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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

JASON KANDER

SECRETARY OF STATE

MISSOURI REGISTER

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August 17, 2015	**September 15, 2015**	September 30, 2015	October 30, 2015

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

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RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

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

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2014.

EXECUTIVE ORDER
15-01

WHEREAS, Executive Order 14-15 created the Ferguson Commission consisting of sixteen individuals; and

WHEREAS, Bethany A. Johnson-Javois has resigned as a member of the Ferguson Commission to assume the role of managing director of the Commission; and

WHEREAS, it is important that the Ferguson Commission continue to operate with a full complement of commission members.

NOW, THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and Laws of the State of Missouri, do here appoint Byron M. Watson to the Ferguson Commission to fill the vacancy created by the resignation of Bethany A. Johnson-Javois.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 2nd day of January, 2015.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

Jason Kander
Secretary of State

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

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

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

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

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

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

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

Title 1—OFFICE OF ADMINISTRATION
Division 10—Commissioner of Administration
Chapter 10—Shared Leave for Adoptive and Foster Placement and Care

PROPOSED RULE

1 CSR 10-10.010 ShareLeave for Foster and Adoptive Placement and Care

PURPOSE: This rule prescribes guidelines and standards regarding donated leave programs under the authorization of section 105.271 RSMo. These guidelines and standards shall provide a framework to agencies for the establishment of their ShareLeave for Foster and Adoptive Placement and Care program for the purpose of arranging for a foster or adopted child's placement or caring for the child after placement.

(1) The state agencies that are covered under section 105.271, RSMo, shall establish a leave sharing program within their agencies for employees to donate annual leave, overtime, or compensatory time to an employee who is arranging for a foster or adopted child's placement or caring for the child after placement. Nothing in this section shall be construed as prohibiting a leave sharing program for other purposes. This program may be established under the conditions set out within the following guidelines:

(A) As used in this rule, unless the context clearly indicates otherwise, the following terms shall mean:

1. "ShareLeave for Foster and Adoptive Placement and Care" means a pool of leave hours donated by eligible employees that may be conveyed to other eligible employees for the purpose of arranging for a foster or adopted child's placement or caring for the child after placement;

2. "State ShareLeave Pool" means a statewide repository of eligible leave hours that is maintained by the Commissioner of Administration or designee for the purposes set forth under the ShareLeave for Foster and Adoptive Placement and Care program for the purpose of arranging for a foster or adopted child's placement or caring for the child after placement;

3. "Department ShareLeave Pool" means a repository of eligible leave hours that is maintained by a department or agency of state government for the purposes set forth under the ShareLeave for Foster and Adoptive Placement and Care program for the purpose of arranging for a foster or adopted child's placement or caring for the child after placement; and

4. "Foster or adoptive parent" means both those pursuing to foster or adopt a child and those who have a foster or adopted child placed in the home;

(B) Employees eligible to donate leave are those employees who are employed full time in benefit-eligible positions of a permanent or continuing nature. Employees eligible to receive ShareLeave pool benefits are those employees who are employed full time in benefit-eligible positions of a permanent or continuing nature;

(C) Annual leave as defined by 1 CSR 20-5.010(1) may be donated between employees. Overtime or compensatory time as defined by 1 CSR 20-5.010(1)(C), (D), and (E) and 1 CSR 20-5.010(2)(E) may be donated between employees. Sick leave benefits, which are a grant from the employer and in no sense the property of individuals, may not be donated;

1. Any department or agency which opts in to the State ShareLeave Pool shall send a letter and copy of agreement which indicates cross agency acceptance to the Commissioner of Administration. The State ShareLeave Pool shall be the only program allowed for multi-agency ShareLeave for Foster and Adoptive Placement and Care purposes;

2. Any department or agency which chooses to participate in the State ShareLeave Pool shall designate one (1) employee to serve on a statewide ShareLeave for Foster and Adoptive Placement and Care committee which shall be chaired by the Commissioner of Administration or designee;

(D) Any donated leave shall only be used by the recipient employee for purposes of arranging for the foster or adopted child's placement or caring for the child after placement, which includes, but is not limited to:

1. Appointments with state officials, child placing agencies, social workers, health professionals, or attorneys;

2. Court proceedings;

3. Required travel;

4. Training and licensure as a foster parent;

5. Any periods of time during which foster or adoptive parents are ordered or required by the state, a child placing agency, or by a court to take time off from work to care for the foster or adopted child; or

6. Any other activities necessary to allow the foster care or adoption to proceed;

(E) The final decision concerning the granting of leave under this section shall rest with the chief administrative officer in the case of leave benefits from a Department ShareLeave Pool, and with the Statewide ShareLeave for Foster and Adoptive Placement and Care Committee in the case of leave benefits from the State ShareLeave Pool, and shall be based upon the degree to which the employee is responsible for providing care and attention in connection with the adoption or fostering of the child(ren);

(F) Recipient employees must have exhausted all of their own applicable leave and compensatory time prior to using donated leave;

(G) Donation of leave shall not be made for the benefit of specific individuals, but to the Department ShareLeave Pool. Donations may be transferable between different departments or agencies, with the agreement of the chief administrative officer of such departments or agencies. Such leave shall be deposited into the State ShareLeave Pool;

(H) The chief administrative officer will establish a method for determining the eligibility of persons who apply for leave benefits from the Department ShareLeave Pool;

(I) The Statewide ShareLeave for Foster and Adoptive Placement and Care Committee shall meet as necessary to determine the eligibility of persons who apply for leave benefits from the State ShareLeave Pool;

(J) All eligible recipients will receive an equitable share of leave from that available in the applicable donation pool;

(K) The maximum benefit for any one (1) employee for any one (1) instance of eligibility shall not exceed the equivalent of four (4) months of regular salary;

(L) An employee receiving donated leave shall be credited with additional leave earnings during this period; and

(M) All donations of eligible leave shall be voluntary. No employee may intimidate, threaten, or coerce any other employee with respect to donating or requesting leave under this program. Individual leave records are confidential, and no individual employees shall receive remuneration of any kind for leave donated.

(2) Each appointing authority, as that term is defined in section 36.020(2), RSMo, that adopts a program under this rule shall submit a formal written policy and updates to the Personnel Advisory Board for review.

AUTHORITY: section 105.271, RSMo Supp. 2014. Original rule filed Jan. 12, 2015.

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 Commissioner of Administration, PO Box 809, Jefferson City, MO, 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 13—Blind Pension

PROPOSED RULE

13 CSR 40-13.020 Vision Re-examination

PURPOSE: This rule establishes the requirements to determine whether an individual previously eligible for a blind pension is required to submit to a re-examination of the individual's vision every five (5) years.

(1) Scope: This rule specifies how and when an individual eligible for a blind pension is required to submit to a re-examination of the individual's vision every five (5) years.

(2) An individual has "no usable vision" when—

(A) One (1) or both of the following two (2) conditions are met:

1. The individual has no vision of any kind; or

2. The individual's vision, with or without proper adjusted glasses, or assistive technology is determined to be up to, but not including, 5/200, or whose best visual field is five (5) degrees as tested with five (5) millimeter target or perimeter; and

(B) The individual's vision loss at this level is permanent; or is medically unlikely to return or improve, with or without assistive technology.

(3) Applicants for a blind pension and pensioners may apply to the Family Support Division for a waiver of the requirement that they submit to a re-examination of their vision every five (5) years as authorized in section 209.040, RSMo. To qualify for the waiver the individual shall have no useable vision as certified by an ophthalmologist, a physician skilled in diseases of the eye, or an optometrist, designated or approved by the Family Support Division after a examination. The certification required by this section shall be in writing and submitted to the Family Support Division on a form provided by the division or in a letter on the provider's letterhead within ninety (90) days of the examination conducted to determine if the individual has no usable vision. The form or letter shall be personally signed by the health care provider conducting the examination. The form or letter shall include the following information:

(A) The name and license number of the ophthalmologist, physician skilled in disease of the eye, or optometrist who conducted the examination;

(B) The name of the individual examined and the date of the examination;

(C) The ophthalmologist, physician skilled in disease of the eye, or optometrist who conducted the examination shall state whether—

1. The individual has no vision of any kind; or

2. The individual's vision, with or without proper adjusted glasses, is up to, but not including, 5/200, or his/her best visual field is five (5) degrees or less as tested with a five (5) millimeter target or perimeter;

(D) The ophthalmologist, physician skilled in disease of the eye, or optometrist who conducted the examination shall state whether that the individual's vision loss is—

1. Permanent; or

2. Is medically unlikely to return or improve, with or without glasses or assistive technology.

(4) The Family Support Division shall grant the waiver to applicants for a blind pension and blind pensioners upon receipt of the certification required in section (3).

(5) Blind pensioners who have been granted a waiver under this regulation shall notify the Family Support Division if they experience any improvement in their vision, with or without assistive technology, within sixty (60) days of the change in vision. The notification shall be in writing and shall comply with the requirements of section (5).

(6) Blind pensioners who have been granted a waiver of the vision re-examination shall certify that their vision has not improved at the time of their annual eligibility redetermination. The individual shall provide the following information when making the written certification:

(A) The name of the individual making the certification;

(B) The individual's current physical address;
(C) Mailing address, if different from physical address;
(D) The individual's department client number or Social Security number;
(E) A statement that the pensioner certifies subject to penalty of perjury that his or her vision has not improved, with or without glasses or assistive technology; and
(F) The certification shall be signed by the blind pensioner.

(7) Whenever the blind pensioner reports that his or her vision has improved or the Family Support Division otherwise has reasonable cause to believe that a blind pensioner's vision has improved, the Family Support Division shall require the blind pensioner to submit to a vision examination to determine whether the individual is still qualified for the waiver or for blind pension benefits. The blind pensioner shall promptly submit to an eye examination by ophthalmologist, a physician skilled in diseases of the eye, or an optometrist, designated or approved by the Family Support Division when requested to do so by the division.

(8) The Family Support Division shall deny or terminate a waiver at any time the Family Support Division determines that a blind pensioner who has applied for, or who is under a waiver under this section—
(A) Is not eligible for the waiver;
(B) Has failed to timely notify the Family Support Division of any change in his or her vision, who fails to submit to a re-examination under section (6); or
(C) Who otherwise fails to comply with his or her responsibilities under this section.

(9) Any blind pension payment made to a pensioner under a waiver who was not qualified for the waiver shall be a debt immediately due to the state and collected as overpayment. The blind pensioner shall repay the sum of the blind pension payments that the individual was not entitled to receive. Repayment shall be in a lump sum, or may be deducted from the blind pensioner's blind pension payment in equal installments over a period not to exceed sixty (60) months.

(10) Certifications submitted by mail, or any commonly available electronic means such as fax or e-mail shall be accepted and treated the same as an in-person filing of a certification. A blind pensioner who submits a certification by electronic transmission certifies under penalty of perjury that the certification and the information contained therein is true, accurate, and authentic. The blind pensioner shall retain and provide the original certification to the Family Support Division upon request.

(11) Any blind pensioner who intentionally or knowingly submits, or causes to be submitted, false information to the Family Support Division in support of a waiver under this regulation shall not be deemed a person of good moral character and shall not be eligible for a blind pension.

(12) All information provided to the Missouri Department of Social Services, Family Support Division in the certification shall be true, accurate, and complete.

(13) A blind pensioner who is aggrieved by a decision of the division under this regulation may appeal the division's decision pursuant to section 209.110, RSMo.

AUTHORITY: section 209.040, RSMo Supp. 2014, and section 660.017, RSMo 2000. Original rule filed Jan. 12, 2015.

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 Family Support Division, Alyson Campbell, PO Box 2320 Jefferson City, MO 65102-2320. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

13 CSR 70-15.220 Disproportionate Share Hospital Payments. The division is amending sections (1)–(10).

PURPOSE: This amendment provides for the following changes: updates the state DSH survey used to determine interim Disproportionate Share Hospital (DSH) payments beginning with SFY 2016 to be Version 4, which is the independent DSH audit survey, and provides for the survey to be collected by the independent DSH auditors as the division's authorized agent; changes the trends applied to the state DSH survey to be global industry trends; revises the interim DSH payment definitions, calculations, and reporting requirements relating to the new state DSH survey and trends; clarifies that the uncompensated care costs eligible for an interim DSH payment exclude estimated out of state DSH payments; provides for a DSH Waiver form to be completed if a hospital elects not to receive an interim DSH payment for a given SFY; indicates that a hospital that does not receive an interim DSH payment will not be included in the independent DSH audit unless it requests to do so; allows the state share of DSH liabilities that have not been redistributed to hospitals with DSH shortfalls to be paid to non-Department of Mental Health (DMH) hospitals as a state-only quality improvement payment based on staffed hospital beds, if not otherwise used to make upper payment limit payments; clarifies that records should be retained until the independent DSH audits are complete; references the new Medicare/Medicaid Cost Report form (CMS 2552-10) that hospitals are required to complete for fiscal years beginning on and after May 1, 2010; moves the definitions to the beginning of the rule to clarify the terms used in the remaining sections of the rule; combines sections (1), (2), and (3) to clarify the rule and eliminate redundancy; and corrects the references throughout the rule resulting from these changes.

(1) General Reimbursement Principles.

(A) In order to receive federal financial participation (FFP), disproportionate share payments are made in compliance with federal statutes and regulations. Section 1923 of the Social Security *[Care]* Act (42 U.S. Code) describes the hospitals that must be paid DSH payments and those that the state may elect to pay DSH payments.

[(B) Hospitals that must be paid DSH payments are considered to be federally-deemed disproportionate share hospitals. The state must pay DSH payments to hospitals that meet the following criteria:

1. Obstestrics requirements as described in paragraph (2)(A)1.; and

2. Have a Medicaid Inpatient Utilization Rate (MIUR) at least one (1) standard deviation above the statewide mean as defined in paragraph (2)(A)2., or a Low Income Utilization Rate (LIUR) greater than twenty-five percent (25%) as defined in paragraph (2)(A)3.]

(B) Federally-Deemed DSH Hospitals. The state must pay disproportionate share payments to hospitals that meet the specific obstetric requirements set forth below in paragraph (1)(B)1. and have either a Medicaid Inpatient Utilization Rate (MIUR) at least one (1) standard deviation above the state mean or a Low Income Utilization Rate (LIUR) greater than twenty-five percent (25%). The state shall not make DSH payments in excess of each hospital's estimated hospital-specific DSH limit.

