

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 If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission.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 3—Preapproval of Claims and Accounts**

PROPOSED RULE

1 CSR 10-3.020 Deduction of Amounts Owed by Employees to the State

PURPOSE: Section 33.103.2(4), RSMo provides that the Commissioner may deduct from a state employee's compensation warrant "[a]ny amount determined to be owed by the employee to the state in accordance with guidelines established by the commissioner of administration which shall include notice to the employee and an appeal process." This rule sets forth the guidelines by which amounts owed by employees to the state may be deducted from compensation warrants.

(1) Definitions.

(A) All terms used in this rule have the same meanings as in Chapter 33, RSMo, unless otherwise indicated.

(B) The term "decision" shall have the same meaning as in section 536.010, RSMo.

(C) The term "Division of Accounting" shall mean the Division of Accounting of the Office of Administration. Contact information for the Division of Accounting may be found on the Office of Administration's website, <https://oa.mo.gov>.

(D) The term "employee" shall include both current state employees and former state employees.

(2) Deduction Procedure.

(A) Deductions Initiated by a State Agency.

1. State Agency Responsibilities. A state agency seeking to recoup an amount owed by an employee to the state from the employee's compensation warrant must comply with the following procedure before the Division of Accounting will effectuate a deduction from an employee's compensation warrant pursuant to section 33.103.2(4), RSMo:

A. The employee must have received notice in compliance with paragraph 2. of this subsection;

B. The state agency must provide a written communication to the Division of Accounting explaining the justification for the deduction, the method by which notice to the employee was given, a copy of the notice, the amount of the deduction, and the requested coding for the deduction;

C. The state agency must provide the Division of Accounting with the name and contact information of the state agency contact person who should field any questions or requests for additional information regarding the deduction; and

D. The state agency must fully comply with this procedure no later than 12:00 p.m. six (6) working days prior to the proposed effective date of the deduction.

2. Notice to the Employee. A state agency will present to the Division of Accounting as sufficient evidence of notice to the employee of the deduction, a copy of a written communication to the employee, either in paper or electronic format, informing the employee of the amount of the deduction, the reasons for the deduction, and his/her right to appeal the deduction pursuant to this rule.

3. Requests for Additional Information. The state agency shall promptly respond to inquiries from the Division of Accounting relating to a requested deduction and provide additional information as needed. Failure to promptly provide additional information requested by the Division of Accounting may prevent the Division of Accounting from being able to process a requested deduction.

4. Deduction Processing. The Division of Accounting will process a deduction after sufficient evidence of the appropriateness of the deduction and notice to the employee has been provided by the state agency. Deductions will be processed by the Division of Accounting as near to the effective date proposed by the state agency as is practicable under the circumstances.

(B) Deductions Initiated by the Division of Accounting.

1. Division of Accounting Responsibilities. The Division of Accounting will utilize the following procedure to effectuate the deduction of an amount owed by an employee to the state from an employee's compensation warrant pursuant to section 33.103.2(4), RSMo:

A. The Division of Accounting may initiate deductions of amounts owed by an employee to the state due to erroneous overpayments, borrowed leave, or other circumstances in which the Division of Accounting can determine the amount of the deduction without receiving additional information from the state agency;

B. Prior to the effective date of the deduction, or as soon as practicable thereafter, the Division of Accounting will provide written notice to the employee, either in paper or electronic format, of the amount to be deducted, the reasons for the deduction, and his/her

right to appeal the deduction pursuant to this rule; and

C. The Division of Accounting will provide notice of the deduction to the state agency no later than when notice is provided to the employee.

(3) Appeal Procedure.

(A) Timing of Appeal. Appeals of deductions must be received in hard-copy by mail or hand-delivery in the Office of the Commissioner, State Capitol Building, Room 125, PO Box 809, Jefferson City, Mo 65102-0809, no later than thirty (30) calendar days after the later of the date notice is sent to the employee or the effective date of the deduction from the employee's compensation warrant, or by the next working day thereafter if the appeal period ends on a weekend or holiday. For example, if an employee was paid on January 15, received notice of the deduction prior to that date, and wishes to appeal a deduction taken from that paycheck, an appeal must be received no later than February 14, or by the next working day thereafter if February 14 falls on a weekend or holiday.

(B) Effect of Appeal on Pending Deduction. The submission of an appeal prior to the effective date of the deduction will not prevent the deduction from occurring so long as the state agency and/or Division of Accounting have complied with the applicable deduction procedure described in this rule, except in instances where a final decision is reached to modify the amount of the deduction or reverse the deduction with sufficient time remaining to effectuate the final decision prior to the deduction.

(C) Contents of Appeal. Appeals should set out in clear, concise language the employee's understanding of the events preceding the deduction, any inaccuracies in the state agency's communications to the employee regarding the deduction, the reason(s) why the employee believes the deduction is inappropriate, and attach all evidence supporting the employee's position.

(D) Standard of Review. Appeals shall involve a review of the appropriateness of the deduction in light of all of the relevant facts and law.

(E) Optional Hearing. The commissioner or his/her designee may or may not decide to hold an informal hearing to gather additional information regarding the deduction. It is expected that the employee, one or more representatives of the state agency, and/or one (1) or more representatives of the Division of Accounting will attend this hearing if held. The employee may request that the commissioner or his/her designee allow the attendance of individuals with first-hand knowledge relevant to the deduction. The parties shall all proceed in a respectful and orderly fashion as directed by the commissioner or his/her designee so as to allow the commissioner or his/her designee the opportunity to gather information regarding the deduction.

(F) Final Decision. At any time following the receipt of a timely appeal of a deduction after sufficient information has been gathered to make an informed decision, the commissioner shall issue a written decision disposing of the employee's appeal by either upholding the deduction, modifying the amount of the deduction, or reversing the deduction. The employee may request a stay of the appeal pending the resolution of other relevant administrative, civil, or criminal proceedings and the commissioner or his/her designee may rule on the request in an exercise of their discretion. Any unrulled request for stay will be presumed denied.

(4) Appeals from Final Decisions. Final decisions of the commissioner under this rule may be appealed pursuant to section 536.150, RSMo.

AUTHORITY: sections 33.103 and 536.023, RSMo 2016. Emergency rule filed April 16, 2020, effective April 30, 2020, expires Oct. 30, 2020. Original rule filed April 16, 2020.

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 Office 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 1—OFFICE OF ADMINISTRATION
Division 20—Personnel Advisory Board and Division of Personnel
Chapter 5—Working Hours, Holidays and Leaves of Absence

PROPOSED RULE

1 CSR 20-5.030 Borrowed Leave

PURPOSE: This rule provides for borrowed leave use and availability in response to Coronavirus Disease 2019 (COVID-19).

(1) Scope. This rule establishes the availability and eligibility requirements of borrowed leave within state agencies subject to section 36.350, RSMo, notwithstanding any other rule in this chapter to the contrary. The board expects that section (2) of this rule will be rescinded when the availability of borrowed leave in response to the COVID-19 pandemic is no longer necessary.

(2) Borrowed Leave.

(A) State agencies may permit employees who have exhausted their sick leave balance to borrow against future sick leave accruals in circumstances caused directly or indirectly by COVID-19 as specified in this rule.

(B) Borrowed leave may be approved by state agencies in accordance with a written interagency memorandum issued by the Commissioner of the Office of Administration. The board does not anticipate that this memorandum will substantially affect the legal rights of, or procedures available to, the public or any segment thereof, because it only impacts the internal management of state agencies. In response to the exigencies created by the COVID-19 pandemic, the memorandum may describe any of the following:

1. The circumstances in which borrowed leave may be approved;
2. The amount of borrowed leave available, which may vary by circumstance;
3. Documentation requirements applicable to borrowed leave, which may vary by circumstance;
4. Additional requirements applicable upon taking threshold amounts of borrowed leave;
5. The procedure by which borrowed leave will be repaid while the employee remains in state service;
6. The establishment of ShareLeave programs by which eligible employees may donate leave hours to assist recipient employees in the repayment of borrowed leave; and
7. Any other procedures or requirements incident to the administration of leave as the commissioner believes to be appropriate and necessary to address the emergency created by the COVID-19 pandemic.

