relevant Driving Experience: Mr. Ogle is currently employed with a water company and has been for over thirteen (13) years. Mr. Ogle indicated that he has over fourteen (14) years commercial motor vehicle driving experience. He currently has a Class A driver's license. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in August 2011, his optometrist certified, "In my medical opinion, Mr. Ogle's visual deficiency is stable, he has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle, and his condition will not adversely affect his ability to operate a commercial motor vehicle safely."

Traffic Accidents and Violations: No accidents or violations on record.

**Request for Comments**
The Missouri Department of Transportation, Motor Carrier Services Division, pursuant to section 622.555, RSMo, and rule 7 CSR 10-25.010, requests public comment from all interested persons on the applications for issuance of Skill Performance Evaluation Certificates described in this notice. We will consider all comments received before the close of business on the closing date indicated earlier in this notice.

Issued on: November 1, 2011

*Jan Skouby, Motor Carrier Services Director, Missouri Department of Transportation.*

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

### NOTIFICATION OF REVIEW: APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. A decision is tentatively scheduled for January 9, 2012. These applications are available for public inspection at the address shown below.

**Date Filed**

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

**10/25/11**

**#4689 RS:** The Fremont Assisted Living
Springfield (Greene County)
$5,083,767, Establish 72-bed ALF

**10/26/11**

**#4710 HS:** Saint Luke's Cancer Institute, LLC
Kansas City (Jackson County)
$4,324,997, Replace linear accelerator

**10/27/11**

**#4716 HS:** Hedrick Medical Center
Chillicothe (Livingston County)
$35,289,468, Establish 25-bed critical access hospital

**#4721 NS:** Stockton Nursing Home
Stockton (Polk County)
$5,933,820, Replace 75-bed SNF and add 15 SNF beds

**10/28/11**

**#4706 HS:** Landmark Hospital
Joplin (Newton County)
$1,311,000, Add 12 SNF beds

**#4714 HS:** University of Kansas Hospital
Kansas City (Jackson County)
$1,718,680, Acquire MRI unit

**#4715 HS:** St. Clare Health Center
St. Louis (St. Louis County)
$6,300,000, Acquire CyberKnife

**#4720 HS:** St. Mary's Health Center
Richmond Heights (St. Louis County)
$2,970,000, Replace Cardiac Electrophysiology Laboratory

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by November 28, 2011. All written requests and comments should be sent to—

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
Post Office Box 570
Jefferson City, MO 65102

For additional information, contact
Karla Houchins, (573) 751-6403.

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

### NOTIFICATION OF REVIEW: APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. A decision is tentatively scheduled for December 22, 2011. These applications are available for public inspection at the address shown below.

**Date Filed**

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

**11/10/11**

**#4730 NP:** Ambrose Park Residential Care
Cole Camp (Benton County)
$375,000, Long-term Care Expansion of 8 RCF beds

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by December 9, 2011. All written requests and comments should be sent to—

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
Post Office Box 570
Jefferson City, MO 65102

For additional information, contact
Karla Houchins, (573) 751-6403.

## STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is a list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. In addition, this list includes contractor(s) that have agreed to placement on the list maintained by the Secretary of State pursuant to Section 290.330 as a part of the resolution of criminal charges of violating the Missouri Prevailing Wage Law. Under this statute, no public body shall award a contract for public works to any contractor or subcontractor, or simulation thereof, during the time that such contractor or subcontractor's name appears on this state debarment list maintained by the Secretary of State.

### Contractors Convicted of Violations of the Missouri Prevailing Wage Law

| Name of Contractor | Name of Officers | Address | Date of Conviction | Debarment Period |
|---|---|---|---|---|
| Rycoblake Corp.<br>Case No. 0916-CR03145<br>(Jackson County Cir. Ct.) | | 4212 SE Saddlebrook Cir<br>Lee's Summit, MO 64082 | 7/13/11 | 7/13/11 to 7/13/12 |

### Contractors Agreeing to Placement on the Public Works Debarment List as Part of an Agreement Relating to Criminal Pleas

| Name of Contractor | Name of Officers | Address | Date of Conviction | Debarment Period |
|---|---|---|---|---|
| Rycoblake Corp. | | 4212 SE Saddlebrook Cir<br>Lee's Summit, MO 64082 | | 7/13/11 to 12/1/12 |
| Gerald Chevalier | | 4212 SE Saddlebrook Cir<br>Lee's Summit, MO 64082 | | 7/13/11 to 12/1/12 |

Dated this 2 day of August 2011.