1. Obstestrics requirements and exemptions.

A. Hospitals must have two (2) obstetricians, with staff privileges, who agree to provide non-emergency obstetric services to Medicaid eligibles. Rural hospitals, as defined by the federal Executive Office of Management and Budget, may qualify any physician with staff privileges as an obstetrician.

B. Hospitals are exempt from the obstetric requirements if the facility did not offer non-emergency obstetric services as of December 22, 1987.

C. Hospitals are exempt if inpatients are predominantly under eighteen (18) years of age.

[(C) Hospitals that may be paid DSH must meet obstetric requirements as defined in paragraph (2)(A)1. and have a MIUR of at least one percent (1%).]

(C) State-Elected DSH Payments. The state may elect to make disproportionate share payments to hospitals that meet the obstetric requirements set forth in paragraph (1)(B)1. and have a MIUR of at least one percent (1%).

[(2) Federally-Deemed DSH Hospitals.

(A) The state must pay disproportionate share payments to hospitals that meet specific obstetric requirements and have either a MIUR at least one (1) standard deviation above the state mean or a LIUR greater than twenty-five percent (25%). The state shall not make DSH payments in excess of each hospital's estimated hospital-specific DSH limit.

1. Obstetric requirements and exemptions.

A. Hospitals must have two (2) obstetricians, with staff privileges, who agree to provide non-emergency obstetric services to Medicaid eligibles. Rural hospitals, as defined by the federal Executive Office of Management and Budget, may qualify any physician with staff privileges as an obstetrician.

B. Hospitals are exempt from the obstetric requirements if the facility did not offer non-emergency obstetric services as of December 21, 1987.

C. Hospitals are exempt if inpatients are predominantly under eighteen (18) years of age.

2. MIUR calculations.

A. As determined from the fourth prior year desk-reviewed cost report, the facility has a MIUR of at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals.

B. The MIUR is calculated as follows:

(I) The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID); and

(II) The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded.

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

3. LIUR calculations.

A. As determined from the fourth prior year desk-reviewed cost report, the LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

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

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

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

(3) State-Elected DSH Payments.

(A) The state may elect to make hospital disproportionate share payments to hospitals that meet the obstetric requirements defined in paragraph (2)(A)1. and have a MIUR of at least one percent (1%) as calculated in subparagraph (2)(A)2.B.]

(2) 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) Division. Unless otherwise specified, division refers to the MO HealthNet Division, the division of the Department of Social Services charged with the administration of Missouri's MO HealthNet Program.

(C) Estimated Medicaid net cost. Estimated Medicaid net cost is the cost of providing inpatient (IP) and outpatient (OP) 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 reporting methodologies described in this rule and is calculated using data reported on the state DSH survey. Depending on the hospital's response to questions 14, 15, and 16 of the state DSH survey, versions 1, 2, and 3, 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.

1. The estimated Medicaid net cost determined from the state DSH surveys prior to SFY 2016 is the sum of the following estimated data from the "Settlement Calculation" tab:

A. In-state Medicaid inpatient net cost;

B. In-state Medicaid outpatient net cost;

C. Out-of-state Medicaid inpatient net cost;

D. Out-of-state Medicaid outpatient net cost;

E. Medicaid organ acquisition net cost; and

F. Medicaid/Medicare crossover net cost.

2. Beginning with SFY 2016, the estimated Medicaid net cost is determined from the state DSH survey using the "Report Summary" tab and is calculated as follows:

A. Total Cost of Care for Medicaid IP/OP Services, trended as set forth below in subparagraph (2)(C)3.A.;

B. Less Regular IP/OP Medicaid FFS Rate Payments (excluding any other Medicaid payments as defined in subsection (2)(S)), trended as set forth below in subparagraph (2)(C)3.B.; and

C. Less IP/OP Medicaid MCO Payments, trended as set forth below in subparagraph (2)(C)3.B.

3. The following trends shall be used to determine the trended estimated Medicaid net cost from the state DSH survey:

A. The Total Cost of Care for Medicaid IP/OP Services shall be multiplied by the trend factor(s) listed in 13 CSR 70-15.010 from the year subsequent to the state DSH survey to the current SFY. The first year's trend shall be adjusted to bring the cost to a common fiscal year end of June 30, and the full trends shall be applied for the remaining years.

B. The Regular IP/OP Medicaid FFS Rate Payments (excluding any other Medicaid payments as defined in subsection (2)(S)) and the IP/OP Medicaid MCO Payments shall be trended from the year subsequent to the state DSH survey to the current SFY based upon the industry average percentage change in total Fee for Service (FFS) payments using the division's MMIS data for the second, third, and fourth prior years. The total trend applied to the payments is calculated by multiplying the industry average percentage change by four (4) years (i.e., for the year subsequent to the state DSH survey to the current SFY is four (4) years). The first year's trend shall be adjusted to bring the payments to a common fiscal year end of June 30 and the full trends shall be applied for the remaining years. The industry average percentage change shall be determined and applied separately for IP and OP payments.

(D) Estimated uninsured net cost. Estimated uninsured net cost is the cost of providing inpatient and outpatient hospital services to individuals without health insurance or other third party coverage for the hospital services they receive during the year less uninsured payments received on a cash basis for the applicable Medicaid state plan year. 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.

1. The estimated uninsured net cost determined from the state DSH survey prior to SFY 2016 is calculated as the sum of the following:

A. Uninsured inpatient net cost; and

B. Uninsured outpatient net cost.

2. Beginning with SFY 2016, the estimated uninsured net cost determined from the state DSH survey using the "Report Summary" tab is the Total IP/OP Uninsured Cost of Care less Total IP/OP Indigent Care/Self-Pay Revenues, trended as set forth above in subparagraph (2)(C)3.A.

(E) Estimated uninsured uncompensated care cost (UCC).

1. The estimated uninsured uncompensated care cost from the state DSH survey prior to SFY 2016 is the estimated uninsured net cost less Section 1011 payments.

2. Beginning with SFY 2016, the estimated uninsured uncompensated care cost from the state DSH survey using the "Report Summary" tab is the Estimated Uninsured Net Cost less the Total Applicable Section 1011 Payments.

(F) 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.

(G) Hospital DSH liability. The hospital DSH liability is the amount of DSH overpayments subject to recoupment. It is the lesser 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, other Medicaid payments, and data provided in the most recent independent DSH audit, if applicable, which is used in determining the interim DSH payment adjustments for SFY 2011.

(H) 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, other Medicaid payments, and data provided in the most recent independent DSH audit, if applicable, which is used in determining the interim DSH payments.

(I) Individuals Without Health Insurance or Other Third Party Coverage.

1. Individuals who have no health insurance or other source of third party coverage for the specific inpatient or outpatient hospital services they received during the year can be considered uninsured. As set forth in CMS' final rule published in the *Federal Register*, December 3, 2014, for 42 CFR 447.295, a service-specific approach must be used to determine whether an individual is uninsured. The service-specific coverage determination can occur only once per individual per service provided and applies to the entire service, including all elements as that service, or similar services, would be defined by MO HealthNet. Determination of an individual's third party coverage status is not dependent on receipt of payment by the hospital from the third party.

2. The costs for inpatient and outpatient hospital services provided to individuals without health insurance or other third party coverage can be considered uninsured and included in calculating the hospital-specific DSH limit.

3. The following individuals shall be considered uninsured:

A. Individuals whose benefit package does not cover the hospital service received. If the service is not included in an individual's health benefits coverage through a group health plan or health insurer, and there is no other legally liable third party, the individual is considered uninsured; or

B. Individuals who have reached lifetime insurance limits for certain services or with exhausted insurance benefits at the time of service. When a lifetime or annual coverage limit is imposed by a third party payer, specific services beyond the limit would not be within the individual's health benefit package from that third party payer and would be considered uninsured; or

C. For American Indians/Alaska Natives, Indian Health Services (IHS) and tribal coverage is only considered third party coverage when services are received directly from IHS or tribal health programs or when IHS or a tribal health program has authorized coverage through the contract health service program.

4. The costs associated with the following shall not be included as uninsured costs:

A. Bad debts or unpaid coinsurance/deductibles for individuals with third party coverage. Administrative denials of payment or requirements for satisfaction of deductible, copayment, or coinsurance liability do not affect the determination that a specific service is included in the health benefits coverage; and

B. Prisoners. Individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges are considered to have a source of third party coverage. However, an individual can be included as uninsured if a person has been released from secure custody and is

referred to the hospital by law enforcement or corrections authorities and is admitted as a patient rather than an inmate to the hospital.

5. These definitions, and the resulting uninsured costs includable in calculating the hospital-specific DSH limit, are subject to change based on any changes that may be incorporated in the final publication of 42 CFR 447.295.

(J) Institution for Mental Diseases (IMD) DSH allotment. The IMD DSH allotment is a portion of the state-wide DSH allotment and is the maximum amount set by the federal government that may be paid to IMD hospitals. Any unused IMD DSH allotment not paid to IMD hospitals for any plan year may be paid to hospitals that are under their projected hospital-specific DSH limit.

(K) 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.

(L) Lifetime or annual health insurance coverage limit. An annual or lifetime limit, imposed by a third party payer, that establishes a maximum dollar value, or maximum number of specific services on a lifetime or annual basis, for benefits received by an individual.

(M) Longfall. The longfall is the total amount a hospital has been paid (including all DSH payments) in excess of their hospital-specific DSH limit. 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, other Medicaid payments, and data provided in the most recent independent DSH audit, if applicable.

(N) Low Income Utilization Rate (LIUR). The LIUR shall be calculated as follows:

1. As determined from the fourth prior year desk-reviewed cost report, the LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

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

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

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

(O) Medicaid Inpatient Utilization Rate (MIUR). The MIUR shall be calculated as follows:

1. As determined from the fourth prior year desk-reviewed cost report, the MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID); and

2. The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded.

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

(P) 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.

(Q) Medicare cost reporting methodologies. Medicaid and uninsured costs will be determined utilizing Medicare Cost Report (form CMS 2552) methodologies. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996 and prior to May 1, 2010. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010. If the Medicare CMS 2552-10 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. The Medicaid Cost Report is completed using the Medicare Cost Report form CMS 2552 using the Medicare cost reporting methodologies. The only difference between the Medicare and Medicaid Cost Report is that the Federal Reimbursement Allowance (FRA) (i.e., the Missouri hospital provider tax) is not reflected in the cost in the Medicaid Cost Report. 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 or the Medicaid Cost Report, as applicable. Costs such as the Missouri Medicaid hospital provider tax 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.

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

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

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

(U) 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.

(V) 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, other Medicaid payments, and data provided in the most recent independent DSH audit, if applicable.

(W) 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, or the same as, 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 (3) and the SFY 2012 interim DSH payments set forth in section (4).

2. Version 2 (9/11) or Version 3 (2/12). The hospital may elect to complete either Version 2 (9/11) or Version 3 (2/12) on which its SFY 2013 interim DSH payments will be calculated. 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.

3. Version 3 (2/12) will be used to calculate interim DSH payments beginning with SFY 2014 as set forth in section (4). The survey shall be referred to as the SFY to which payments will relate.

4. Version 4, designated as Myers and Stauffer LC, DSH Version 7.10, will be used to calculate interim DSH payments beginning with SFY 2016 as set forth in section (4). The state DSH survey shall be the most recent DSH survey collected during the independent DSH audit of the fourth prior SFY (i.e., the most recent survey collected by the independent DSH auditor for the SFY 2012 independent DSH audit will also be used to calculate the interim DSH payment for SFY 2016). If Myers and Stauffer LC, DSH Version 7.10, is superseded by an alternate state DSH survey reporting tool, that tool must be used for the applicable SFY. The survey shall be referred to as the SFY to which payments will relate.

(X) 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.

(Y) 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 by revenues received from Medicaid (not including DSH payments), Medicare, private pay, managed care, self pay, other third parties, 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 without health insurance or other third-party coverage as defined in this rule, consistent with 42 CFR 447.

(Z) 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.

*[(4)]***(3)** 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 **other** 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 **other** 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*[.]***; and**

(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*[.]***; and**

(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)]***(3)**(A)1.A., *[(4)]***(3)**(A)1.B., and *[(4)]***(3)**(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)]***(3)**(A)1.A., *[(4)]***(3)**(A)1.B., and *[(4)]***(3)**(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)]***(3)**(A)1.D.(I) for each hospital plus the combined amount determined in part *[(4)]***(3)**(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)]***(3)**. 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)]***(6)**.

(B) Any payments that are recouped from hospitals as a result of the state's calculation in subsection *[(4)]***(3)**(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)]***(4)** *[Disproportionate Share Hospital (DSH)]* Interim **DSH** 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 **other** 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 **other** 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 **calculated in accordance with subsection (2)(C)***[.]***;**

B. Less estimated **other** 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 **calculated in accordance with subsection (2)(E)***[.]***; and**

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*[.]***; and**

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]* **their estimated payments for the SFY** are expected to exceed their estimated hospital-specific DSH limit; and

4. Qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments (costs exceed payments) will receive interim DSH payments. The interim DSH payments are subject to the federal DSH allotment and the estimated hospital-specific DSH limits **less estimated OOS DSH payments**. 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]* **to each hospital with a positive estimated UCC net of OOS DSH payments, and the allocation shall result in each hospital receiving the same percentage of their estimated UCC net of OOS DSH payments. The allocation percentage will be calculated at the beginning of the SFY by dividing the available federal DSH allotment to be distributed by the total hospital industry's 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.

(C) Hospitals may elect not to receive an interim DSH payment for a SFY by completing a DSH Waiver form. Hospitals that elect not to receive an interim DSH payment for a SFY must notify the division, or its authorized agent, that it elects not to receive an interim DSH payment for the upcoming SFY. If a hospital does not receive an interim DSH payment for a SFY, it will not be included in the independent DSH audit related to that SFY and will not be eligible for final DSH audit payment adjustments related to that SFY unless it submits a request to the division to be included in the independent DSH audit.