(3) Repayment of Borrowed Leave. Employees approved to borrow against future sick leave accruals must repay the borrowed leave in full. In addition to repaying borrowed leave with sick leave, the interagency memorandum may specify that other accumulated time may be used by employees and, in the event of separation must be used, to repay borrowed leave. In the event an employee separates from

state service prior to full repayment of borrowed leave, the remaining balance will be deducted from the employee's compensation warrants in accordance with subdivision (4) of subsection 2 of section 33.103, RSMo, and guidelines established pursuant thereto. To the extent the employee's compensation warrants are insufficient to fully repay their borrowed leave balance, collection of the remaining balance is authorized.

AUTHORITY: section 36.350, RSMo 2016, and sections 36.060 and 36.070, RSMo Supp. 2019. Emergency rule filed April 16, 2020, effective April 30, 2020, expires Oct. 30, 2020. Original rule filed April 16, 2020.

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 Personnel Advisory Board, Attn: Casey Osterkamp, Secretary, 301 W. High St., Room 430, Jefferson City, MO 65101. 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 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 2—Health Requirements for Movement of
Livestock, Poultry and Exotic Animals**

PROPOSED AMENDMENT

2 CSR 30-2.005 Vesicular Stomatitis Restrictions on Domestic and Exotic Ungulates (Hoofed Animals) Entering Missouri. The director is amending section (1).

PURPOSE: This amendment reflects current scientific research on Vesicular Stomatitis disease control.

(1) In addition to any other entry requirements, any domestic or exotic ungulate(s) (hoofed animal) originating from a [state] county affected with Vesicular Stomatitis, meaning a [state] county with a premises under quarantine for Vesicular Stomatitis, must meet the following requirements:

(B) The Certificate of Veterinary Inspection must be issued within seven (7) days prior to entering Missouri and must state that the animals listed are free of clinical signs of Vesicular Stomatitis and have not been exposed to Vesicular Stomatitis or located [within ten (10) miles of] on a premises quarantined for Vesicular Stomatitis within the past [thirty (30)] fourteen (14) days.

(C) These requirements shall remain in place until a quarantine release has been issued for all affected premises in the [state] county from which the animal originates.

AUTHORITY: section 267.645, RSMo [2000] 2016. Emergency rule filed July 14, 1995, effective July 24, 1995, expired Nov. 20, 1995. Original rule filed Aug. 15, 2005, effective March 30, 2006. Amended: Filed April 30, 2020.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment by website: <https://agriculture.mo.gov/proposed-rules/> or by mail: Missouri Department of Agriculture, attn: Dr. Steve Strubberg, PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days of publication of this notice in the *Missouri Register*. No public hearing is scheduled.

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

PROPOSED AMENDMENT

13 CSR 40-2.160 State Hearing Procedures. The department is updating sections (1)-(8) and adding new sections (9)-(18) that cover discovery, continuances, representation, dismissal, and timely hearing decisions.

PURPOSE: The department is amending the entire rule to conform to changes in federal and state law, particularly federal regulations and state laws that have been issued since 1990. The amendment also accounts for changes in technology, and addresses issues that commonly occur in the appeals process and that the rule, in its current form, does not address.

(1) [If an Old Age Assistance, Nursing Care, Aid to Dependent Children, General Relief, Permanent and Total Disability Assistance or Aid to the Blind application is not acted upon within a reasonable length of time after the filing of the application or is denied in whole or in part, or if any benefits are cancelled or modified and concurrently with each reinvestigation, the applicant or recipient shall be notified in writing by the county family services office of his/her right to appeal to the director of the Division of Family Services; however, those recipients receiving the maximum payment allowed by law will not be notified of their right to appeal on the basis of the amount of grant, following the completion of a reinvestigation of their case. (Original rule filed Sept. 26, 1951, effective Oct. 6, 1951.)] This rule outlines the procedure for participant appeals resulting from the operation of the programs administered by the Missouri Department of Social Services pursuant to section 208.080, RSMo. For anything in this rule that conflicts with appeals of decisions regarding Temporary Assistance screening or testing for illegal controlled substances, the regulation at 13 CSR 40-2.440 shall control. For anything in this rule that conflicts with a federal or state law or regulation relevant to the program for which the appeal is made, the relevant federal or state law or regulation controls.

(2) Definitions.

(A) "Authorized Representative" means an individual or organization who a participant has legally authorized to act on behalf of the participant in the appeal process as provided for under 13 CSR 40-2.015. Participants shall designate an authorized representative in ways that are approved by the division and are authorized by state and federal law. If the participant is unable to reduce such authorization to writing or to a form approved by the division, the hearing officer or other division employee may assist the participant in doing so as allowed by law.

(B) "Division" means the relevant division of the Department of Social Services to whom a participant is requesting an appeal. Pursuant to section 208.080, RSMo, this shall be either the Family Support Division, Children's Division, or MO HealthNet Division.

(C) "Electronic access account" means the use of available

online application processes or other available electronic systems by participants to submit an application or otherwise conduct business with the division.

(D) "Good cause" means a mistake or conduct beyond the control of the participant that is not intentionally or recklessly designed to impede the hearing process. For purposes of this regulation, failure to advise the division of a current mailing address shall not constitute good cause.

(E) "Hearing" means a legal proceeding to provide documents and testimony for the division. The proceeding shall be conducted for the purpose of presenting evidence relevant to the participant's appeal. The Hearing Officer may appear in person, by telephone or other electronic means.

(F) "Hearing Notice" means a document, sent by the Division of Legal Services of the Department of Social Services, advising the participant of the time, date, and place of their hearing.

(G) "Participant" means an individual or vendor who has applied for, is receiving, or has been denied benefits or services provided by the Department of Social Services or by other applicable programs administered by the Department of Social Services.

[(2)](3) In addition to appeal rights conveyed by section 208.080, RSMo, [if] if an institutionalized spouse, a community spouse or a representative of either has requested an assessment of countable resources for the month in which institutionalization begins, in accordance with [13 CSR 40-2.030] 42 USC 1396r-5, upon the determination of the spousal share, the institutionalized spouse and the community spouse shall be notified in writing by the [county family services office] division of their rights to appeal to the director of the [Division of Family Services] division. This notice shall inform the institutionalized spouse and community spouse that appeal rights are effective upon application for [Medicaid vendor] applicable MO HealthNet benefits for the institutionalized spouse. Hearings regarding assessment issues shall be held within thirty (30) days of the date of the request for the hearing.

[(3)](4) Upon the determination of the community spouse monthly income allowance described in [13 CSR 40-2.200, the county family services office] 42 USC 1396r-5, the division shall notify, in writing, the institutionalized spouse and the community spouse, of their rights to appeal to the director of the [Division of Family Services] division.

[(4) Notice of hearing shall be mailed by registered United States mail to the appellant at least seven (7) days before the date of the hearing, specifying the time, date and place of hearing; provided, however, that a shorter notice period may be used if not prejudicial to the parties. A copy of the notice also will be mailed to the county family services office and to any party of record representing the appellant. (Original rule filed Feb. 20, 1947, effective March 2, 1947.)]

(5) A participant may appeal any division decision that delays, denies, or adversely affects the participant's benefits or services to the division director, pursuant to section 208.080, RSMo. This may include a failure of the division to act, as provided by law.

(A) A participant may request an appeal in person, by telephone, by mail, or through other commonly available electronic means that are used by the division, including email and facsimile transmission.

(B) Proper blank forms for requesting an appeal shall be available at local division offices and online through the division website.

(C) A request for an appeal shall include, at a minimum:

1. The name and Departmental Client Number (DCN), Social Security number, or date of birth of the participant for which the hearing has been requested, or the name and

Departmental Vendor Number (DVN) of the vendor for which the hearing has been requested;

2. The name of the person requesting the hearing, if requested by someone other than the participant;

3. The current address and phone number of the participant, and the current address and phone number of the person requesting the hearing if requested by someone other than the participant; and

4. A brief description of the reason the appeal is being requested.

(D) An electronic signature shall serve as a valid signature for the purposes of requesting an appeal under this regulation.