Carla Buschjost

Carla Buschjost, Director

## ADDITION TO STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is an addition to the list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works (1) to Mr. Saxon W. Johnson, (2) to any other contractor or subcontractor that is owned, operated or controlled by Mr. Saxon W. Johnson including The Tile Doctor or (3) to any other simulation of Mr. Saxon W. Johnson or of The Tile Doctor for a period of one year, or until September 2, 2012.

| Name of Contractor | Name of Officers | Address | Date of Conviction | Debarment Period |
|---|---|---|---|---|
| Saxon W. Johnson<br>DBA The Tile Doctor<br>Case No. 10CA-CR01318<br>Cass County Cir. Ct. | | 10724 Haskins Ct<br>Shawnee Mission, KS 66210 | 9/2/2011 | 9/2/2011-9/2/2012 |

Dated this 13 day of September 2011.

Carla Buschjost, Director

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to dissolutions@sos.mo.gov.

## NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST AVA C-STORE, LLC

On October 24, 2011, AVA C-STORE, LLC, a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o John M. Carnahan III, Carnahan, Evans, Cantwell & Brown, P.C., 2805 S. Ingram Mill, Springfield, Missouri 65804, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number; 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last of filing or publication of this Notice.

## NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST NORTH GLENSTONE C-STORE, LLC

On October 24, 2011, NORTH GLENSTONE C-STORE, LLC, a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o John M. Carnahan III, Carnahan, Evans, Cantwell & Brown, P.C., 2805 S. Ingram Mill, Springfield, Missouri 65804, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number; 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last of filing or publication of this Notice.

## NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST LESLIE D. DAVIS, LLC

On October 3, 2011, Leslie D. Davis, LLC, a Missouri limited liability company (the "Company") filed its Notice of Winding Up and Articles of Termination with the Missouri Secretary of State, effective on the filing date. Any and all claims against the Company must be submitted in writing to Leslie D. Davis, 5413 Willow Ave., Raytown, MO 64133. Each claim must include (1) the name, address and telephone number of the claimant; (2) the amount claimed; (3) the basis of the claim; (4) the date on which the claim arose; and (5) documentation supporting the claim. All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

## NOTICE OF DISSOLUTION AND WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST PAUL AND ANN LUX ASSOCIATES, L.P.

On October 4, 2011, PAUL AND ANN LUX ASSOCIATES, L.P., a Missouri limited partnership, was dissolved upon the filing of a Certificate of Cancellation with the Secretary of State.

Said partnership requests that all persons and organizations who have claims against it present them immediately by letter to: Christopher E. Erblich, Esq., Husch Blackwell LLP, 190 Carondelet Plaza, Suite 600, St. Louis, MO 63105. All claims must include the claimant's name, address and telephone number, the amount, date and basis for the claim.

ANY CLAIMS AGAINST PAUL AND ANN LUX ASSOCIATES, L.P. WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN THREE YEARS AFTER THE LAST PUBLICATION DATE OF THE NOTICES AUTHORIZED BY STATUTE.

## NOTICE OF DISSOLUTION AND WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST LUX MANAGEMENT, LLC

On October 12, 2011, LUX MANAGEMENT, LLC, a Missouri limited liability company, filed its Notice of Winding Up with the Missouri Secretary of State.

Said company requests that all persons and organizations who have claims against it present them immediately by letter to: Christopher E. Erblich, Esq., Husch Blackwell LLP, 190 Carondelet Plaza, Suite 600, St. Louis, MO 63105. All claims must include the claimant's name, address and telephone number, the amount, date and basis for the claim.

NOTICE: BECAUSE OF THE WINDING UP OF LUX MANAGEMENT, LLC, ANY CLAIMS AGAINST IT WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN THREE YEARS AFTER THE PUBLICATION OF THE THREE NOTICES AUTHORIZED BY STATUTE, WHICHEVER IS PUBLISHED LAST.