*[(C)]***(D)** Hospitals may elect to receive an upper payment limit payment as defined in 13 CSR 70-15.230 in lieu of DSH payments. Hospitals that elect to receive an upper payment limit payment rather than a DSH payment must submit a request to the MO HealthNet Division on an annual basis. **If a hospital does not receive an interim DSH payment for a SFY, it will not be included in the independent DSH audit related to that SFY, and will not be eligible for final DSH audit payment adjustments related to that SFY unless it submits a request to the division to be included in the independent DSH audit.**

*[(D)]***(E)** Disproportionate share payments will coincide with the semimonthly claim payment schedule.

*[(E)]***(F)** New facilities that do not have a Medicare/**Medicaid** cost report on which to base the state DSH survey will be paid the lesser of the estimated hospital-specific DSH limit **less OOS DSH payments** based on the estimated state DSH survey or the industry average estimated interim DSH payment. The industry average estimated interim DSH payment**,** as determined from subsection *[(5)]***(4)**(B)**,** is 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 **interim** 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)]***(4)**(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 **less OOS DSH payments**.

*[(6)]***(5)** Department of Mental Health Hospital (DMH) DSH Adjustments and Payments.

(A) Effective June 1, 2011, interim DSH payments made to DMH hospitals will be revised based on the results of a DMH state DSH survey which uses federally-mandated DSH audit standards. These revisions are to serve as interim adjustments until the federally-mandated DSH audits are complete in 2014.

(B) Beginning in SFY 2012, due to structural changes occurring at the DMH facilities, interim DSH payments will be based on the third prior base year cost report trended to the current SFY adjusted for the federal reimbursement allowance (FRA) assessment paid by DMH hospitals. The interim DSH payments calculated using the third prior base year cost report may be revised based on the results of a DMH state DSH survey. Additional adjustments may be done based on the results of the federally-mandated DSH audits as set forth below in subsection *[(7)]***(6)**(A).

(C) If the Medicaid program's original DSH payments did not fully expend the federal Institute for Mental Disease (IMD) DSH allotment for any plan year, the remaining IMD DSH allotment may be paid to hospitals that are under their projected hospital-specific DSH limit.

*[(7)]***(6)** 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**. The hospital's DSH liability shown on the final independent DSH audit report, that is required to be submitted to CMS by December 31, will be due to the division by March 31 of the following year**;

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 **less OOS DSH payments**;

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**. The state share of the final DSH recoupments that has not been redistributed to hospitals with DSH shortfalls may be used to make a hospital upper payment limit payment and/or a state-only Quality Improvement payment to all non-DMH hospitals. The state-only Quality Improvement payment will be paid proportionally to non-DMH hospitals based on the number of hospital staffed beds to total staffed beds for the same state fiscal year the final DSH adjustment relates to. Staffed beds are reported on the Missouri Annual Licensing Survey which is mandated by the Department of Health and Senior Services in accordance with 19 CSR 10-33.030**; 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 **less OOS DSH payments**.

*[(8)]***(7)** Record Retention.

(A) Records used to complete the state's DSH survey shall be kept until the final audit is completed. For example, the SFY 2011 state DSH survey will use 2009 cost data which must be maintained until the 2014 DSH audits are completed in SFY 2015.

(B) Records provided by hospitals to the state's independent auditor shall also be maintained until the *[2014]* federal **independent** DSH audit is complete.

*[(9)]***(8)** State DSH Survey Reporting Requirements.

(A) **Prior to SFY 2016,** *[E]*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 31 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 adjusted to reflect anticipated operations for the interim DSH payment period. The historical Medicare cost report data may be adjusted for inflationary trends, volume adjustments, changes in reimbursement methodology, and/or other business decisions (i.e., expanded or terminated services, etc.) 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.

1. If a new facility does not have a third prior year Medicare cost report, the state DSH survey shall be completed using the second prior year Medicare cost report, if available, adjusted to reflect anticipated operations for the interim DSH payment period.

2. If a new facility does not have a second prior year Medicare cost report, the state DSH survey shall be completed using the prior year Medicare cost report, if available, adjusted to reflect anticipated operations for the interim DSH payment period.

3. If a new facility does not have a prior year Medicare cost report, the state DSH survey shall be completed using facility projections to reflect anticipated operations for the interim DSH payment period. Interim DSH payments determined from this state DSH survey are limited to the industry average estimated interim DSH payment as set forth in subsection *[(5)(E)]***(4)(F)**.

(B) Beginning with SFY 2016, each hospital must complete and submit the state DSH survey set forth in paragraph (2)(W)4. to the independent DSH auditor, the MO HealthNet Division's authorized agent, in order to be considered for an interim DSH payment. The state DSH survey is due to the independent DSH auditor by the March 1 preceding the beginning of each state fiscal year (i.e., the state DSH survey used for SFY 2016 interim DSH payments will be due to the independent DSH auditor by March 1, 2015). Hospitals that do not submit the state DSH survey by March 1 will not be eligible to receive an interim DSH payment for that SFY.

1. A new facility that does not have cost report data for the fourth prior year may complete the state DSH survey using actual, untrended cost and payment data from the most recent twelve- (12-) month cost report filed with the division.

2. A new facility that has not yet filed a Medicaid cost report with the division may complete the state DSH survey using facility projections to reflect anticipated operations for the interim DSH payment period. Trends shall not be applied to the data used to complete the state DSH survey. Interim DSH payments determined from this state DSH survey are limited to the industry average estimated interim DSH payment as set forth in subsection (4)(F).

3. Hospitals may elect not to receive an interim DSH payment for a SFY by completing a DSH Waiver form. Hospitals that elect not to receive an interim DSH payment for a SFY must notify the division, or its authorized agent, that it elects not to receive an interim DSH payment for the upcoming SFY. If a hospital does not receive an interim DSH payment for a SFY, it will not be included in the independent DSH audit related to that SFY, and will not be eligible for final DSH audit payment adjustments related to that SFY unless it submits a request to the division to be included in the independent DSH audit.

4. If a hospital received an interim DSH payment and later determined that it did not have uncompensated care costs for Medicaid and the uninsured to support part or all the interim DSH payment that it received or is receiving, the hospital may request that the interim DSH payments be stopped or it may return the entire interim DSH payment it received.

5. Extraordinary Circumstances. A hospital may submit a request to the division to complete the state DSH survey using the actual, untrended cost and payment data from the most recent twelve- (12-) month cost report filed with the division in lieu of the fourth prior year if it experiences extraordinary circumstances. The division may, at its discretion and for good cause shown, accept such survey and use it in determining the interim DSH payment for the upcoming SFY. The request must be submitted to the division within fourteen (14) days of receiving the state DSH survey template for the SFY and include an explanation of the extraordinary circumstance, the impact it had on the state DSH survey period, and how it causes the data to be materially misstated or unrepresentative. The division shall review the facility's request and notify the facility of its decision regarding the request. The state DSH survey shall be completed using the data period approved by the division and is due by the March 1 preceeding the beginning of each SFY.

A. Extraordinary circumstances include unavoidable circumstances that are beyond the control of the facility and include the following:

(I) Act of nature (i.e., tornado, hurricane, flooding, earthquake, lightening, natural wildfire, etc.);

(II) War;

(III) Civil disturbance; or

(IV) If the data to complete the state DSH survey set forth in paragraph (2)(W)4. is not available due to a change in ownership because the prior owner is out of business and is uncooperative and unwilling to provide the necessary data.

B. A change in hospital operations or services (i.e., terminating or adding a service or a hospital wing; or, a change of owner, except as noted in part (8)(B)5.A.(IV), manager, control, operation, leaseholder or leasehold interest, or Medicare provider number by whatever form for any hospital previously certified at any time for participation in the MO HealthNet program, etc.) does not constitute an extraordinary circumstance.

6. Interim DSH Payment Adjustment. A hospital may request an adjustment to its interim DSH payment if it can provide a revised state DSH survey completed using actual, untrended cost and payment data from the most recent twelve- (12-) month cost report filed with the division that demonstrates the hospital's revised estimated hospital-specific DSH limit is materially different from the estimated hospital-specific DSH limit calculated by the division. The division may, at its discretion and for good cause shown, accept such survey and use it in determining a revised interim DSH payment for the SFY. The division will process interim DSH payment adjustments once a year. After all requests are received, the division will determine whether revisions to the interim DSH payments are appropriate. Any revisions to the interim DSH payments are subject to the unobligated DSH allotment remaining for the SFY and availability of state funds.

A. The request must meet the following criteria to be considered:

(I) The request must be submitted by December 31 of the current SFY for which interim DSH payments are being made;

(II) The request must be accompanied by a completed, revised state DSH survey based on actual, untrended cost and payment data from the most recent twelve- (12-) month cost report filed with the division;

(III) The request must include an explanation of the change in the hospital's operations, services, or other circumstances causing the original state DSH survey to be materially misstated or unrepresentative, including the impact it had on the state DSH survey period and how it causes the data to be materially misstated or unrepresentative; and

(IV) The revised estimated hospital-specific DSH limit must be at least eighty percent (80%) higher than the estimated hospital-specific DSH limit calculated by the division. No trends shall be applied to the revised state DSH survey in determining the revised estimated hospital-specific DSH limit.

B. Interim DSH payment adjustments will be calculated as follows:

(I) The DSH allotment for the SFY that has not otherwise been obligated will be distributed proportionally to the hospitals determined to meet the above criteria, based on the revised estimated hospital-specific DSH limit, less OOS DSH payments, subject to the availability of state funds.

[(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 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 without health insurance or other third party coverage for the hospital services they receive during the year less uninsured payments received on a cash basis for the applicable Medicaid state plan year. 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) Individuals Without Health Insurance or Other Third Party Coverage.

1. Individuals who have no health insurance or other source of third party coverage for the specific inpatient or outpatient hospital services they received during the year can be considered uninsured. As set forth in CMS' proposed rule published in the Federal Register, January 18, 2012, for 42 CFR 447.295, a service-specific approach must be used to determine whether an individual is uninsured. The service-specific coverage determination can occur only once per individual per service provided and applies to the entire service, including all elements as that service, or similar services, would be defined by MO HealthNet. Determination of an individual's third party coverage status is not dependent on receipt of payment by the hospital from the third party.

2. The costs for inpatient and outpatient hospital services provided to individuals without health insurance or other third party coverage can be considered uninsured and included in calculating the hospital-specific DSH limit.

3. The following individuals shall be considered uninsured:

A. Individuals whose benefit package does not cover the hospital service received. If the service is not included in an individual's health benefits coverage through a group health plan or health insurer, and there is no other legally liable third party, the individual is considered uninsured; or

B. Individuals who have reached lifetime insurance limits for certain services or with exhausted insurance benefits at the time of service. When a lifetime or annual coverage limit is imposed by a third party payer, specific services beyond the limit would not be within the individual's health benefit package from that third party payer and would be considered uninsured; or

C. For American Indians/Alaska Natives, Indian Health Services (IHS) and tribal coverage is only considered third party coverage when services are received directly from IHS or tribal health programs or when IHS or a tribal health program has authorized coverage through the contract health service program.

4. The costs associated with the following shall not be included as uninsured costs:

A. Bad debts or unpaid coinsurance/deductibles for individuals with third party coverage. Administrative denials of payment or requirements for satisfaction of deductible,

copayment, or coinsurance liability do not affect the determination that a specific service is included in the health benefits coverage; and

B. Prisoners. Individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges are considered to have a source of third party coverage. However, an individual can be included as uninsured if a person has been released from secure custody and is referred to the hospital by law enforcement or corrections authorities and is admitted as a patient rather than an inmate to the hospital.

5. These definitions, and the resulting uninsured costs includable in calculating the hospital-specific DSH limit, are subject to change based on any changes that may be incorporated in the final publication of 42 CFR 447.295.

(I) Institution for Mental Diseases (IMD) DSH allotment. The IMD DSH allotment is a portion of the state-wide DSH allotment and is the maximum amount set by the federal government that may be paid to IMD hospitals. Any unused IMD DSH allotment not paid to IMD hospitals for any plan year may be paid to hospitals that are under their projected hospital-specific DSH limit.

(J) 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.

(K) Lifetime or annual health insurance coverage limit. An annual or lifetime limit, imposed by a third party payer, that establishes a maximum dollar value, or maximum number of specific services on a lifetime or annual basis, for benefits received by an individual.

(L) 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.

(M) 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.

(N) 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.

(O) 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.

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

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

(R) 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.

(S) 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.

(T) 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) or Version 3 (2/12). The hospital may elect to complete either Version 2 (9/11) or Version 3 (2/12) on which its SFY 2013 interim DSH payments will be calculated. 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.

3. Version 3 (2/12) will be used to calculate interim DSH payments beginning with SFY 2014 as set forth in section (5). The survey shall be referred to as the SFY to which payments will relate.

(U) 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.

(V) 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 without health insurance or other third-party coverage as defined in this rule, consistent with 42 CFR 447.

(W) 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.]

*AUTHORITY: sections 208.152, 208.153, and 208.201, RSMo Supp. [2011] **2014**, and section 208.158, RSMo 2000. Emergency rule filed May 20, 2011, effective June 1, 2011, expired Nov. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012. Emergency amendment filed June 20, 2012, effective July 1, 2012, expired Dec. 28, 2012. Amended: Filed April 2, 2012, effective Oct. 30, 2012. Amended: Filed Jan. 13, 2015.*

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

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

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

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 400—Life, Annuities and Health
Chapter 1—Life Insurance and Annuity Standards

PROPOSED AMENDMENT

20 CSR 400-1.130 Annuity Mortality Tables for Use in Determining Reserve Liabilities for Annuities. The director is amending the existing sections (1) through (5), adding a new section (3), and adding Appendices I through IV.

PURPOSE: This amendment changes the actuarial table to be used in determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2016, except as provided in subsection (2)(E) of this rule as amended.

(1) Definitions.

(A) As used in this rule*[,]* **"**1983 Table A**"** means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners.

(B) As used in this rule **"**1983 Group Annuity Mortality (GAM) Table**"** means that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners.

(C) As used in this rule **"**1994 Group Annuity Reserving (GAR) Table**"** means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force. The 1994 GAR Table is included in the report on pages 865-919 of Volume XLVII of the "Transactions of the Society of Actuaries (1995)."

(D) As used in this rule **"**Annuity 2000 Mortality Table**"** means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research. The Annuity 2000 Mortality Table is included in the report on pages 211-249 of Volume XLVII of the "Transactions of the Society of Actuaries (1995)."