(6) A participant may request an expedited hearing if the participant's life, health, or ability to attain, maintain, or regain maximum function would be jeopardized by the time ordinarily permitted for a standard hearing, or as otherwise required by law.

(A) A health care provider may request an expedited hearing on behalf of the participant and in regards to the participant's eligibility for benefits and services governed by section 208.080, RSMo, or alternatively, may submit documentation supporting the individual's request for an expedited hearing.

(B) A request for an expedited hearing may be made in the same manner as any other request for a hearing, as set forth in paragraph (5)(C)2., above.

(C) If the hearing officer denies the request for an expedited hearing, the hearing officer shall notify the participant through electronic means or orally, and if orally, with written notice sent within two (2) calendar days of the denial.

(D) If the hearing officer denies the request for an expedited hearing, the denied request shall still serve as a valid request for an appeal under this regulation.

(7) The department shall send notice to the participant electronically at the participant's last known electronic mail address, or by posting it to the participant's electronic access account, at least ten (10) days before the date of the hearing, specifying the time, date, and location of the hearing. If the department determines that the participant has no electronic mail address on record and does not have an electronic access account, or has opted out of receiving electronic communications, the department shall send the notice by regular United States mail to the participant's last known mailing address.

(A) The burden is on the participant to keep the division advised of his or her current mailing address and other pertinent contact information.

(B) Service of notice to the participant's last known electronic or mailing address of record, pursuant to this section, shall be deemed proper service.

(C) If the department receives information prior to the scheduled hearing that the participant did not receive the notice, the department shall reset the scheduled hearing to a new hearing date and issue a new hearing notice to the participant's updated contact location. If the participant's updated contact location, or the contact location of his/her authorized representative or attorney, cannot be determined, the division shall take the appropriate action regarding the participant's benefits or services as provided for by law for situations in which the division is unable to locate a participant.

(D) The department may use a shorter notice period if it is not prejudicial to the parties.

(E) A copy of the notice also will be sent to any attorney, legal guardian, and/or authorized representative who has notified the division that they are representing the participant.

[(5)](8) Procedure with reference to the hearings shall be [simple,] informal [and summary] with respect to the conduct of the hearings, but the rules of evidence as applied to civil cases in

Missouri shall be applied. Exceptions to adverse rulings are automatically saved to the party ruled against]. The Missouri Administrative Procedure Act, as set forth in section 536.070, RSMo, shall apply to hearings pursuant to this regulation unless in conflict with another statute or federal regulation, or as otherwise set forth herein.

(A) Stipulations may be entered into prior to final disposition to—

1. [w/Withdraw the application for a hearing;
2. [a/Agree to a statement of facts; or
3. [a/Agree to any other pertinent matter or order.

(B) [Hearings may be adjourned, postponed or continued from time-to-time or place-to-place at the discretion of the director or referee. Continuances of hearings will not be granted as a matter of course unless the request for continuance is received five (5) days prior to the date scheduled for the hearing. Continuances will be granted during the five (5)-day period prior to the hearing only when the hearing officer determines from the request that extraordinary circumstances exist.] An attorney shall not act as an advocate at a hearing in which the attorney is likely to be a necessary witness.

[(C) Subpoenas to compel the attendance of witnesses and the production of records may be issued by the director or referee upon a statement of the necessity therefore filed by the party requesting the issuance of the subpoena.

(D) Witness and mileage fees to any witness duly subpoenaed shall be paid as follows: Witnesses shall receive one dollar and fifty cents (\$1.50) for each day's attendance and in all cases five cents (5¢) per mile for each mile actually traveled. These witnesses and mileage fees may be claimed only at the time and place of hearing or the hearing adjournment and shall be certified by the witness and approved by the director or referee. Payment shall be made as other payments out of the Division of Family Services Administration Fund. Under no circumstances shall parties to the case or their relatives be granted witness fees.

(E) If any appellant fails to enter his/her appearance either in person or by duly authorized representative or show good cause for not appearing at any hearing, his/her appeal shall be dismissed for want of prosecution.]

[(F)](C) Briefs setting forth written argument on the law and the facts may be filed in any case within a specified time designated by the [director or referee] hearing officer.

(D) In order to protect the integrity and fairness of the appeals process, the hearing officer requires all parties and persons acting in a representational capacity to comply with the following rules of conduct:

1. All individuals shall appear for the hearing and be ready to proceed no later than the starting time listed on the notice. A hearing officer may find a participant in default and dismiss the appeal if the participant or the participant's representative does not appear within ten (10) minutes after the starting time. However, the hearing officer shall retain the authority to commence the hearing at a time appropriate to the circumstances;

2. All individuals shall comply with all directions given by a hearing officer during a hearing. If any individual fails to follow these directions, the hearing officer may exclude the individual from the hearing, or may adjourn the hearing.

[(G) Within a reasonable time after the conclusion of a hearing, the director of the Division of Family Services will render a decision which shall include a statement of the Findings of Fact and Conclusions of Law. A copy of the decision will be sent to the appellant by registered United States mail. A copy also will be mailed to the county family services office and to any duly authorized representative of the appellant. (Original rule filed Feb. 20, 1947, effective March 2, 1947.)]

[[6]](9) [There are established the positions of state hearing officer within the Division of Legal Services] The department's Division of Legal Services (DLS) has established hearing officer positions in order to comply with all pertinent federal and state law and regulations.

(A) Hearing officers shall be licensed to practice law in the State of Missouri at all times relevant herein.

(B) The [state] hearing officers shall have authority to conduct state-level hearings of a pre-termination or appeal nature. They shall serve as [direct representatives] designees of the division director, [of the Division of Family Services] as required by federal or state law.

(C) All decisions issued [as a result of the hearing so] after state-level hearings conducted by the hearing officers shall be in the name of the division director [of the Division of Family Services] or the director's designee, as required by federal or state law.

(D) [Although the hearing officers may be assigned to a certain area, this] The hearing officers' authority to conduct hearings shall be statewide.

(E) The authority of the hearing officers to conduct hearings arises under section 208.080, RSMo, and shall apply to all programs administered by the director of the [Division of Family Services. (Original rule filed April 1, 1975, effective April 10, 1975.)] Department as set forth in section 208.080, RSMo.

(10) Any party shall be entitled to conduct depositions pursuant to section 536.073 RSMo, as amended, and the Missouri Rules of Civil Procedure. The costs of the depositions shall be borne by the party conducting the deposition unless otherwise agreed to by the parties or ordered by a court of competent jurisdiction.

(A) Pursuant to section 536.073, RSMo, no discovery shall be allowed for hearings conducted pursuant to this rule unless it is expressly identified herein.

(11) Subpoenas to compel the attendance of witnesses and subpoenas *duces tecum* to compel the production of records may be issued by the hearing officer upon a statement of necessity filed by the party requesting the issuance of the subpoena pursuant to section 536.077, RSMo.

(A) The witness shall be entitled to the same fees and, if compelled to travel more than forty (40) miles from his or her place of residence, shall be entitled to the same tender of fees for travel and attendance, and at the same time, as is now or may hereafter be provided for witnesses in civil actions in the circuit court, such fees to be paid by the party requesting the subpoena, except where the payment of such fees is otherwise provided for by law.

(B) Under no circumstances shall the department grant witness fees to parties to the case or their relatives.

(12) The hearing officer may, as allowed by state and federal law, keep the record of the administrative hearing open to a fixed day so as to order, and receive the results of, a physical or mental health examination, to allow the parties to submit additional evidence, or for other good cause.

(A) In cases in which the hearings unit keeps the record open to a fixed day in order to allow the parties to submit additional evidence, if the additional evidence is not received by the department by the fixed day and no requests have been made to extend the record (in which case the hearing officer may extend the record further), the hearing officer shall close the record and the director will issue a decision based on the record.

(B) A request for a continuance of the hearing date must be communicated to the hearing officer and any other parties to the hearing, if possible, at least five (5) days prior to the date of the scheduled hearing. Continuances will be granted only when the hearing officer determines from the request that extraordinary circumstances exist.