(E) As used in this rule "period table" means a table of mortality rates applicable to a given calendar year (the period).

(F) As used in this rule "generational mortality table" means a mortality table containing a set of mortality rates that decrease for a given age from one (1) year to the next based on a combination of a period table and a projection scale containing rates of mortality improvement.

(G) As used in this rule "2012 IAR Table" means that generational mortality table developed by the Society of Actuaries Committee on Life Insurance Research and containing rates, q_x^{2012+n}, derived from a combination of the 2012 IAM Period Table and Projection Scale G2, using the methodology stated in section (3).

(H) As used in this rule "2012 Individual Annuity Mortality Period Life (2012 IAM Period) Table," included herein, means the period table containing loaded mortality rates for calendar year 2012. This table contains rates, q_x^{2012}, developed by the Society of Actuaries Committee on Life Insurance Research and is shown in Appendices I and II.

(I) As used in this rule "Projection Scale G2 (Scale G2)," included herein, is a table of annual rates, $G2_x$, of mortality improvement by age for projecting future mortality rates beyond calendar year 2012. This table was developed by the Society of Actuaries Committee on Life Insurance Research and is shown in Appendices III and IV.

(2) Individual Annuity or Pure Endowment Contracts.

(C) Except as provided in subsections (D) **and (E)** of this section, the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1 *[of the year following the effective date of this rule]***, 2001**.

(D) Except as provided in subsection (E) of this section, the 2012 IAR Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2016.

*[(D)]***(E)** The 1983 Table A without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after January 1 *[of the year following the effective date of this rule]*, **2001,** solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

1. Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

2. Settlements involving similar actions such as workers' compensation claims; or

3. Settlements of long-term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

(3) Application of the 2012 IAR Table.

In using the 2012 IAR Table, the mortality rate for a person aged x in year (2012+n) is calculated as follows:

$$q_x^{2012+n} = q_x^{2012}(1 - G2_x)^n$$

where the q_x^{2012} and $G2_x$ are as specified in the 2012 IAM Period Table and Scale G2, Appendices I-IV.

The result q_x^{2012+n} shall be rounded to three decimal places per 1,000, e.g., 0.741 deaths per 1,000. Also, the rounding shall occur according to the formula above, starting at the 2012 period table rate. For example, it is incorrect to use an already rounded q_x^{2012+n} to calculate $q_x^{2012+n+1}$.

*[(3)]***(4)** Group Annuity or Pure Endowment Contracts.

(A) Except as provided in subsection (B) and (C) of this section, the 1983 GAM Table, the 1983 Table A and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one **(1)** of these table may be used for purposes of valuation for any annuity or pure endowment purchased on or after September 28, 1979, under a group annuity or pure endowment contract.

(B) Except as provided in subsection (C) of this section, either the 1983 GAM Table or the 1994 GAR Table is to be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1987 under a group annuity or pure endowment contract.

(C) The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1 of the year following the effective date of this rule under a group annuity or pure endowment contract.

*[(4)]***(5)** Application of the 1994 GAR Table. In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 + n) is calculated as follows:

$$q_x^{\underline{1994+n}} = q_x^{\underline{1994}}(1\text{-}AA_x)^{\underline{n}}$$

where the $q_x^{\underline{1994}}$*[s]* and AA_x*[s]* are as specified in the 1994 GAR Table.

*[(5)]***(6)** Separability. If any provision of this rule or the application of this rule to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of that provision to other persons or circumstances shall not be affected by it.

APPENDIX I

2012 IAM Period Table
Female, Age Nearest Birthday

AGE	1000 * q_x^{2012}	AGE	1000 * q_x^{2012}	AGE	1000 * q_x^{2012}	AGE	1000 * q_x^{2012}
0	1.621	30	0.300	60	3.460	90	88.377
1	0.405	31	0.321	61	3.916	91	97.491
2	0.259	32	0.338	62	4.409	92	107.269
3	0.179	33	0.351	63	4.933	93	118.201
4	0.137	34	0.365	64	5.507	94	130.969
5	0.125	35	0.381	65	6.146	95	146.449
6	0.117	36	0.402	66	6.551	96	163.908
7	0.110	37	0.429	67	7.039	97	179.695
8	0.095	38	0.463	68	7.628	98	196.151
9	0.088	39	0.504	69	8.311	99	213.150
10	0.085	40	0.552	70	9.074	100	230.722
11	0.086	41	0.600	71	9.910	101	251.505
12	0.094	42	0.650	72	10.827	102	273.007
13	0.108	43	0.697	73	11.839	103	295.086
14	0.131	44	0.740	74	12.974	104	317.591
15	0.156	45	0.780	75	14.282	105	340.362
16	0.179	46	0.825	76	15.799	106	362.371
17	0.198	47	0.885	77	17.550	107	384.113
18	0.211	48	0.964	78	19.582	108	400.000
19	0.221	49	1.051	79	21.970	109	400.000
20	0.228	50	1.161	80	24.821	110	400.000
21	0.234	51	1.308	81	28.351	111	400.000
22	0.240	52	1.460	82	32.509	112	400.000
23	0.245	53	1.613	83	37.329	113	400.000
24	0.247	54	1.774	84	42.830	114	400.000
25	0.250	55	1.950	85	48.997	115	400.000
26	0.256	56	2.154	86	55.774	116	400.000
27	0.261	57	2.399	87	63.140	117	400.000
28	0.270	58	2.700	88	71.066	118	400.000
29	0.281	59	3.054	89	79.502	119	400.000
						120	1000.000

APPENDIX II

2012 IAM Period Table
Male, Age Nearest Birthday

AGE	1000 * q_x^{2012}	AGE	1000 * q_x^{2012}	AGE	1000 * q_x^{2012}	AGE	1000 * q_x^{2012}
0	1.605	30	0.741	60	5.096	90	109.993
1	0.401	31	0.751	61	5.614	91	123.119
2	0.275	32	0.754	62	6.169	92	137.168
3	0.229	33	0.756	63	6.759	93	152.171
4	0.174	34	0.756	64	7.398	94	168.194
5	0.168	35	0.756	65	8.106	95	185.260
6	0.165	36	0.756	66	8.548	96	197.322
7	0.159	37	0.756	67	9.076	97	214.751
8	0.143	38	0.756	68	9.708	98	232.507
9	0.129	39	0.800	69	10.463	99	250.397
10	0.113	40	0.859	70	11.357	100	268.607
11	0.111	41	0.926	71	12.418	101	290.016
12	0.132	42	0.999	72	13.675	102	311.849
13	0.169	43	1.069	73	15.150	103	333.962
14	0.213	44	1.142	74	16.860	104	356.207
15	0.254	45	1.219	75	18.815	105	380.000
16	0.293	46	1.318	76	21.031	106	400.000
17	0.328	47	1.454	77	23.540	107	400.000
18	0.359	48	1.627	78	26.375	108	400.000
19	0.387	49	1.829	79	29.572	109	400.000
20	0.414	50	2.057	80	33.234	110	400.000
21	0.443	51	2.302	81	37.533	111	400.000
22	0.473	52	2.545	82	42.261	112	400.000
23	0.513	53	2.779	83	47.441	113	400.000
24	0.554	54	3.011	84	53.233	114	400.000
25	0.602	55	3.254	85	59.855	115	400.000
26	0.655	56	3.529	86	67.514	116	400.000
27	0.688	57	3.845	87	76.340	117	400.000
28	0.710	58	4.213	88	86.388	118	400.000
29	0.727	59	4.631	89	97.634	119	400.000
						120	1000.000

APPENDIX III

Projection Scale G2
Female, Age Nearest Birthday

AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$
0	0.010	30	0.010	60	0.013	90	0.006
1	0.010	31	0.010	61	0.013	91	0.006
2	0.010	32	0.010	62	0.013	92	0.005
3	0.010	33	0.010	63	0.013	93	0.005
4	0.010	34	0.010	64	0.013	94	0.004
5	0.010	35	0.010	65	0.013	95	0.004
6	0.010	36	0.010	66	0.013	96	0.004
7	0.010	37	0.010	67	0.013	97	0.003
8	0.010	38	0.010	68	0.013	98	0.003
9	0.010	39	0.010	69	0.013	99	0.002
10	0.010	40	0.010	70	0.013	100	0.002
11	0.010	41	0.010	71	0.013	101	0.002
12	0.010	42	0.010	72	0.013	102	0.001
13	0.010	43	0.010	73	0.013	103	0.001
14	0.010	44	0.010	74	0.013	104	0.000
15	0.010	45	0.010	75	0.013	105	0.000
16	0.010	46	0.010	76	0.013	106	0.000
17	0.010	47	0.010	77	0.013	107	0.000
18	0.010	48	0.010	78	0.013	108	0.000
19	0.010	49	0.010	79	0.013	109	0.000
20	0.010	50	0.010	80	0.013	110	0.000
21	0.010	51	0.010	81	0.012	111	0.000
22	0.010	52	0.011	82	0.012	112	0.000
23	0.010	53	0.011	83	0.011	113	0.000
24	0.010	54	0.011	84	0.010	114	0.000
25	0.010	55	0.012	85	0.010	115	0.000
26	0.010	56	0.012	86	0.009	116	0.000
27	0.010	57	0.012	87	0.008	117	0.000
28	0.010	58	0.012	88	0.007	118	0.000
29	0.010	59	0.013	89	0.007	119	0.000
						120	0.000

APPENDIX IV

Projection Scale G2
Male, Age Nearest Birthday

AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$	AGE	$G2_x$
0	0.010	30	0.010	60	0.015	90	0.007
1	0.010	31	0.010	61	0.015	91	0.007
2	0.010	32	0.010	62	0.015	92	0.006
3	0.010	33	0.010	63	0.015	93	0.005
4	0.010	34	0.010	64	0.015	94	0.005
5	0.010	35	0.010	65	0.015	95	0.004
6	0.010	36	0.010	66	0.015	96	0.004
7	0.010	37	0.010	67	0.015	97	0.003
8	0.010	38	0.010	68	0.015	98	0.003
9	0.010	39	0.010	69	0.015	99	0.002
10	0.010	40	0.010	70	0.015	100	0.002
11	0.010	41	0.010	71	0.015	101	0.002
12	0.010	42	0.010	72	0.015	102	0.001
13	0.010	43	0.010	73	0.015	103	0.001
14	0.010	44	0.010	74	0.015	104	0.000
15	0.010	45	0.010	75	0.015	105	0.000
16	0.010	46	0.010	76	0.015	106	0.000
17	0.010	47	0.010	77	0.015	107	0.000
18	0.010	48	0.010	78	0.015	108	0.000
19	0.010	49	0.010	79	0.015	109	0.000
20	0.010	50	0.010	80	0.015	110	0.000
21	0.010	51	0.011	81	0.014	111	0.000
22	0.010	52	0.011	82	0.013	112	0.000
23	0.010	53	0.012	83	0.013	113	0.000
24	0.010	54	0.012	84	0.012	114	0.000
25	0.010	55	0.013	85	0.011	115	0.000
26	0.010	56	0.013	86	0.010	116	0.000
27	0.010	57	0.014	87	0.009	117	0.000
28	0.010	58	0.014	88	0.009	118	0.000
29	0.010	59	0.015	89	0.008	119	0.000
						120	0.000

*AUTHORITY: section[s] 374.045, RSMo Supp. [1999] **2014,** and **section** 376.380, RSMo [Supp. 1994] **2000**. This rule was previously filed as 4 CSR 190-13.270. Original rule filed April 2, 1986, effective Aug. 25, 1986. Amended: Filed June 23, 2000, effective Dec. 30, 2000. Amended: Filed Jan. 15, 2015.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Kelly A. Hopper, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for 10:00 AM, March 20, 2015, at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri.*

SPECIAL NEEDS: If you have any special needs addressed by the Americans with Disabilities Act, please notify us at (573) 751-2619 at least five (5) working days prior to the hearing.

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

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

Title 1—OFFICE OF ADMINISTRATION
Division 10—Commissioner of Administration
Chapter 4—Vendor Payroll Deduction Regulations

ORDER OF RULEMAKING

By the authority vested in the Commissioner of the Office of Administration under sections 33.103, 536.010, and 536.023, RSMo Supp. 2014, and section 370.395, RSMo 2000, the commissioner amends a rule as follows:

1 CSR 10-4.010 State of Missouri Vendor Payroll Deductions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 3, 2014 (39 MoReg 1658). 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 1—OFFICE OF ADMINISTRATION
Division 10—Commissioner of Administration
Chapter 15—Cafeteria Plan

ORDER OF RULEMAKING

By the authority vested in the Commissioner of the Office of Administration under section 33.103, RSMo Supp. 2014, the commissioner amends a rule as follows:

1 CSR 10-15.010 Cafeteria Plan **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 3, 2014 (39 MoReg 1658–1734). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 100—Petroleum Storage Tank Insurance Fund Board of Trustees
Chapter 5—Claims

ORDER OF RULEMAKING

By the authority vested in the Board of Trustees for the Petroleum Storage Tank Insurance Fund (PSTIF) under section 319.129, RSMo Supp. 2014, the Board of Trustees amends a rule as follows:

10 CSR 100-5.010 Claims for Cleanup Costs **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 2, 2014 (39 MoReg 1443–1445). 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 of Trustees received twelve (12) comments on the proposed amendment from five (5) persons.

COMMENTS #1, #2, #3, and #4: David Pate with Industrial Petroleum Environmental Services and Jason Smith with Environmental Works, Inc., supported the proposed change to paragraph (8)(B)1. requiring cost estimates for site characterization to include a site conceptual model. Joe Leahy with Smith & Company Engineers opposed this change; Bruce Wylie with American Council of Engineering Companies of Missouri also opposed this change but said his organization encourages the preliminary development of a site conceptual model at the beginning stages of a project and refinement of the model as additional information is obtained.

RESPONSE: The board concurs with Messrs. Pate and Smith. The board notes that both the 2004 and 2013 versions of the Department of Natural Resources' Risk-Based Guidance for Tank Sites state that, following confirmation of a release, the first step of a risk-based decision-making process is development of a site conceptual model to guide data collection and assist in overall management of the environmental project.

Mr. Wylie acknowledges this is standard practice among engineering professionals and refers to a site conceptual model as a "foundational tenet" of risk-based decision-making. The board observes that petroleum tank releases are typically confirmed in one (1) of three (3) ways: during a Phase II Assessment, during removal or permanent closure of tanks/piping, or as a result of a site check to investigate a suspected release. In all three (3) cases, information is readily available with which to initially conceptualize risks and plan sampling activities. Both Mr. Leahy and Mr. Wylie err in alleging that such planning costs are not reimbursed by the PSTIF; they routinely are.

The board made no changes in response to these comments.

COMMENTS #5, #6, and #7: David Pate with Industrial Petroleum Environmental Services supported the proposed change to paragraph (8)(B)1. requiring cost estimates for site characterization to include conclusions regarding current and reasonably anticipated future land use. Joe Leahy with Smith & Company Engineers and Bruce Wylie with American Council of Engineering Companies of Missouri opposed this change.
RESPONSE: An evaluation of land use is part of a site conceptual model; thus, the comments regarding this change are closely related to the previous comments regarding submittal of a site conceptual model. The board concurs with Mr. Pate that clearly presenting land use conclusions in cost estimates will result in more efficient and cost-effective investigations. The board notes state law, (section 319.109, RSMo), specifies that the requirements imposed by the state on persons responding to releases from regulated underground storage tanks must be based on land use. In addition, the Department of Natural Resources' implementing regulations and guidance specify that site characterization and cleanup activities must be based on land use. Mr. Leahy and Mr. Wylie acknowledge such conclusions are "foundational" or "core" tenets of risk-based decision-making and opine that environmental professionals must come to conclusions regarding land use – be they tentative or final – as part of their initial planning process; the board concurs and believe these arguments support the board's rationale for its rule. Mr. Leahy and Mr. Wylie also note that an environmental professional may conduct successive rounds of site characterization, during which time the site conceptual model and conclusions regarding land use may be modified; the board concurs. Mr. Wylie even notes the amendment does not prohibit refinement of the site conceptual model over time; the board concurs, has observed this occurring on numerous files, and is confident that both the environmental professionals managing these projects and the Department of Natural Resources' staff overseeing the projects will assure that thorough risk assessments are completed for petroleum tank releases. Both Mr. Leahy and Mr. Wylie err in alleging that planning costs are not reimbursed by the PSTIF; they routinely are. The board has made no change in response to these comments.

COMMENT #8: David Pate with Industrial Petroleum Environmental Services supported the proposed change to (8)(D)3. to add language regarding the salvage value of remediation equipment.
RESPONSE: The board appreciates Mr. Pate's support of this change and concurs that the amendment will clarify its policy on this issue.

COMMENT #9: Joe Leahy with Smith & Company Engineers opposed the requirement to submit multiple cost estimates for corrective action.
RESPONSE: The board's claims rule has always required fund participants and beneficiaries to obtain and submit enough proposals to assure a cost-effective approach and has always clearly stated that the board may require multiple proposals. The board's rule is actually more flexible in this regard than the prior rules governing fund operations, which required a minimum of three bids for all work. The amendment makes no change to this longstanding requirement; it simply clarifies such proposals may include the various approaches allowed by the Department of Natural Resources' rules governing risk-based cleanups. No change has been made in response to this comment.

COMMENTS #10 and #11: Bruce Wylie with American Council of Engineering Companies of Missouri and Rick Elgin with Midwest Environmental Consultants requested a change to administrative procedures to allow electronic submittal of documents in lieu of paper submittals.
RESPONSE: The rule does not address how documents are to be sent to the board's office; the board believes this is an administrative issue which does not require regulatory language. While the board supports efforts to "go paperless," its current contract with its service provider requires PSTIF files to be maintained in paper form; thus, the service provider requires submittal of most documents in paper form to a central mail box. The board will consider this issue as it plans future operations.

COMMENT #12: Joe Leahy with Smith & Company Engineers suggested the board should increase its coverage limit.
RESPONSE: The rule does not address coverage limits; they are set by state statute and thus cannot be changed by the Board of Trustees. No change has been made in response to this comment.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 100—Petroleum Storage Tank Insurance Fund Board of Trustees
Chapter 6—UST Operator Training

ORDER OF RULEMAKING

By the authority vested in the Board of Trustees for the Petroleum Storage Tank Insurance Fund under section 319.130, RSMo Supp. 2014, the Board of Trustees adopts a rule as follows:

10 CSR 100-6.010 UST Operator Training **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 2, 2014 (39 MoReg 1445–1450). 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: One (1) person submitted three (3) comments on the proposed rule to the Board of Trustees.

COMMENT #1: Timothy Ganz with Missouri American Water Company asked whether a facility will be required to have at least one (1) Class A/B operator and at least one (1) Class C operator, and whether the same person can serve as both.
RESPONSE: The board's rule does not specify how many Class A/B operators or Class C operators there must be for a UST facility. Rather, it specifies that persons who have certain responsibilities must be trained. The board anticipates some facility owners will designate the same individual as both their Class A/B and Class C operator.

COMMENT #2: Mr. Ganz also suggested sample test questions be made available to prospective trainees.
RESPONSE: The Board of Trustees engaged a contractor to create web-based courses and tests, which are available free of charge on the board's website. By accessing these, a person can view test questions at any time. The courses and tests allow users to retake them if they fail to receive a passing score the first time; the board believes this adequately responds to Mr. Ganz' suggestion.

COMMENT #3: Mr. Ganz also asked whether a certificate will be issued and, if so, when it expires.
RESPONSE: The board's free, web-based courses and tests are only one (1) of the options available for complying with this rule; users who pass the test can print a certificate, which has no expiration date. The board does not know which of the other courses and/or tests offered or approved by adjacent states provide operators with a certificate, though it is believed most do.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 10—Licensee's Responsibilities

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission (MGC)

under section 313.805, RSMo Supp. 2014, the commission amends a rule as follows:

11 CSR 45-10.040 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2014 (39 MoReg 1569). Changes have been made to the text of the proposed amendment, so it is reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on this proposed amendment on November 5, 2014. Rayna Stover, Director of Regulatory Compliance for River City Casino, attended the public hearing, but offered no comments. The Missouri Gaming Commission received written comments on the proposed amendment from Penn National Gaming, Inc. (Penn National), Gaming & Leisure Properties, Inc. (GLPI), Pinnacle Entertainment (Pinnacle), and Isle of Capri Casinos, Inc. (Isle of Capri).

Due to the similarity of the following four (4) comments, they are addressed with one (1) response.
COMMENT #1: Penn National stated its concern that the proposed language in paragraph (8)(A)2. was overbroad and would have the "potential to be an impediment to sales, transfers and leases of property that are immaterial to gaming operations . . . , as well as de minimus transactions" and transactions involving the rental of interior space in the non-gaming portion of the floor.
COMMENT #2: GLPI was also concerned that the proposed language in paragraph (8)(A)2. was overbroad and would have unintended effects on its non-gaming "tenants and their ability to operate the properties effectively and efficiently."
COMMENT #3: Pinnacle proposed adding language to paragraph (8)(A)2. to make it clear that this regulation would not apply to "leases in the normal course of business related to restaurants, bars, entertainment venues or other retail space."
COMMENT #4: Isle of Capri expressed concern that the proposed language in paragraph (8)(A)2. was "overly broad and has the potential to create unnecessary delays and burdens for both the licensee and the Commission," in that, as written, it is unclear whether "non-gaming operations" would be included in the breadth of this regulation.
RESPONSE AND EXPLANATION OF CHANGE: The staff concurs with the sentiments expressed and has made changes to paragraph (8)(A)2. so that the regulation only applies to those leases that affect the gaming floor. Paragraph (8)(A)2. will be changed.

Due to the similarity of the following three (3) comments, they are addressed with one (1) response.
COMMENT #5: Penn National commented that subsection (12)(C)'s language as proposed "appears so broad that it could be nearly impossible to satisfy in any significant transaction." It proposed modifying the language of that subsection to require the petitioner to prove that the transaction would "not result in undue economic concentration in the ownership or control of riverboat gaming licenses in any region of the state."
COMMENT #6: GLPI stated that the language proposed for subsection (12)(C) "is an incredibly high standard that would almost certainly be impossible to achieve."
COMMENT #7: Pinnacle suggested adding the term "material" to modify the "negative competitive impact" of subsection (12)(C).
RESPONSE AND EXPLANATION OF CHANGE: The staff believes that the language in subsection (12)(C) is a reasonable and appropriate standard for the commission to evaluate in response to a petition to approve a material change in ownership or control. As such the changes proposed by Penn National will not be made. However, the term "material" has been added to subsection (12)(C) to describe the negative competitive impact that would be considered by the commission in evaluating a petition to approve a material change in ownership or control.

Due to the similarity of the following two (2) comments, they are addressed with one (1) response.
COMMENT #8: Penn National commented that subsection (12)(E) "is vague since the term 'significant changes' is not defined." It proposed modifying the language of that subsection such that the commission would make a determination as to whether the transaction "would call into doubt the financial ability of the licensee to successfully operate the riverboat gaming facility."
COMMENT #9: GLPI again commented that the language proposed for subsection (12)(E) "is an incredibly high standard that would almost certainly be impossible to achieve." It also suggested "that the Commission should be in a position to reject a change in control transaction if the adverse impact of that transaction calls into question the financial stability of the licensee after giving effect to the transaction."
RESPONSE AND EXPLANATION OF CHANGE: The substantially similar language proposed by Penn National and GLPI is too narrow and restrictive as to the determination of financial impact on the licensee. However, the terms "potentially" and "negative" have been added to subsection (12)(E) to modify the significant changes that the commission would consider.

COMMENT #10: Isle of Capri requested the commission to give consideration "to a provision that allows for prior 'notice' as opposed to a petition for approval if the transaction is between a Class A or B licensee and an affiliate."
RESPONSE: The staff believes the approval of the commission should be received prior to the consummation of any transaction described in this rule. Therefore, no such change will be made.

11 CSR 45-10.040 Prohibition and Reporting of Certain Transactions

(8) The following definitions apply to the terms used in 11 CSR 45-10.040:

(A) Material change in ownership or control:

1. Any transfer or issuance of ownership interest in a gaming licensee or holding company or other contract or arrangement resulting in a person or group of persons acting in concert, directly or indirectly:

A. Owning, controlling, or having power to vote twenty-five percent (25%) or more of the voting ownership interest in the gaming licensee or holding company, if the acquiring person or group of persons did not previously hold twenty-five percent (25%) or more of the voting ownership interest of the gaming licensee or the holding company prior to the change in control; or

B. Controlling in any manner the election of a majority of the directors or managers of a gaming licensee or holding company, if the controlling person or group of persons did not previously exercise such control;

2. Any sale, transfer, or lease by a licensee of all or any portion of the real estate upon which a riverboat gaming operation is conducted or located; provided, however, that this section shall not apply to leases in the normal course of business related to restaurants, bars, entertainment venues or other retail space, as long as it does not include any portion of the gaming floor.

(12) Upon any voluntary material change in ownership or control, the license held by the gaming licensee that is the subject of the material change in ownership or control or that is a direct or indirect subsidiary of the holding company that is the subject of the material change in ownership or control, shall automatically become null and void and of no legal effect, unless the commission has approved such material change in ownership or control by vote of the commissioners

prior to its consummation. The commission may grant a petition to approve a material change in ownership or control if the petitioner proves by clear and convincing evidence that—

(C) It would have no material negative competitive impact;

(E) It would not potentially result in any significant negative changes in the financial condition of the licensee.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 4—Conditions of Participant Participation, Rights and Responsibilities

ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 208.633, 208.650, 208.655, and 208.657, RSMo 2000, and sections 208.631, 208.636, 208.640, 208.643, 208.646, 208.647, and 208.658, RSMo Supp. 2014, the division amends a rule as follows:

13 CSR 70-4.080 State Children's Health Insurance Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 3, 2014 (39 MoReg 1773–1776). 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 20—Division of Community and Public Health
Chapter 51—Hemp Extract Registration

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Health and Senior Services under section 192.945, RSMo Supp. 2014, and section 192.006, RSMo 2000, the department adopts a rule as follows:

19 CSR 20-51.010 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on November 3, 2014 (39 MoReg 1777–1780). 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 Department of Health and Senior Services (DHSS) received one (1) letter with eleven (11) comments and an additional comment from a DHSS staff member. The letter was received from Bradley L. Schlaggar, M.D., Ph.D., and K. Scott Gronowski, R.Ph., JD, representing Washington University School of Medicine and BJC HealthCare (hereinafter "BJC HealthCare").

COMMENT #1: BJC HealthCare requests DHSS clarify the definition of "intractable epilepsy" to require that 1) the failed treatments be appropriate for the condition or for the patient, 2) that the treatments be tried at an adequate strength, and that 3) the treatments be tried for an adequate amount of time in order for a patient to be eligible for treatment with hemp extract oil.
RESPONSE: Making these changes would require DHSS to set standards for the scope of practice of neurology. The Missouri Board of Registration for the Healing Arts determines the standards of practice for physicians by peer review. No changes have been made to the rule as a result of this comment.

COMMENT #2: BJC HealthCare suggests the rule provide a distinction between patients with epileptic and psychogenic non-epileptic seizures so as to prevent unnecessary and potentially harmful hemp extract treatment for patients who have been determined by a neurologist to have psychogenic non-epileptic seizures.
RESPONSE: The neurologist is responsible for determining appropriate treatment and monitoring the effects of the treatment. As written, the rule does not change the neurologist's responsibilities. No changes have been made to the rule as a result of this comment.

COMMENT #3: BJC HealthCare suggests enhancing in rule the definition of neurologist to include "is Board Certified or Board Eligible in Neurology by the American Board of Psychiatry and Neurology."
RESPONSE: Adopting this specific change would result in excluding neurologists who are board certified or board eligible in neurology by other creditable organizations, such as the American Osteopathic Board of Neurology and Psychiatry. No changes have been made to the rule as a result of this comment.

COMMENT #4: BJC HealthCare is concerned that the rule is silent on the following issues: definition of "oversight" of treatment, standards of care for patients eligible to receive hemp extract, and the role of epilepsy specialists.
RESPONSE: Making any changes to address these issues would require DHSS to set standards for the scope of practice of neurology. The Missouri Board of Registration for the Healing Arts determines the standards of practice for physicians by peer review. No changes have been made to the rule as a result of this comment.