(13) For any time limit imposed by state or federal law under which the division must take final administrative action, starting with the date of the request for a hearing and ending on the date of the division's action, and as allowed by federal and state law, the time limit is tolled for the length of any delay in the hearing process caused either by one (1) of the reasons identified in section (12) of this rule, the claimant's actions, or by the actions of, or at the request of, the claimant's authorized representative, guardian, conservator, or attorney.

(A) If the record at an administrative hearing is held open at the request of a claimant under section (12) of this rule, the deadline for administrative action is extended by the number of calendar days between the date of the request for a hearing and the fixed day identified in section (12).

(B) Example: The division receives a request for a hearing regarding a person's eligibility for MO HealthNet on the basis of disability on May 1, 2020. Under federal law, the division has ninety (90) days to take a final action on the outcome of the hearing. The division must therefore take final administrative action on or before July 30, 2020. The hearings unit sets a hearing date for May 15, 2020 (fourteen (14) days into the ninety- (90-) day timeline). The claimant then requests a continuance of the hearing date, and the hearing is rescheduled for May 31, 2020. The ninety- (90-) day count stops on May 15, 2020 at fourteen (14) days. It resumes on May 31, 2020. This results in an extension of the deadline for administrative action by sixteen (16) days to cover the continuance period of May 15 through May 31, 2020. The new deadline for administrative action becomes August 15, 2020.

(14) Any party may represent themselves, be represented by an authorized representative, by a licensed Missouri attorney, by a nonresident attorney appearing in compliance with Supreme Court Rule 9, or by an eligible law student complying with Missouri Supreme Court Rule 13.

(15) All persons who will be acting in a representative capacity on behalf of a party before the hearing officer shall file notice of their intent to represent the party as soon as possible after being retained or chosen. Non-attorneys shall file proof that they are authorized representatives of the participant pursuant to 13 CSR 40-2.015. Attorneys shall file an entry of appearance.

(16) The Hearings Unit shall dismiss an appeal under the following circumstances:

(A) The appeal was not timely requested;

(B) The division has not taken an action affording (or has not been inactive to such an extent as to afford) the participant a right to appeal; or

(C) The participant, having been notified of the time, date, and place of the hearing, fails to appear at the hearing without good cause.

(17) If the participant dies prior to or at any time during the appeal, the participant's attorney's or authorized representative's authority shall terminate.

(A) Upon being advised of the death of the participant, the hearing officer shall continue the hearing.

(B) Following the participant's death, only the duly authorized personal representative of or legal counsel for the participant's estate shall be allowed to represent the participant at the hearing.

(C) If the duly authorized personal representative of the participant's estate does not enter an appearance with the hearing officer within thirty (30) days after the hearing date, the hearing officer will dismiss the appeal.

(D) This section shall not terminate an authorized representative's authority to assist with an application for MO HealthNet

benefits prior to the participant's death, as allowed under 13 CSR 20-2.015(16).

(18) Within a reasonable time after the conclusion of a hearing, the division director or the director's designee, as required by federal and state law, will render a decision in compliance with section 208.080.7, RSMo.

(A) A copy of the decision will be sent to the participant and to the participant's legal guardian, attorney, and/or authorized representative by regular United States mail, or electronically if the participant so chooses and the department has the capability to send an electronic notice.

(B) A copy will also be sent to the division.

AUTHORITY: [section 207.020, RSMo 1986. Filing dates for original rules are shown in the text of the rule.] sections 207.022 and 660.017, RSMo 2016. Original section (1) filed separately Sept. 26, 1951, effective Oct. 6, 1951. Original section (4) filed separately Feb. 20, 1947, effective March 2, 1947. Original subsection (5)(G) filed separately Feb 20, 1947, effective March 2, 1947. Original section (6) filed separately April 1, 1975, effective April 10, 1975. This version filed March 24, 1976. Amended: Filed April 14, 1980, effective Aug. 11, 1980. Emergency amendment filed Sept. 19, 1989, effective Oct. 1, 1989, expired Jan. 28, 1990. Amended: Filed Nov. 2, 1989, effective Jan. 26, 1990. Amended: Filed Jan. 10, 1990, effective April 12, 1990. Amended: Filed April 29, 2020.

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, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comments@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement [Plan; Outpatient Hospital Services Reimbursement] Methodology. The division is amending the title, sections (1)-(5), removing sections (6), (9)-(11), (13)-(18), and (21), amending new sections (6), (7), and (11), adding new section (10), and renumbering as necessary.

PURPOSE: This amendment deletes outdated terms, language, and provisions regarding the calculation of inpatient hospital services reimbursement. Paragraphs (6) and (15) are being deleted and moved to 13 CSR 70-15.015. This amendment updates the regulation citations and the incorporation language for the hospital provider manual. Lastly, this amendment moves the Enhanced GME Payment provision to section (10).

(1) General Reimbursement Principles.

(C) The Title XIX reimbursement for hospitals, excluding those located outside Missouri and in-state federal hospitals, shall include

per diem payments, outpatient payments, disproportionate share payments [as described in this regulation through May 31, 2011, and as described in 13 CSR 70-15.220 beginning June 1, 2011]; and various MO HealthNet Add-On payments, as described in this rule; or a safety net adjustment, paid in lieu of Direct Medicaid Payments described in section (15) and Uninsured Add-Ons described in this regulation through May 31, 2011, and described in 13 CSR 70-15.220 beginning June 1, 2011]. Reimbursement shall be subject to availability of federal financial participation (FFP).

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

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

3. Disproportionate share [reimbursement—*The disproportionate share payments described in section (16) and subsection (18)(B)*], include both the federally-mandated reimbursement for hospitals which meet the federal requirements listed in section (6) and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation. These Safety Net and Uninsured Add-Ons shall not exceed one hundred percent (100%) of the unreimbursed cost for MO HealthNet and the cost of the uninsured unless otherwise permitted by federal law. Beginning June 1, 2011, hospital disproportionate share reimbursements] payments are [defined] described in 13 CSR 70-15.220.

4. MO HealthNet Add-Ons—*MO HealthNet Add-Ons*] are described in sections [(13), (14), (15), (19), and (21)] (9) and (10) of this rule and 13 CSR 70-15.015 and are in addition to MO HealthNet per diem payments. These payments are subject to the federal Medicare Upper Limit test.

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

(2) Definitions.

(B) Bad debt. Bad debts [should] include the costs of caring for patients who have insurance but are not covered for the particular services, procedures, or treatment rendered. Bad debts [should] do not include the cost of caring for patients whose insurance covers the given procedures but limits coverage. In addition, bad debts [should] do not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

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

[(E)](D) Charity care. Results from a provider's policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

[(F)](E) Contractual allowances. Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

[(G)](F) Cost report. A cost report details, for purposes of both Medicare and MO HealthNet reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. [The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal

years ending on or after September 30, 1996.] The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

[(H)](G) Critical access. Hospitals which meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act. A Missouri expanded definition of critical access shall also include hospitals which meet the federal definitions of both a rural referral center and sole community provider and is adjacent to at least one (1) county that has a Medicaid eligible population of at least twenty-five percent (25%) of the total population of the county or hospitals which are the sole community hospital located in a county that has a Medicaid population of at least twenty-five percent (25%) of the total population of the county.

[(I)](H) Disproportionate share reimbursement. The disproportionate share payments [described in section (16), and subsection (18)(B)], include both the federally-mandated reimbursement for hospitals which meet the federal requirements listed in section (6) and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation. These Safety Net and Uninsured Payment Add-Ons shall not exceed one hundred percent (100%) of the unreimbursed cost for MO HealthNet and the cost of the uninsured unless otherwise permitted by federal law. Beginning June 1, 2011, disproportionate share reimbursement is] are described in 13 CSR 70-15.220.

[(J)](I) Effective date.

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification to the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.

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

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

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

1. Allowances for return on equity capital;

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

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

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

[(N)](M) Per diem rates. The per diem rates shall be determined from the individual hospital cost report in accordance with section (3) of [the] this regulation.