COMMENT #5: BJC HealthCare is concerned that the rule is silent on the practical issues of keeping patient evaluation records and transmitting them to DHSS as stated in 19 CSR 20-51.010(3)(B) and (4)(B).
RESPONSE: The cited provisions do not specify any requirements for submitting patient evaluation records beyond what must be submitted with the annual neurologist certification. At this time, DHSS is working to determine the type and extent of evaluation records to be transmitted and the method of transmission. Once the department has made this determination, the rule will be amended to add these requirements. No changes have been made to the rule as a result of this comment.

COMMENT #6: BJC HealthCare suggests changes to be made to the Hemp Extract Registration Card Neurologist Certification Form (to be consistent with other changes requested to the rule) to require that the neurologist certify that: 1) the physician is Board Certified in Neurology by the American Board of Psychiatry and Neurology, 2) the physician has personally overseen the treatment options as "oversight" is defined in rules and regulations, 3) the failed treatments are appropriate for the condition or the patient, 4) the failed treatments were tried at an adequate strength, 5) the failed treatments were tried for an adequate amount of time, and 6) the patients epileptic seizures have been distinguished on clinical grounds from non-epileptic seizures or psychogenic seizures in the last year.
RESPONSE: Making these changes would require DHSS to set standards for the scope of practice of neurology. The Missouri Board of Registration for the Healing Arts determines the standards of practice for physicians by peer review. Also, adopting this change would result in excluding neurologists who are board certified or board eligible in neurology by other creditable organizations, such as the American Osteopathic Board of Neurology and Psychiatry. No changes have been made to the form referenced in rule as a result of this comment.

COMMENT #7: BJC HealthCare is concerned the rule is silent on legal issues regarding prescribing of a Schedule I drug.
RESPONSE: Section 195.207, RSMo, does not require a physician to prescribe the drug, only to certify that the individual suffers from intractable epilepsy and may benefit from treatment with hemp extract. No changes have been made to the rule as a result of this comment.

COMMENT #8: BJC HealthCare believes explicit language is needed in rules to authorize clinical trials involving hemp extract, consistent with state and federal regulations.
RESPONSE: State and federal controlled substance laws allow for research with Schedule I controlled substances, provided that the federal Food and Drug Administration (FDA) has determined the researcher to be qualified and competent and the research protocol to be meritorious. Researchers who meet these criteria must obtain state and federal controlled substance registrations to conduct research with a Schedule I controlled substance. Schedule I substances in these research projects are provided to participating medical providers by the federal government or directly from drug manufacturers. Drug manufacturers and the participating medical providers must be registered to conduct research with Schedule I controlled substances. The medical providers, in turn, dispense or administer the Schedule I controlled substance directly to subjects participating in the FDA-approved clinical drug trial. Since state and federal laws already provide for this process, subjects participating in such trials with hemp extract are not required to obtain a Hemp Extract Registration Card pursuant to section 192.945, RSMo. No changes have been made to the rule as a result of this comment.

COMMENT #9: BJC HealthCare recognizes the rule defines the amount of hemp extract that may be possessed but is silent on how much hemp extract may be purchased and how often and requests clarity regarding this issue.
RESPONSE: The rule regarding possession mirrors the statute. The statute is silent on the issues regarding purchases. No changes have been made to the rule as a result of this comment.

COMMENT #10: BJC HealthCare is concerned that hospital staff will be in violation of state and federal laws if they possess hemp extract because the patient or patient's family is required to turn over all drugs to the hospital pharmacy while in the hospital.
RESPONSE: The requirement for hospital patients to turn over all drugs to the hospital pharmacy is a hospital specific policy and not a state or federal requirement. No changes have been made to the rule as a result of this comment.

COMMENT #11: BJC HealthCare is concerned that the rule does not make explicit how mandatory reporters are suppose to respond when they learn that parents or guardians are providing to their child diagnosed with medically intractable epilepsy cannabidiol (CBD) oil/hemp extract or other Schedule I products that, under the present law, are illegal in Missouri.
RESPONSE: This issue is not addressed in rule as it is beyond the scope of the department's rulemaking authority. No changes have been made to the rule as a result of this comment.

COMMENT #12: A DHSS staff member commented that the chapter and rule title as published in the *Missouri Register* is indicated as "Hemp Extraction" when it is usually referred to as "Hemp Extract" within the rest of the rule.
RESPONSE AND EXPLANATION OF CHANGE: The DHSS agrees that this is an error. The correct chapter name is "Hemp Extract Registration" and the correct title is "Hemp Extract Registration Card." Changes have been made to the title of the rule chapter and the rule itself.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20—Division of Community and Public Health
Chapter 51—Hemp Extract Registration

19 CSR 20-51.010 Hemp Extract Registration Card

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the executive director rescinds a rule as follows:

22 CSR 10-2.094 Tobacco-Free Incentive Provisions and Limitations **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 1, 2014 (39 MoReg 1572). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the executive director adopts a rule as follows:

22 CSR 10-2.094 Tobacco-Free Incentive Provisions and Limitations **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2014 (39 MoReg 1572–1573). 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 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the executive director rescinds a rule as follows:

22 CSR 10-2.120 Wellness Program **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 1, 2014 (39 MoReg 1573–1574). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the executive director adopts a rule as follows:

22 CSR 10-2.120 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2014 (39 MoReg 1574–1575). 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 Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed rule.

COMMENT #1: MCHCP staff commented that under section (5), the number of health risks that identify a member for participation in Behavior Modification Health Coaching should be changed from three (3) to four (4).
RESPONSE AND EXPLANATION OF CHANGE: MCHCP will remove participation in Behavior Modification Health Coaching as a requirement for the Partnership Incentive. Subparagraphs (5)(A)2.C. and (5)(B)2.C. and sections (6) through (9) have been deleted. Subsequent sections (10) through (12) have been renumbered. MCHCP will make participation in Behavior Modification Health Coaching an optional activity as added by new subsection (5)(D).

22 CSR 10-2.120 Partnership Incentive Provisions and Limitations

(5) Participation—

(A) Eligible members who enroll in MCHCP medical coverage during open enrollment for the 2015 plan year—

1. Must complete the following by November 30, 2014 to earn the Partnership Incentive from January 1 through June 30, 2015:

A. The online Partnership Agreement;

B. Provide the available preferred contact phone number or email address; and

C. The online Health Assessment.

2. Must complete all of the following by May 31, 2015 to continue to receive the Partnership Incentive from July 1 through December 31, 2015:

A. Receive an annual wellness exam on or after June 1, 2014, but not later than May 31, 2015; and

B. Submit a completed Health Care Provider Form to MCHCP;

(I) The Health Care Provider Form must include the following:

(a) The provider's printed name and signature;
(b) The member's printed name and signature;
(c) The date the annual wellness exam was received; and
(d) The member's height, weight, and blood pressure.

(B) Eligible members adding MCHCP medical coverage with an effective date falling on November 1, 2014 through May 1, 2015—

1. Must complete all of the following, in the order stated, to receive the Partnership Incentive effective the first day of the second month after completion of the Health Assessment:

A. The online Partnership Agreement;

B. Provide the available preferred contact phone number or email address; and

C. The online Health Assessment by May 31, 2015 or within sixty (60) days of their coverage effective date, whichever is earlier; and

2. Must complete all of the following by May 31, 2015 to continue to receive the incentive July 1 through December 31, 2015:

A. Receive an annual wellness exam on or after June 1, 2014, but not later than May 31, 2015; and

B. Submit a completed Health Care Provider Form to MCHCP.

(I) The Health Care Provider Form must include the following:

(a) The provider's printed name and signature;
(b) The member's printed name and signature;
(c) The date the annual wellness exam was received; and
(d) The member's height, weight, and blood pressure.

(D) Eligible members may enroll and actively participate in Behavior Modification Health Coaching if they have health risks such as low back, weight, nutrition, stress, physical activity, tobacco use, pre-diabetes, blood pressure, health maintenance, alcohol abuse, insomnia, anxiety, depression, or cholesterol.

(6) A waiver may be granted, in whole or in part, for the applicable plan year if a member requests a waiver of a requirement(s) in writing along with a provider's written certification that it is medically inadvisable for the member to participate in the applicable requirement(s).

(7) Audit—MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from Behavior Modification Health Coaching, loss of the Partnership Incentive, and/or prosecution.

(8) Coordination of programs—MCHCP and its wellness vendor may utilize participation data for purposes of offering additional programs in accordance with MCHCP's privacy policy.

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, March 16, 2015.

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 270, Jefferson City, MO 65102-0270
• *Hand Delivery:* 830 MoDOT 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, 830 MoDOT 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: Kathy J. Hatfield, Motor Carrier Investigations Specialist, (573) 526-9926, MoDOT Motor Carrier Services Division, PO Box 270, Jefferson City, MO 65102-0270. 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. 2014, MoDOT may issue an SPE 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 an 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 #106

Renewal Applicant's Name & Age: Kirk E. Bufford, 52

Relevant Physical Condition: Vision impaired.
Mr. Bufford's best-corrected visual acuity in his right eye is 20/25 Snellen and his best corrected visual acuity in his left eye is 20/200 Snellen. Kirk has had amblyopia in his left eye since birth.

Relevant Driving Experience: Mr. Bufford is currently employed as a concrete truck driver. He currently holds a Class B CDL license, and has approximately sixteen (16) years commercial motor vehicle driving experience. He drives personal vehicle(s) daily.

Doctor's Opinion and Date: Following an examination in December 2014, his optometrist certified his condition would not adversely affect his ability to operate a commercial vehicle safely.

Traffic Accidents and Violations: No accidents or violations on record for the previous three (3) years.

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: January 7, 2015

Scott Marion, Motor Carrier Services Director, Missouri Department of Transportation.

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. 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. In addition, this list includes contractor(s) that have agreed to entry of an injunction permanently prohibiting them and any persons and entities related to them from engaging in, or having any involvement in, any business in Missouri.

Contractors Convicted of Violations of the Missouri Prevailing Wage Law

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Urban Metropolitan Development, LLC Case No. 12AO-CR01752 (Jasper County Cir. Ct.)		1101 Juniper St., Ste. 925 Atlanta, Georgia 30309	08/08/2013	08/08/2013 to 08/08/2014

Contractors Agreeing to Permanent Prohibition from Engaging In, or Having Any Involvement In, Any Business in Missouri

Name of Contractor	Name of Officers	Address	Date of Injunction	Debarment Period
Urban Metropolitan Development, LLC		1101 Juniper St., Ste. 925 Atlanta, Georgia 30309	09/27/2013	Permanent
Troy Langley		1101 Juniper St., Ste. 925 Atlanta, Georgia 30309	09/27/2013	Permanent

Dated this 7th day of March 2014.

John E. Lindsey, Division 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 AND DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST LOVELAND PROPERTIES MISSOURI, LLC

On December 23, 2014, Loveland Properties Missouri, LLC, a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

Claims against Company must be submitted to Spectrum Financial Services, Inc., Attn: Daniel A. Hamann, The Mark Building, 9290 West Dodge Road, Suite 203, Omaha, Nebraska 68114-3320. Claims must include: name and address of claimant; amount of claim; basis of the claim; and documentation of claim.

By law, all claims against the Company shall be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this Notice.

NOTICE OF DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST TEXAS ART MERCER VALWOOD RETURN, LLC

On November 19, 2014, Texas ART Mercer Valwood Return, LLC, a Missouri limited liability company (hereinafter the "**Company**"), filed its Notice of Winding Up for a Limited Liability Company with the Missouri Secretary of State.

Any claims against the Company may be sent to: Douglas M. Neeb, 1111 Main Street, Suite 1600, Kansas City, Missouri, 64105. Each claim must include the following information: name, address and phone number of the claimant; amount claimed; date on which the claim arose; basis for the claim; and documentation in support of the claim

All claims against the Company will be barred unless the proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF DISSOLUTION
TO ALL CREDITORS AND CLAIMANTS AGAINST
NOZOMI THERAPEUTICS, LLC

Nozomi Therapeutics, LLC, a Missouri limited liability company (the "Company"), was dissolved on December 30, 2014. Any and all claims against the Company may be sent to Ms. Anne Cordial Harkin, VP of Operations, c/o The Jack & JT Snow Scientific Research Foundation, P.O. Box 84, Wildwood, MO 63040. Each claim should include the following information: The name, address and telephone number of the claimant; the amount of the claim; the basis of the claim and the date(s) on which the event(s) on which the claim is based occurred. Any and all claims against the Company will be barred unless a proceeding to enforce such claim is commenced within two (2) years after the date this notice is published.

Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—37 (2012) and 38 (2013). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				37 MoReg 1859 38 MoReg 2053 39 MoReg 2074
1 CSR 10-4.010	Commissioner of Administration	39 MoReg 1637	39 MoReg 1658	This Issue	
1 CSR 10-10.010	Commissioner of Administration		This Issue		
1 CSR 10-15.010	Commissioner of Administration	39 MoReg 1637	39 MoReg 1658	This Issue	
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-2.010	Animal Health		39 MoReg 1925		
2 CSR 30-2.020	Animal Health		39 MoReg 1927		
2 CSR 30-6.020	Animal Health		39 MoReg 1930		
2 CSR 30-10.010	Animal Health	39 MoReg 1559	39 MoReg 1568	40 MoReg 136	
2 CSR 70-14.005	Plant Industries	39 MoReg 1638	39 MoReg 1735		
2 CSR 70-14.010	Plant Industries	39 MoReg 1639	39 MoReg 1735		
2 CSR 70-14.020	Plant Industries	39 MoReg 1640	39 MoReg 1736		
2 CSR 70-14.030	Plant Industries	39 MoReg 1641	39 MoReg 1739		
2 CSR 70-14.040	Plant Industries	39 MoReg 1642	39 MoReg 1742		
2 CSR 70-14.050	Plant Industries	39 MoReg 1643	39 MoReg 1744		
2 CSR 70-14.060	Plant Industries	39 MoReg 1643	39 MoReg 1744		
2 CSR 70-14.070	Plant Industries	39 MoReg 1644	39 MoReg 1744		
2 CSR 70-14.080	Plant Industries	39 MoReg 1644	39 MoReg 1744		
2 CSR 70-14.090	Plant Industries	39 MoReg 1645	39 MoReg 1745		
2 CSR 70-14.100	Plant Industries	39 MoReg 1646	39 MoReg 1748		
2 CSR 70-14.110	Plant Industries	39 MoReg 1648	39 MoReg 1751		
2 CSR 70-14.120	Plant Industries	39 MoReg 1648	39 MoReg 1753		
2 CSR 70-14.130	Plant Industries	39 MoReg 1649	39 MoReg 1755		
2 CSR 70-14.140	Plant Industries	39 MoReg 1650	39 MoReg 1757		
2 CSR 70-14.150	Plant Industries	39 MoReg 1651	39 MoReg 1759		
2 CSR 70-14.160	Plant Industries	39 MoReg 1651	39 MoReg 1761		
2 CSR 70-14.170	Plant Industries	39 MoReg 1652	39 MoReg 1764		
2 CSR 70-14.180	Plant Industries	39 MoReg 1653	39 MoReg 1766		
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3 CSR 10-4.117	Conservation Commission		39 MoReg 1772	40 MoReg 61	
3 CSR 10-6.415	Conservation Commission		N.A.	40 MoReg 61	
3 CSR 10-6.550	Conservation Commission		39 MoReg 849	39 MoReg 1155	
3 CSR 10-6.610	Conservation Commission		39 MoReg 1772	40 MoReg 61	
3 CSR 10-7.430	Conservation Commission		N.A.	40 MoReg 61	
3 CSR 10-7.450	Conservation Commission		N.A.	40 MoReg 62	
3 CSR 10-7.455	Conservation Commission				40 MoReg 77
3 CSR 10-9.110	Conservation Commission		39 MoReg 1772	40 MoReg 62	
3 CSR 10-9.425	Conservation Commission		39 MoReg 1772	40 MoReg 62	
3 CSR 10-9.625	Conservation Commission		39 MoReg 1773	40 MoReg 62	
3 CSR 10-11.180	Conservation Commission		39 MoReg 1773	40 MoReg 63	
3 CSR 10-11.210	Conservation Commission		N.A.	40 MoReg 63	
3 CSR 10-11.215	Conservation Commission		N.A.	40 MoReg 63	
3 CSR 10-12.109	Conservation Commission		N.A.	40 MoReg 64	
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4 CSR 85-8.010	Division of Business and Community Services	38 MoReg 1925 39 MoReg 489T			
4 CSR 85-8.020	Division of Business and Community Services	38 MoReg 1934 39 MoReg 489T			
4 CSR 85-8.030	Division of Business and Community Services	38 MoReg 1934 39 MoReg 489T			
4 CSR 85-9.010	Division of Business and Community Services	38 MoReg 1935 39 MoReg 489T			
4 CSR 85-9.020	Division of Business and Community Services	38 MoReg 1936 39 MoReg 489T			
4 CSR 85-9.030	Division of Business and Community Services	38 MoReg 1937 39 MoReg 490T			
4 CSR 85-9.040	Division of Business and Community Services	38 MoReg 1947 39 MoReg 490T			

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4 CSR 85-10.020	Division of Business and Community Services		39 MoReg 723		
4 CSR 85-10.030	Division of Business and Community Services		39 MoReg 724		
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4 CSR 340-2.010	Division of Energy		39 MoReg 2118		
4 CSR 340-2.020	Division of Energy		39 MoReg 2120		
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5 CSR 10-2.020	Commissioner of Education		39 MoReg 1932		
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5 CSR 30-660.080	Division of Financial and Administrative Services		40 MoReg 55		
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6 CSR 10-2.190	Commissioner of Higher Education		39 MoReg 1614	40 MoReg 136	
6 CSR 10-6.040	Commissioner of Higher Education		39 MoReg 1614	40 MoReg 137	
6 CSR 10-12.010	Commissioner of Higher Education		39 MoReg 1116 40 MoReg 7		
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7 CSR 10-9.010	Missouri Highways and Transportation Commission		39 MoReg 2121R		
7 CSR 10-9.020	Missouri Highways and Transportation Commission		39 MoReg 2121R		
7 CSR 10-9.030	Missouri Highways and Transportation Commission		39 MoReg 2122R		
7 CSR 10-9.040	Missouri Highways and Transportation Commission		39 MoReg 2122R		
7 CSR 10-9.050	Missouri Highways and Transportation Commission		39 MoReg 2122R		
7 CSR 10-9.060	Missouri Highways and Transportation Commission		39 MoReg 2123R		
7 CSR 10-17.010	Missouri Highways and Transportation Commission		39 MoReg 2123R		
7 CSR 10-17.020	Missouri Highways and Transportation Commission		39 MoReg 2123		
7 CSR 10-17.030	Missouri Highways and Transportation Commission		39 MoReg 2126		
7 CSR 10-17.040	Missouri Highways and Transportation Commission		39 MoReg 2127		
7 CSR 10-17.050	Missouri Highways and Transportation Commission		39 MoReg 2127		
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7 CSR 10-22.010	Missouri Highways and Transportation Commission		39 MoReg 2132R		
7 CSR 10-22.020	Missouri Highways and Transportation Commission		39 MoReg 2132R		
7 CSR 10-22.030	Missouri Highways and Transportation Commission		39 MoReg 2132R		
7 CSR 10-22.040	Missouri Highways and Transportation Commission		39 MoReg 2132R		
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7 CSR 10-25.020	Missouri Highways and Transportation Commission		40 MoReg 55		
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10 CSR 10-6.110	Air Conservation Commission		39 MoReg 1509	40 MoReg 138	
10 CSR 100-5.010	Petroleum Storage Tank Insurance Fund Board of Trustees		39 MoReg 1443	This Issue	
10 CSR 100-6.010	Petroleum Storage Tank Insurance Fund Board of Trustees		39 MoReg 1445	This Issue	
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11 CSR 10-2.010	Adjutant General		40 MoReg 12		
11 CSR 10-3.015	Adjutant General		40 MoReg 12		
11 CSR 30-14.010	Office of the Director		39 MoReg 1451	40 MoReg 64	
11 CSR 40-5.165	Division of Fire Safety		39 MoReg 2135		
11 CSR 40-5.170	Division of Fire Safety		39 MoReg 2135		
11 CSR 40-5.175	Division of Fire Safety		39 MoReg 2136		
11 CSR 40-5.180	Division of Fire Safety		39 MoReg 2137		
11 CSR 40-5.190	Division of Fire Safety		39 MoReg 2137		
11 CSR 40-5.195	Division of Fire Safety		39 MoReg 2138		
11 CSR 45-1.090	Missouri Gaming Commission		39 MoReg 1451	40 MoReg 17	
11 CSR 45-5.053	Missouri Gaming Commission	39 MoReg 1419	39 MoReg 1451	40 MoReg 17	
11 CSR 45-5.090	Missouri Gaming Commission		39 MoReg 1452	40 MoReg 17	
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11 CSR 45-5.183	Missouri Gaming Commission		39 MoReg 1453	40 MoReg 18	
11 CSR 45-5.184	Missouri Gaming Commission		39 MoReg 1453	40 MoReg 18	
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11 CSR 45-8.140	Missouri Gaming Commission	39 MoReg 1420	39 MoReg 1458	40 MoReg 19	

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11 CSR 45-8.142	Missouri Gaming Commission	39 MoReg 1422	39 MoReg 1464	40 MoReg 19	
11 CSR 45-9.040	Missouri Gaming Commission	39 MoReg 1422	39 MoReg 1466	40 MoReg 20	
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11 CSR 45-9.117	Missouri Gaming Commission	39 MoReg 1429	39 MoReg 1482	40 MoReg 24	
11 CSR 45-9.118	Missouri Gaming Commission	39 MoReg 1429	39 MoReg 1482	40 MoReg 25	
11 CSR 45-10.040	Missouri Gaming Commission		39 MoReg 1569	This Issue	
11 CSR 50-2.010	Missouri State Highway Patrol		40 MoReg 13		
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11 CSR 50-2.240	Missouri State Highway Patrol		40 MoReg 14		
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11 CSR 50-2.290	Missouri State Highway Patrol		40 MoReg 15		
11 CSR 50-2.321	Missouri State Highway Patrol		40 MoReg 15		
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12 CSR 40-10.010	State Lottery		39 MoReg 1348	40 MoReg 64	
12 CSR 40-10.040	State Lottery		39 MoReg 1348	40 MoReg 64	
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12 CSR 40-15.010	State Lottery		39 MoReg 1349	40 MoReg 65	
12 CSR 40-20.010	State Lottery		39 MoReg 1349	40 MoReg 65	
12 CSR 40-20.020	State Lottery		39 MoReg 1349	40 MoReg 65	
12 CSR 40-20.030	State Lottery		39 MoReg 1350	40 MoReg 65	
12 CSR 40-20.040	State Lottery		39 MoReg 1350	40 MoReg 65	
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12 CSR 40-40.012	State Lottery		39 MoReg 1351	40 MoReg 66	
12 CSR 40-40.015	State Lottery		39 MoReg 1352	40 MoReg 66	
12 CSR 40-40.020	State Lottery		39 MoReg 1352	40 MoReg 66	
12 CSR 40-40.030	State Lottery		39 MoReg 1352	40 MoReg 66	
12 CSR 40-40.040	State Lottery		39 MoReg 1353	40 MoReg 66	
12 CSR 40-40.050	State Lottery		39 MoReg 1353	40 MoReg 67	
12 CSR 40-40.060	State Lottery		39 MoReg 1353	40 MoReg 67	
12 CSR 40-40.070	State Lottery		39 MoReg 1353	40 MoReg 67	
12 CSR 40-40.071	State Lottery		39 MoReg 1354	40 MoReg 67	
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12 CSR 40-40.150	State Lottery		39 MoReg 1355	40 MoReg 68	
12 CSR 40-40.160	State Lottery		39 MoReg 1356	40 MoReg 68	
12 CSR 40-40.170	State Lottery		39 MoReg 1356	40 MoReg 68	
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12 CSR 40-40.250	State Lottery		39 MoReg 1358	40 MoReg 69	
12 CSR 40-40.260	State Lottery		39 MoReg 1358	40 MoReg 69	
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12 CSR 40-50.010	State Lottery		39 MoReg 1359	40 MoReg 70	
12 CSR 40-50.030	State Lottery		39 MoReg 1360	40 MoReg 70	
12 CSR 40-50.050	State Lottery		39 MoReg 1360	40 MoReg 70	
12 CSR 40-60.020	State Lottery		39 MoReg 1360	40 MoReg 70	
12 CSR 40-60.030	State Lottery		39 MoReg 1361	40 MoReg 70	
12 CSR 40-60.040	State Lottery		39 MoReg 1361	40 MoReg 71	
12 CSR 40-60.050	State Lottery		39 MoReg 1361	40 MoReg 71	
12 CSR 40-70.010	State Lottery		39 MoReg 1362	40 MoReg 71	
12 CSR 40-70.020	State Lottery		39 MoReg 1362	40 MoReg 71	
12 CSR 40-70.030	State Lottery		39 MoReg 1362	40 MoReg 71	
12 CSR 40-70.050	State Lottery		39 MoReg 1363	40 MoReg 72	
12 CSR 40-70.080	State Lottery		39 MoReg 1363	40 MoReg 72	
12 CSR 40-80.010	State Lottery		39 MoReg 1363	40 MoReg 72	
12 CSR 40-80.020	State Lottery		39 MoReg 1364	40 MoReg 72	
12 CSR 40-80.030	State Lottery		39 MoReg 1364	40 MoReg 72	
12 CSR 40-80.050	State Lottery		39 MoReg 1364	40 MoReg 72	
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12 CSR 40-80.120	State Lottery		39 MoReg 1366	40 MoReg 73	
12 CSR 40-80.130	State Lottery		39 MoReg 1366	40 MoReg 73	
12 CSR 40-85.005	State Lottery		39 MoReg 1366	40 MoReg 73	
12 CSR 40-85.010	State Lottery		39 MoReg 1367	40 MoReg 73	
12 CSR 40-85.020	State Lottery		39 MoReg 1368R	40 MoReg 74R	
12 CSR 40-85.030	State Lottery		39 MoReg 1368	40 MoReg 74	
12 CSR 40-85.050	State Lottery		39 MoReg 1368	40 MoReg 74	
12 CSR 40-85.055	State Lottery		39 MoReg 1369	40 MoReg 74	
12 CSR 40-85.060	State Lottery		39 MoReg 1369	40 MoReg 74	
12 CSR 40-85.070	State Lottery		39 MoReg 1369	40 MoReg 74	
12 CSR 40-85.080	State Lottery		39 MoReg 1370	40 MoReg 75	
12 CSR 40-85.090	State Lottery		39 MoReg 1370	40 MoReg 75	