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

[(P)](O) Specialty pediatric hospital. An inpatient pediatric acute care facility which—

1. Is licensed as a hospital by the Missouri Department of Health and Senior Services under Chapter 197 of the *Missouri Revised Statutes*;

2. Has been granted substantive waivers by the Missouri Department of Health and Senior Services from compliance with material hospital licensure requirements governing a) the establishment and operation of an emergency department, and b) the provision of pathology, radiology, laboratory, and central services; and

3. Is not licensed to operate more than sixty (60) inpatient beds.

[(Q)] Trauma hospital. A trauma center designated by the Missouri Department of Health and Senior Services.]

[(R)](P) Trend factor. The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

[(S)](Q) Children's hospital. An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) years old and which has designated in its licensure application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit [as defined in 19 CSR 30-20.021(4)(F)].

[(T)](R) FRA. The Federal Reimbursement Allowance (FRA) is identified in 13 CSR 70-15.110. Effective January 1, 1999, the assessment shall be an allowable cost.

[(U)](S) Incorporates by Reference. This rule incorporates by reference the following:

1. *[Institutional Provider Manual] The Hospital Provider Manual is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at <http://manuals.momed.com/manuals/>, March 6, 2020. This rule does not incorporate any subsequent amendments or additions; and*

2. *Medicare/Medicaid Cost Report [CMS 2552-96 and] CMS 2552-10, which [are] is incorporated by reference and made a part of this rule as published by the Centers for Medicare and Medicaid Services at website <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html>, [August 1, 2013] February 18, 2020. This rule does not incorporate any subsequent amendments or additions.*

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

(B) Trend Indices (TI). [Trend indices are determined based on the four- (4-) quarter average DRI Index for DRI-Type Hospital Market Basket as published in Health Care Costs by DRI/McGraw-Hill for each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital index as published in Health Care Costs by DRI/McGraw-Hill, or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).] Trend indices starting in SFY 2016 will be determined based on the Hospital Market Basket index as published in Healthcare Cost Review by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).

[1. The TI are—

- A. SFY 1994—4.6%*
- B. SFY 1995—4.45%*
- C. SFY 1996—4.575%*
- D. SFY 1997—4.05%*
- E. SFY 1998—3.1%*
- F. SFY 1999—3.8%*
- G. SFY 2000—4.0%*
- H. SFY 2001—4.6%*
- I. SFY 2002—4.8%*
- J. SFY 2003—5.0%*
- K. SFY 2004—6.2%*
- L. SFY 2005—6.7%*
- M. SFY 2006—5.7%*
- N. SFY 2007—5.9%*
- O. SFY 2008—5.5%*
- P. SFY 2009—5.5%*
- Q. SFY 2010—3.9%*
- R. SFY 2011—3.2%—The 3.2% trend shall not be applied in determining the per diem rate, Direct Medicaid*

payments, or uninsured payments.

S. SFY 2012—4.0%

T. SFY 2013—4.4%

U. SFY 2014—3.7%

V. SFY 2015—4.3%

W. SFY 2016—2.5%

X. SFY 2017—2.7%

Y. SFY 2018—3.2%

Z. SFY 2019—2.8%

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

[3.]1. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid payments computed in accordance with [subsection (15)(B)] 13 CSR 70-15.015.

[4.]2. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, will receive the same inpatient rate and outpatient rate as the previous owner/operator. Such facility will also receive the same Direct Medicaid Add-On Payment and Uninsured Add-On Payment as the previous owner/operator if the facility reenters the MO HealthNet Program during the same state fiscal year. If the facility does not reenter during the same state fiscal year, the Direct Medicaid Add-On Payment and Uninsured Add-On Payment will be determined based on the applicable base year data (i.e., fourth prior year cost report for the Direct Medicaid Payment; see 13 CSR 70-15.220 for the applicable data for the Uninsured Add-On Payment). If the facility does not have the applicable base year data, the Direct Medicaid Add-On Payment and the Uninsured Add-On Payment will be based on the most recent audited data available and will include annual trend factor adjustments from the year subsequent to the cost report period through the state fiscal year for which the payments are being determined.

(4) *Per Diem Rate—New Hospitals.*

[(A)] Facilities Reimbursed by Medicare on a Per Diem Basis. In the absence of adequate cost data, a new facility's MO HealthNet rate shall be determined as set forth below in subsection (4)(B).]

[(B)](A) [Facilities Reimbursed by Medicare on a DRG Basis.] In the absence of adequate cost data, a new facility's initial MO HealthNet rate shall be ninety percent (90%) of the average-weighted, statewide per diem rate for the year it became certified to participate in the MO HealthNet program until a prospective rate is determined on the facility's rate setting cost report as set forth below in paragraph [(4)(B)1.] (4)(A)1. The facility's rate setting cost report shall be the first full fiscal year cost report. If the facility's first full fiscal year cost report does not include any Medicaid costs, the facility shall continue to receive the initial rate, and the prospective rate will be determined from the facility's second full fiscal year cost report. If the facility's second full fiscal year cost report does not include any Medicaid cost, the initial rate shall become the facility's prospective rate and shall be effective the date the facility was enrolled in the MO HealthNet program. The effective date for facilities whose prospective rate was based on the rate setting cost report shall be the first day of the SFY that the rate setting cost report is the base year cost report for determining the Direct Medicaid Add-On Payment as described in 13 CSR 70-15.015.

1. *Prospective Per Diem Reimbursement Rate Computation. Each new hospital shall receive a MO HealthNet prospective per diem rate based on the sum of the following components:*

A. *Total Allowable Cost, less Graduate Medical Education cost, adjusted by the Trend Indices [included] in subsection (3)(B) from the year subsequent to the rate setting cost report period through*

the state fiscal year for which the rate is being determined, divided by Medicaid Inpatient Days; plus

B. Graduate Medical Education cost divided by Medicaid Inpatient Days.

2. The per diem rate shall not exceed the average MO HealthNet inpatient charge per day as determined from the rate setting cost report as adjusted by the applicable Trend Indices.

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

4. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with *[subsection (15)(B)] 13 CSR 70-15.015*.

[(C)](B) In addition to the MO HealthNet rate determined by either subsection (4)(A) *[or (4)(B)]*, the MO HealthNet per diem rate for a new hospital licensed after February 1, 2007, shall include an adjustment for the hospital's estimated Direct Medicaid Add-On Payment per patient day, as determined in *[subsection (15)(C)] 13 CSR 70-15.015*, until the facility's prospective rate is set in accordance with subsection *[(4)(B)] (4)(A)*. The facility's Direct Medicaid Add-On adjustment will then no longer be included in the per diem rate but shall be calculated as a separate Add-On Payment, as set forth in *[section (15)] 13 CSR 70-15.015*.

(5) Reporting Requirements.

(A) Cost Reports.

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

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

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

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

C. The MO HealthNet Division may, at its discretion, delay the withholding of funds specified in subparagraphs (5)(A)2.A. and B. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the buying and selling provider may provide adequate assur-

ances. The buying provider must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold fifty thousand dollars (\$50,000) if the cost report is not timely filed.

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

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

(B) Records.

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

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

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

- (I) Participant name and MO HealthNet number;
- (II) Dates of service;
- (III) If inpatient claim, number of days paid for by MO HealthNet, classified by adults and peds, each subprovider, newborn, or specific type of intensive care;
- (IV) Charges for paid inpatient days and inpatient ancillary charges for paid days classified by cost center as reported in the cost report or allowed outpatient services, classified by cost center as reported on cost report;
- (V) Noncovered charges combined under a separate heading;
- (VI) Total charges;
- (VII) Any partial payment made by third-party payers (claims paid equal to or in excess of MO HealthNet payment rates by third-party payers shall not be included in the log);
- (VIII) MO HealthNet payment received or the adjustment taken; and
- (IX) Date of remittance advice upon which paid claim or adjustment appeared;

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

D. Not to be included in the outpatient log are claims or line item outpatient charges denied by MO HealthNet or claims or

charges paid from an established MO HealthNet fee schedule. This would include payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, payments for certain specified clinical diagnostic laboratory services, or payments for services provided by the hospital through enrollment as a MO HealthNet provider-type other than hospital outpatient.

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

[3. *Records to support and document Disproportionate Share Hospital (DSH) payments must be maintained and available for future federal audits. Records used to complete DSH audit surveys shall be kept seven (7) years following the final DSH audit. For example, the SFY 2011 state DSH survey will use 2009 cost data which must be maintained seven (7) years following the completion of the 2014 DSH audit (2022). Records provided by hospitals to the state's independent auditor shall also be maintained for seven (7) years following the completion of the final federal 2014 DSH audit.*]

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

[5.]4. The MO HealthNet Division shall maintain any responses received on this plan, subsequent changes to this plan, and rates for a period of three (3) years from the date of receipt.

(D) Audits.

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

- A. Desk review all hospital cost reports;
- B. Determine the scope and format for on-site audits;
- C. Perform field audits when indicated in accordance with Title XIX principles; and
- D. Submit to the state agency the final Title XVIII cost report with respect to each provider.

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

3. *Annual DSH audits are completed by an independent auditor in accordance with federal DSH audit standards. Hospitals receiving DSH payments are subject to the annual DSH audit.*]

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

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

2. When rate reconsideration is granted in accordance with subsection (5)(F)1.

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

4. *When a hospital documents to the MO HealthNet Division a change in its status from nonprofit to proprietary,*

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

(F) Rate Reconsideration.

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

2. The following may be subject to review under procedures established by the MO HealthNet Division:

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

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

C. Per diem rate adjustments for critical access hospitals.

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

(a) Hospitals which meet the federal definition as a critical access hospital will have a per diem rate equal to one hundred percent (100%) of their estimated MO HealthNet cost per day as determined in [section (15)] 13 CSR 70-15.015.

(b) Hospitals which meet the Missouri expanded definition as a critical access hospital will have a per diem rate equal to seventy-five percent (75%) of their estimated MO HealthNet cost per day as determined in [section (15)] 13 CSR 70-15.015. This includes new hospitals meeting the Missouri expanded definition as a critical access hospital whose interim MO HealthNet rate was calculated in accordance with [subsection (15)(C)] 13 CSR 70-15.015.

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

A. The use of Medicare standards and reimbursement principles;

B. The method for determining the trend factor;

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

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

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

5. The request for an adjustment must be submitted in writing to the MO HealthNet Division and must specifically and clearly

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

[(6) Disproportionate Share and Direct Medicaid Qualifying Criteria. Effective June 1, 2011, disproportionate share payment methodology and criteria that must be met to receive DSH payments are described in 13 CSR 70-15.220. The definitions set forth in this section (6) will continue to be used to determine eligibility for Direct Medicaid Payments (section (15)) and the Safety Net adjustment (section (16)).

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

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

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

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

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

or

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

(i) Total 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. As determined from the fourth prior year desk-reviewed cost report, the hospital—

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

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

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

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

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

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

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

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

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

(B) Those hospitals which meet the criteria established in paragraphs (6)(A)1., (6)(A)2., and (6)(A)4. shall be deemed safety net hospitals. Those hospitals which meet the criteria established in paragraphs (6)(A)1. and (6)(A)3. shall be deemed first tier Disproportionate Share Hospitals (DSH). Those hospitals which meet only the criteria established in paragraphs (6)(A)1. and (6)(A)2. or (6)(A)1. and (6)(A)5. shall be deemed second tier DSH.

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

(D) Specialty pediatric hospitals shall not qualify for disproportionate share payments by meeting the state defined

requirements. However, they will qualify for disproportionate share payments if they meet the federal requirements as defined in paragraphs (6)(A)1. and (6)(A)2.

(E) Hospitals shall not send amended cost reports or other data necessary for qualification for disproportionate share classification for purposes of rate reconsideration unless the reports or other necessary data are received within sixty (60) days of the date of the division's notification of the final determination of the rate.

(F) Hospital-Specific DSH Cap. Unless otherwise permitted by federal law, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for MO HealthNet and the cost of the uninsured. The hospital-specific DSH cap shall be computed by combining the estimated unreimbursed MO HealthNet costs for each hospital, as calculated in section (15), with the hospital's corresponding estimated uninsured costs, as determined in section (18). If the sum of disproportionate share payments exceeds the estimated hospital-specific DSH cap, the difference shall be deducted in order as necessary from safety net payments, other disproportionate share lump sum payments, direct Medicaid payments, and if necessary, as a reduced per diem. All DSH payments in the aggregate shall not exceed the federal DSH allotment within a state fiscal period. Effective June 1, 2011, hospital-specific DSH limits shall be calculated in accordance with federally-mandated DSH audit standards as described in 13 CSR 70-15.220.]

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

(A) Effective for admissions beginning on or after July 1, 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for MO HealthNet-eligible children under the age of six (6) will be made to hospitals meeting the disproportionate share requirements in [subsection (6)(A)] 13 CSR 70-15.220 and, for MO HealthNet-eligible infants under the age of one (1), will be made to any other MO HealthNet hospital except for specialty pediatric hospitals.

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

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

B. Hospitals requesting outlier review for children one (1) year of age to children under six (6) years of age must have qualified for disproportionate share status under [section (6) of this plan] 13 CSR 70-15.220(1)(B) for the state fiscal year corresponding with the fiscal year end of the cost report referred to in paragraph [(7)(A)5.] (6)(A)5.; and

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

(I) The total reimbursable charges for dates of service as described in paragraph [(7)(A)3.] (6)(A)3. must be at least one hundred fifty percent (150%) of the sum of total third-party liabilities and MO HealthNet inpatient claim payments for that claim; or

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

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

A. Have been submitted to the MO HealthNet Division fiscal agent or the managed care health plan in their entirety for routine claims processing, and claim payment must have been made before the claims are submitted to the division for outlier review; and

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

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

4. The claims may be reviewed for—

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

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

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

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

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

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

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

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

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

A. Sum all reimbursable costs per paragraph [(7)(A)5.] (6)(A)5. for all applicable outlier claims to equal total reimbursable costs;

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

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

(B) Effective for admissions beginning on or after July 1, 1997, outlier adjustments shall also be made for MO HealthNet participants enrolled in managed care. All criteria listed under subsection [(7)(A)] (6)(A) applies to managed care outlier submissions.

(C) Effective for admissions beginning on or after May 1, 2017, outlier adjustments will only be made for the fee for service claims. All criteria listed under subsection [(7)(A)] (6)(A) will continue to be applied to the fee for service outlier submissions.

[(8)](7) Payment Assurance.

[(A)] The state will pay each hospital, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the rules implementing the Hospital Reimbursement Program.

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

(C) Regardless of changes of ownership, management, control, operation, or leasehold interests by whatever form

for any hospital previously certified for participation in the MO HealthNet program, the department will continue to make all the Title XIX payments directly to the entity with the hospital's current provider number and hold the entity with the current provider number responsible for all MO HealthNet liabilities.]

[(9) Provider Participation. Payments made in accordance with the standards and methods described in this rule are designed to enlist participation of a sufficient number of hospitals in the program, so that eligible persons can receive the medical care and services included in the state plan at least to the extent these services are available to the general public.

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

[(11) Plan Evaluation. Documentation will be maintained to effectively monitor and evaluate experience during administration of this plan.]

[(12)](8) Inappropriate Placements.

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

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

2. No MO HealthNet payments will be made on behalf of any participant who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

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

(A) Criteria for Qualifying to Receive Add-On Payments for Trauma:

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

2. Hospital with an emergency department in a county that does not have a trauma center.

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

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

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

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

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

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

(C) Trauma Payment Adjustment Option.

1. If the qualifying hospital for the trauma Add-On payment has a declining case mix index for three (3) consecutive years, the hospital will no longer be eligible to receive the trauma add-on payment.

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

(E) Effective July 1, 2011, trauma Add-On payments will be replaced with Upper Payment Limit payments as described in 13 CSR 70-15.230.

(14) Trauma Outlier Payments.