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12 CSR 40-85.140	State Lottery		39 MoReg 1371	40 MoReg 75	
12 CSR 40-85.170	State Lottery		39 MoReg 1371	40 MoReg 75	
12 CSR 40-85.175	State Lottery		39 MoReg 1372	40 MoReg 75	
12 CSR 40-90.110	State Lottery		39 MoReg 1372	40 MoReg 76	
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13 CSR 40-2.440	Family Support Division		39 MoReg 1937		
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13 CSR 40-13.040	Family Support Division		39 MoReg 1812		
13 CSR 70-3.030	MO HealthNet Division		39 MoReg 1519	40 MoReg 26	
13 CSR 70-4.080	MO HealthNet Division		39 MoReg 1773	This Issue	
13 CSR 70-10.160	MO HealthNet Division		39 MoReg 1519	40 MoReg 26	
13 CSR 70-15.220	MO HealthNet Division		This Issue		
13 CSR 70-65.010	MO HealthNet Division		39 MoReg 1519	40 MoReg 26	
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16 CSR 10-6.060	The Public School Retirement System of Missouri		40 MoReg 57		
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16 CSR 40-1.020	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1951R		
16 CSR 40-2.010	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1951R		
16 CSR 40-2.020	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1951R		
16 CSR 40-2.030	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1952R		
16 CSR 40-2.040	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1952R		
16 CSR 40-2.050	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1952R		
16 CSR 40-2.060	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1952R		
16 CSR 40-2.070	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1953R		
16 CSR 40-2.080	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1953R		
16 CSR 40-2.090	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1953R		
16 CSR 40-3.010	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1953R		
16 CSR 40-3.020	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1954R		
16 CSR 40-3.030	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1954R		
16 CSR 40-3.031	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1954R		
16 CSR 40-3.032	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1954R		
16 CSR 40-3.033	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1955R		
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16 CSR 40-3.040	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1956R		
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16 CSR 40-3.060	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1956R		
16 CSR 40-3.070	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1957R		
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16 CSR 40-3.110	Highways and Transportation Employees and Highway Patrol Retirement System		39 MoReg 1958R		
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20 CSR	Sovereign Immunity Limits				39 MoReg 167 39 MoReg 2149
20 CSR	State Legal Expense Fund Cap				39 MoReg 167 39 MoReg 2149
20 CSR 200-12.020	Insurance Solvency and Company Regulation		39 MoReg 2140		
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20 CSR 2070-2.090	State Board of Chiropractic Examiners	39 MoReg 1843	39 MoReg 1959		
20 CSR 2150-5.100	State Board of Registration for the Healing Arts		39 MoReg 2140		
20 CSR 2200-4.200	State Board of Nursing		39 MoReg 2141		
20 CSR 2220-5.020	State Board of Pharmacy		39 MoReg 1964		
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22 CSR 10-2.020	Health Care Plan	39 MoReg 1847	39 MoReg 1970		
22 CSR 10-2.030	Health Care Plan	39 MoReg 1857	39 MoReg 1981		
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22 CSR 10-2.053	Health Care Plan	39 MoReg 1864	39 MoReg 1986		
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22 CSR 10-2.080	Health Care Plan		39 MoReg 2003		
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22 CSR 10-2.130	Health Care Plan	38 MoReg 1359R	38 MoReg 1420R	38 MoReg 2096R	
22 CSR 10-2.140	Health Care Plan		39 MoReg 2012		
22 CSR 10-2.150	Health Care Plan	39 MoReg 1889	39 MoReg 2013		
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22 CSR 10-3.010	Health Care Plan	39 MoReg 1891	39 MoReg 2015		
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22 CSR 10-3.053	Health Care Plan	39 MoReg 1902	39 MoReg 2025		
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22 CSR 10-3.056	Health Care Plan	39 MoReg 1904	39 MoReg 2027		
22 CSR 10-3.057	Health Care Plan	39 MoReg 1905	39 MoReg 2028		
22 CSR 10-3.060	Health Care Plan		39 MoReg 2038		
22 CSR 10-3.070	Health Care Plan		39 MoReg 2039		
22 CSR 10-3.075	Health Care Plan	39 MoReg 1916	39 MoReg 2039		
22 CSR 10-3.080	Health Care Plan		39 MoReg 2043		
22 CSR 10-3.090	Health Care Plan	39 MoReg 1920	39 MoReg 2043		
22 CSR 10-3.150	Health Care Plan	39 MoReg 1923	39 MoReg 2046		
22 CSR 10-3.160	Health Care Plan		39 MoReg 2047		

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1 CSR 10-4.010	Vendor Payroll Deductions	39 MoReg 1637	Jan. 1, 2015	June 29, 2015
1 CSR 10-15.010	Cafeteria Plan	39 MoReg 1637	Jan. 1, 2015	June 29, 2015
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2 CSR 30-10.010	Inspection of Meat and Poultry	39 MoReg 1559	Aug. 28, 2014	Feb. 26, 2015
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2 CSR 70-14.005	Preemption of All Ordinances and Rules of Political Subdivisions	39 MoReg 1638	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.010	Definitions	39 MoReg 1639	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.020	Application for a Cultivation and Production Facility License	39 MoReg 1640	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.030	Supporting Forms, Documents, Plans, and Other Information to be Submitted with the Applicant's Application for a Cultivation and Production Facility License	39 MoReg 1641	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.040	Application–Selection Criteria	39 MoReg 1642	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.050	Retention of the Application and Supporting Forms, Documents, Plan, and Other Information Submitted by the Applicant	39 MoReg 1643	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.060	Rejection of Cultivation and Production Facility Application Request for Licensure and the Revocation or Suspension of a License	39 MoReg 1643	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.070	Cultivation and Production Facility License Expiration	39 MoReg 1644	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.080	License Not Transferable and Request to Modify or Alter License	39 MoReg 1644	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.090	Cultivation and Production Facility License Stipulations and Requirements	39 MoReg 1645	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.100	Requirements for Production, Manufacture, Storage, Transportation, and Testing of Hemp and Hemp Extract	39 MoReg 1646	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.110	Hemp Monitoring System Records to be Maintained for Manufacture, Storage, Testing, and Distribution of Hemp and Hemp Extract	39 MoReg 1648	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.120	Packaging and Labeling of Hemp and Hemp Extract	39 MoReg 1648	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.130	Cultivation and Production Facility and Cannabidiol Oil Care Center Security Measures, Reportable Events, and Records to be Maintained	39 MoReg 1649	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.140	Waste Disposal of Unusable Hemp and Hemp Extract	39 MoReg 1650	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.150	Pesticide Record Keeping Requirements	39 MoReg 1651	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.160	Inspection of Premises and Facility of License Holder, Samples Collected for Analysis, Issuance of Search Warrant, and Powers of Director During Investigation or Hearing, When the Director May Report Violations to Prosecuting Attorney for Action	39 MoReg 1651	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.170	Stop Sale, Use, or Removal Orders	39 MoReg 1652	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.180	Revocation, Suspension, or Modification of a Cultivation and Production Facility License	39 MoReg 1653	Oct. 18, 2014	April 15, 2015
2 CSR 70-14.190	Penalty for Violations of the Act or Any Regulation Issued Thereunder	39 MoReg 1653	Oct. 18, 2014	April 15, 2015
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4 CSR 85-5.020	Preliminary Application	39 MoReg 1113	May 15, 2014	Feb. 24, 2015
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8 CSR 30-3.060	Occupational Titles of Work Descriptions	39 MoReg 2111	Nov. 17, 2014	May 15, 2015

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11 CSR 45-5.053	Policies	39 MoReg 1419	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-8.140	Application and Verification Procedures for Granting Credit	39 MoReg 1420	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-8.141	Approval of Credit Limits	39 MoReg 1421	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-8.142	Documentation of Customer Credit Transactions	39 MoReg 1422	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-9.040	Commission Approval of Internal Control System	39 MoReg 1422	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-9.104	Minimum Internal Control Standards (MICS)–Chapter D	39 MoReg 1423	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-9.107	Minimum Internal Control Standards (MICS)–Chapter G	39 MoReg 1424	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-9.108	Minimum Internal Control Standards (MICS)–Chapter H	39 MoReg 1425	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-9.109	Minimum Internal Control Standards (MICS)–Chapter I	39 MoReg 1426	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-9.111	Minimum Internal Control Standards (MICS)–Chapter K	39 MoReg 1426	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-9.112	Minimum Internal Control Standards (MICS)–Chapter L	39 MoReg 1427	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-9.116	Minimum Internal Control Standards (MICS)–Chapter P	39 MoReg 1428	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-9.117	Minimum Internal Control Standards (MICS)–Chapter Q	39 MoReg 1428	Aug. 28, 2014	Feb. 26, 2015
11 CSR 45-9.118	Minimum Internal Control Standards (MICS)–Chapter R	39 MoReg 1429	Aug. 30, 2014	Feb. 28, 2015
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12 CSR 10-40.010	Annual Adjusted Rate of Interest	39 MoReg 1843	Jan. 1, 2015	June 29, 2015
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13 CSR 40-13.030	Adjustment of Blind Pension Payments	39 MoReg 1807	Oct. 18, 2014	April 15, 2015
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15 CSR 30-54.210	Notice Filings for Transactions under Regulation D, Rules 505 and 506	Next Issue	Jan. 31, 2015	July 29, 2015
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15 CSR 50-4.020	Missouri Higher Education Savings Program	Next Issue	Feb. 1, 2015	July 30, 2015
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19 CSR 20-51.010	Hemp Extract Registration Card	39 MoReg 1655	Oct. 18, 2014	April 15, 2015
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20 CSR 2070-2.090	Fees	39 MoReg 1843	Nov. 6, 2014	May 4, 2015
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20 CSR 2110-2.170	Fees	39 MoReg 1343	July 18, 2014	Feb. 26, 2015
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20 CSR 2220-4.010	General Fees	39 MoReg 1343	July 18, 2014	Feb. 26, 2015
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22 CSR 10-2.010	Definitions	39 MoReg 1844	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.020	General Membership Provisions	39 MoReg 1847	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.030	Contributions	39 MoReg 1857	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.045	Plan Utilization Review Policy	39 MoReg 1860	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.051	PPO 300 Plan Benefit Provisions and Covered Charges	39 MoReg 1862	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.052	PPO 600 Plan Benefit Provisions and Covered Charges	39 MoReg 1863	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.053	Health Savings Account Plan Benefit Provisions and Covered Charges	39 MoReg 1864	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges	39 MoReg 1866	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.075	Review and Appeals Procedure	39 MoReg 1876	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.089	Pharmacy Employer Group Waiver Plan for Medicare Primary Members	39 MoReg 1880	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.090	Pharmacy Benefit Summary	39 MoReg 1881	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.094	Tobacco-Free Incentive Provisions and Limitations (Res)	39 MoReg 1559	Oct. 1, 2014	March 29, 2015

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22 CSR 10-2.094	Tobacco-Free Incentive Provisions and Limitations	39 MoReg 1560	Oct. 1, 2014	March 29, 2015
22 CSR 10-2.095	TRICARE Supplement Plan	39 MoReg 1884	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.110	General Foster Parent Membership Provisions	39 MoReg 1885	Jan. 1, 2015	June 29, 2015
22 CSR 10-2.120	Wellness Program (Res)	39 MoReg 1561	Oct. 1, 2014	March 29, 2015
22 CSR 10-2.120	Wellness Program	39 MoReg 1562	Oct. 1, 2014	March 29, 2015
22 CSR 10-2.150	Disease Management Services Provisions and Limitations	39 MoReg 1889	Jan. 1, 2015	June 29, 2015
22 CSR 10-3.010	Definitions	39 MoReg 1891	Jan. 1, 2015	June 29, 2015
22 CSR 10-3.020	General Membership Provisions	39 MoReg 1894	Jan. 1, 2015	June 29, 2015
22 CSR 10-3.045	Plan Utilization Review Policy	39 MoReg 1901	Jan. 1, 2015	June 29, 2015
22 CSR 10-3.053	PPO 1000 Plan Benefit Provisions and Covered Charges	39 MoReg 1902	Jan. 1, 2015	June 29, 2015
22 CSR 10-3.055	Health Savings Account Plan Benefit Provisions and Covered Charges	39 MoReg 1903	Jan. 1, 2015	June 29, 2015
22 CSR 10-3.056	PPO 600 Plan Benefit Provisions and Covered Charges	39 MoReg 1904	Jan. 1, 2015	June 29, 2015
22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges	39 MoReg 1905	Jan. 1, 2015	June 29, 2015
22 CSR 10-3.075	Review and Appeals Procedure	39 MoReg 1916	Jan. 1, 2015	June 29, 2015
22 CSR 10-3.090	Pharmacy Benefit Summary	39 MoReg 1920	Jan. 1, 2015	June 29, 2015
22 CSR 10-3.150	Disease Management Services Provisions and Limitations	39 MoReg 1923	Jan. 1, 2015	June 29, 2015

Executive Orders	Subject Matter	Filed Date	Publication
	2015		
15-01	Appoints Byron M. Watson to the Ferguson Commission to fill the vacancy created by the resignation of Bethany A. Johnson-Javois.	Jan. 2, 2015	This Issue
	2014		
14-16	Extends Executive Order 14-07 and further orders that the Disparity Study Oversight Review Committee present its report to the governor and commissioner of administration by January 31, 2015.	Dec. 24, 2014	40 MoReg 129
14-15	Establishes the "Ferguson Commission" which shall study and recommend ways to make the St. Louis region a stronger, fairer place for everyone to live by studying the following subjects: 1) citizen-law enforcement interactions and relations; 2) racial and ethnic relations; 3) municipal government organization and the municipal court system; and 4) disparities in substantive areas.	Nov. 18, 2014	40 MoReg 5
14-14	Declares a state of emergency exists in the state of Missouri and directs the Missouri State Highway Patrol with the St. Louis County Police Department and the St. Louis Metropolitan Police Department to operate as a Unified command and ensure public safety in the City of Ferguson and the St. Louis Region and further orders the Adjutant General to call and order into service such portions of the organized militia as he deems necessary.	Nov. 17, 2014	39 MoReg 2116
14-13	Closes state offices Nov. 28, 2014.	Oct. 31, 2014	39 MoReg 1811
14-12	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Activation Plan be activated.	Oct. 22, 2014	39 MoReg 1809
14-11	Establishes the Office of Community Engagement.	Sept. 18, 2014	39 MoReg 1656
14-10	Terminates Executive Orders 14-08 and 14-09.	Sept. 3, 2014	39 MoReg 1613
14-09	Activates the state militia in response to civil unrest in the City of Ferguson and authorizes the superintendent of the Missouri State Highway Patrol to maintain peace and order.	Aug. 18, 2014	39 MoReg 1566
14-08	Declares a state of emergency exists in the state of Missouri and directs the Missouri State Highway Patrol to command all operations necessary in the city of Ferguson, further orders other law enforcement to assist the patrol when requested, and imposes a curfew.	Aug. 16, 2014	39 MoReg 1564
14-07	Establishes the Disparity Study Oversight Review Committee.	July 2, 2014	39 MoReg 1345
14-06	Orders that the Division of Energy develop a comprehensive State Energy Plan to chart a course toward a sustainable and prosperous energy future that will create jobs and improve Missourians' quality of life.	June 18, 2014	39 MoReg 1262
14-05	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated.	May 11, 2014	39 MoReg 1114
14-04	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated.	April 3, 2014	39 MoReg 1027
14-03	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies.	March 20, 2014	39 MoReg 958
14-02	Orders the Honor and Remember Flag be flown at the State Capitol each Armed Forces Day, held on the third Saturday of each May.	March 20, 2014	39 MoReg 956
14-01	Creates the Missouri Military Partnership to protect, retain, and enhance the Department of Defense activities in the state of Missouri.	Jan. 10, 2014	39 MoReg 491

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