(A) Outlier adjustments for trauma inpatient services involving exceptionally high cost for MO HealthNet-eligible participants will be made to hospitals meeting the criteria established below:

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

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

1. Have been submitted to the MO HealthNet Division fiscal agent in their entirety for routine claims processing, and claim payment must have been made before the claims are submitted to the division for outlier review; and

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

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

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

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

5. The payment for the claim as determined by the product of days of service times the appropriate year cost per day (including the assessment per day and the utilization

adjustment per day) must be less than the cost of the claim as determined by product of charges times the hospital specific cost-to-charge ratio.

(C) Trauma outlier payments for qualifying hospitals will be determined as follows:

1. Multiply charges on claim by hospital specific second prior year cost to charge ratio to determine patient-specific trauma costs;

2. Multiply days of care by the appropriate year's cost per day including the assessment per day and utilization adjustment per day (estimated for SFY 2004 using the 2000 cost report with some exceptions) to determine patient-specific payments; and

3. Determine difference between trauma costs and payments.

(D) The MO HealthNet Division will require a signed affidavit attesting to the validity of the data.

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

(F) Effective July 1, 2011, trauma Add-On payments will be replaced with Upper Payment Limit payments as described in 13 CSR 70-15.230.

(15) Direct Medicaid Payments.

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

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

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

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

4. The increased cost per day resulting from the utilization adjustment. The increased cost per day results from lower utilization of inpatient hospital services by MO HealthNet participants now covered by a managed care health plan;

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

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

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

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

allowable MO HealthNet costs for the outpatient FRA assessment.

A. Effective for payments made on or after May 1, 2017, only the Fee-for-Service and Out-of-State components of the MO HealthNet share of both the inpatient and outpatient FRA assessment will be included in the Direct Medicaid add-on payment.

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The estimated MO HealthNet patient days for the current SFY shall be the better of the sum of the Fee-for-Service (FFS) days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective January 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2010, prior SFY would be SFY 2009) adjusted downward by twenty-five percent (25%) of the difference between the sum of the FFS days plus managed care days and the days used in the prior SFY's Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as follows: The FFS days are determined by applying a trend to the second prior Calendar Year (CY) days (i.e., for SFY 2010, second prior CY would be 2008) as determined from the state's Medicaid Management Information System (MMIS). The trend is determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by twenty-five percent (25%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by twenty-five percent (25%), and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

B. Effective July 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the SFY 2009 Direct Medicaid payment calculation adjusted downward by fifty percent (50%) of the difference between

the sum of the FFS days plus managed care days and the days used in the SFY 2009 Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by fifty percent (50%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by fifty percent (50%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

C. Effective July 1, 2011, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the SFY 2009 Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) of the difference between the sum of the FFS days plus managed care days and the days used in the SFY 2009 Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by seventy-five percent (75%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

D. Effective July 1, 2012, the estimated MO HealthNet patient days shall be the sum of the FFS days plus managed care days. The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

E. Effective for payments made on or after May 1, 2017, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2017, second prior CY would be 2015) by:

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY; and

(II) The days estimated to shift from FFS to managed care effective May 1, 2017. The estimated managed care days for populations added to managed care beginning May 1, 2017 will be subtracted from the trended FFS days to yield the estimated MO HealthNet patient days.

F. Effective for payments made on or after July 1, 2018, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2019, second prior CY would be 2017) by:

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY;

(II) A percentage adjustment shall be applied to the regression due to statewide managed care;

(III) The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report to yield the estimated MO HealthNet patient days; and

(IV) From the total estimated MO HealthNet patient days, remove the SFY 2019 estimated managed care days to yield the estimated MO HealthNet FFS patient days.

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

(I) Effective for dates of service beginning July 1, 2010, the Missouri Specific Trend shall no longer be applied to inflate base period costs.

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

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

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

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

A. Effective January 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B) will receive sixty-seven percent (67%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4.

Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

B. Effective July 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P) will receive thirty-four percent (34%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Children's hospitals and specialty pediatric hospitals will receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

C. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P). Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.;

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

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

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

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

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

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

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

hospital, its MO HealthNet per diem rate and Direct Medicaid Payment will be determined in accordance with subsection (5)(F).

5. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its Direct Medicaid Payments determined in accordance with paragraph (3)(B)4.

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

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

(B) The safety net adjustment for facilities which qualify under subparagraph (6)(A)4.D. of this regulation shall be computed in accordance with the Direct Medicaid payment calculation described in section (15) and up to one hundred percent (100%) of the uninsured costs calculation described in subsection (18)(B) of this regulation. The safety net adjustment will include the last three (3) quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

(C) The state share of the safety net adjustment for hospitals described in subparagraphs (6)(A)4.A. and (6)(A)4.D. shall come from cash subsidy (CS) certified by the hospitals. If the aggregate CS are less than the state match required, the total aggregate safety net adjustment will be adjusted downward accordingly, and distributed to the hospitals in the same proportions as the original safety net adjustments.

(D) Notwithstanding subsection (16)(B), the safety net adjustment for governmental facilities in state fiscal year 2004 and 2005 shall be up to one hundred seventy-five percent (175%) of unreimbursed Medicaid costs plus one hundred seventy-five percent (175%) of the uninsured costs calculation described in subsection (18)(B) subject to the state's disproportionate share allotment and Institution for Mental Diseases (IMD) cap. The safety net adjustment shall be on a state fiscal year basis in these years.

(E) Effective June 1, 2011, DSH payment calculations and criteria are described in 13 CSR 70-15.220.

(17) OBRA 93 Limitation. In accordance with OBRA 93, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for MO HealthNet and the cost of the uninsured, unless otherwise permitted by federal law.

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

(A) Medicaid Add-Ons for Shortfall. The Medicaid Add-On for the period of July 1, 1998 to December 31, 1998 will be based on fifty percent (50%) of the unreimbursed

Medicaid costs as calculated for SFY 98 (Medicaid Shortfall); and

(B) Uninsured Add-Ons. The hospital shall receive eighty-nine percent (89%) of the uninsured costs prorated over the SFY. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center, the Primary Care Resource Initiative for Missouri (PRIMO), and Patient Safety Initiatives shall receive ninety percent (90%) of its uninsured costs prorated over the SFY. DMH hospitals shall receive up to one hundred percent (100%) of their uninsured costs. The uninsured Add-On will include:

1. The Add-On payment for the cost of the uninsured will be based on a three (3) year average of the fourth, fifth, and sixth prior base year cost reports. For any hospital that has both a twelve- (12-) month cost report and a partial year cost report, its base period cost report for that year will be the twelve- (12-) month cost report. Cost of the uninsured is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio for allowable hospital services from the base year cost report's desk review. The cost of the uninsured is then trended to the current year using the trend indices reported in subsection (3)(B). Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure, or treatment;

2. An adjustment to recognize the uninsured patients' share of the FRA assessment not included in the desk-reviewed cost. The FRA assessment for uninsured patients is determined by multiplying the current FRA assessment by the ratio of uninsured days to total inpatient days from the base year cost report;

3. The difference in the projected General Relief per diem payments and trended costs for General Relief patient days;

4. The increased costs per day resulting from the utilization adjustment in subsection (15)(B) is multiplied by the estimated uninsured days; and

5. Notwithstanding any other provision, the Add-On payment for the cost of the uninsured for any public hospital that is not a safety net hospital in state fiscal year 2004 and 2005 shall be up to one hundred seventy-five percent (175%) of the uninsured costs calculation described in this paragraph subject to the state's disproportionate share allotment and IMD cap. The Add-On for hospitals other than safety net hospitals shall be on a state fiscal year basis in these years.

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

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

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

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

4. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its uninsured payments determined in accordance with subsection (18)(C).

(D) Uninsured Add-Ons effective July 1, 2005 for all facilities except DMH safety net facilities as defined in subparagraph (6)(A)4.D. DMH safety net facilities will continue to be calculated in accordance with subsection (18)(B). The Uninsured Add-On for all facilities except DMH safety net

facilities will be based on the following:

1. Determination of the cost of the uninsured—

A. Allocate the uninsured population as determined from the Current Population Survey (CPS), Annual Social and Economic Supplement (Table H105) as published by the U.S. Census Bureau, to the same categories of age (COA) and age groups as the managed care rate cells as determined by the Managed Care Unit of the MO HealthNet Division;

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

C. Determine the amount of the total annual projected cost of the uninsured population that is related to hospital services by multiplying the total annual projected cost of the uninsured population as calculated in paragraph (18)(D)1. above by the percentage of the contract PMPM for each individual rate cell that is related to hospital services. This would be the maximum amount of Uninsured Add-On payments that could be made to hospitals. This amount is also subject to the DSH cap;

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

A. Determine each individual hospital's Uninsured Add-On payment by dividing the individual hospital's uninsured cost as determined from the three- (3-) year average of the fourth, fifth, and sixth prior base-year cost reports by the total uninsured cost for all hospitals as determined from the three- (3-) year average of the fourth, fifth, and sixth prior base-year cost reports, multiplied by either the total annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals whichever is lower. The DSH cap for hospitals is the federal DSH allotment less the IMD allotment less other DSH expenditures.

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

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

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

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

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

(E) Uninsured Add-Ons effective July 1, 2009, for all facilities except Department of Mental Health (DMH) safety net facilities as defined in subparagraph (6)(A)4.D. DMH safety net facilities will continue to be calculated in accordance with subsection (18)(B). The Uninsured Add-On for all facilities except DMH safety net facilities will be based on the following:

1. Determination of the cost of the uninsured—

A. Allocate the uninsured population as determined from the Current Population Survey (CPS), Annual Social and Economic Supplement (Table H105) as published by the U.S. Census Bureau, to the same categories of age (COA) and age groups as the managed care rate cells as determined by

the Managed Care Unit of the MO HealthNet Division;

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

C. Determine the amount of the total annual projected cost of the uninsured population that is related to hospital services by multiplying the total annual projected cost of the uninsured population as calculated in paragraph (18)(E)1. above by the percentage of the contract PMPM for each individual rate cell that is related to hospital services. This would be the maximum amount of uninsured add-on payments that could be made to hospitals. This amount is also subject to the DSH cap; and

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

A. Determine each individual hospital's Uninsured Add-On payment by dividing the individual hospital's uninsured cost as determined from the three- (3-) year average of the fourth, fifth, and sixth prior base-year cost reports by the total uninsured cost for all hospitals as determined from the three- (3-) year average of the fourth, fifth, and sixth prior base-year cost reports, multiplied by either the total annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals, whichever is lower. The DSH cap for hospitals is the federal DSH allotment less the IMD allotment less any redirections of DSH for Medicaid coverage of uninsured individuals as authorized by appropriation;

B. Hospitals which qualify as safety net hospitals under subparagraphs (6)(A)4.B. and C. shall receive payment up to one hundred percent (100%) of their proration. The percentage of proration payable to non-safety net hospitals shall be up to ninety-nine percent (99%), unless the hospital contributes through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) and Patient Safety Initiative, in which case they shall receive up to one hundred percent (100%);

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

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

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

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

(F) Uninsured Add-On payments will coincide with the semimonthly claim payment schedule established by the MO HealthNet fiscal agent. Each hospital's semimonthly add-on payment shall be the hospital's total cost of the uninsured as determined in section (18) divided by the number of semimonthly pay dates available to the hospital in the state fiscal year.

(G) Effective June 1, 2011, DSH payment calculations and criteria are described in 13 CSR 70-15.220.]

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

(A) The MO HealthNet GME Add-On for MO HealthNet participants covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base

year cost report shall be the fourth prior fiscal year (i.e., the base year for SFY 1999 is the FY 1995 cost report). The hospital per diem shall continue to include a component for GME related to MO HealthNet participants not included in a managed care system.

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

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

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

(A) The enhanced GME payment shall be computed in accordance with subsection (10)(B). The payment shall be made following the end of the state fiscal year. The enhanced GME payment for each state fiscal year shall be computed using the most recent cost data available when the enhanced GME payment is computed. If the cost report is less than or more than a twelve- (12-) month period, the cost report data will be adjusted to reflect a twelve- (12-) month period. The state share of the enhanced GME payment to a hospital that has cash subsidies shall come from funds certified by the hospital.

(B) The enhanced GME payment will be computed by first determining the percentage difference between the McGraw-Hill CPI index for hospital services and Medicare update factors applied to the per resident amounts from 1986 to the most recent SFY. For example, the percentage difference has been computed to be eighty-five and sixty-two one-hundredth percent (85.62%) for SFY 2000. The percentage difference is then multiplied by the MO HealthNet share of the aggregate approved amount reported on worksheet E-4 of the Medicare cost report (CMS 2552-10) for the fourth prior fiscal year and trended to the current state fiscal year. The resulting product is the enhanced GME payment.

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

(A) The disproportionate share status of the merged hospital provider shall be—

1. The same as the surviving hospital's status was prior to the merger for the remainder of the state fiscal year in which the merger occurred; and

2. Determined based on the combined desk-reviewed data from the appropriate cost reports for the merged hospitals in subsequent fiscal years.

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

1. For the remainder of the state fiscal year in which the merger occurred by multiplying each hospital's estimated MO HealthNet paid days by its per diem rate, summing the estimated per diem payments and estimated MO HealthNet paid days, and then dividing the total estimated per diem payments by the total estimated paid days to determine the weighted per diem rate. The effective date of the weighted per diem rate will be the date of the merger. This merged rate will also be used in fiscal years following the effective date.

(C) The Direct Medicaid Payments, Uninsured Add-On Payments, and GME payments, if the surviving facility continues the GME program, shall be—

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

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

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

(E) Merger of State Hospitals.

1. A state hospital is defined as a hospital which is either owned or operated by the DMH or owned or operated by the board of curators as provided for in Chapters 172 and 199, RSMo.

2. When a hospital owned or operated by the DMH merges with a hospital owned or operated by the board of curators, the per diem rate effective with the date of the merger shall be the surviving state hospital's per diem rate prior to the merger and not calculated as defined in subsection (20)(B).

3. When a hospital owned or operated by the DMH merges with a hospital owned or operated by the board of curators, the Direct Medicaid Payments effective with the date of merger shall be calculated using the surviving state hospital's trended cost per day from the surviving hospital's base-year cost report, the surviving hospital's per diem rate, and the combined estimated MO HealthNet patient days for both hospitals.

4. When a hospital owned or operated by the DMH merges with a hospital owned or operated by the board of curators, the Uninsured Add-Ons effective with the date of the merger shall be the Uninsured Add-On for the surviving hospital as determined from the surviving hospital's base-year cost reports in accordance with subsection (18)(D).]

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

(A) The enhanced GME payment shall be computed in accordance with subsection (21)(B). The payment shall be made following the end of the state fiscal year. The enhanced GME payment for each state fiscal year shall be computed using the most recent cost data available when the enhanced GME payment is computed. If the cost report is less than or more than a twelve- (12-) month period, the cost report data will be adjusted to reflect a twelve- (12-) month period. The state share of the enhanced GME payment to a hospital that has cash subsidies shall come from funds certified by the hospital.

(B) The enhanced GME payment will be computed by first determining the percentage difference between the McGraw-Hill CPI index for hospital services and Medicare update factors applied to the per resident amounts from 1986 to the most recent SFY. For example, the percentage difference has been computed to be eighty-five and sixty-two one-hundredth percent (85.62%) for SFY 2000. The percentage difference is then multiplied by the MO HealthNet share of the aggregate approved amount reported on worksheet E-3 part IV and E-3 part VI of the Medicare cost report (HCFA 2552-96) and worksheet E-4 of the Medicare cost report (CMS 2552-10) for the fourth prior fiscal year and trended to the current state fiscal year. The

resulting product is the enhanced GME payment.]

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. [2018] 2019. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history please consult the Code of State Regulations. Amended: Filed April 30, 2020.

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, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED RULE

13 CSR 70-15.015 Direct Medicaid Payments

PURPOSE: This rule provides for the calculation of the Direct Medicaid payments made on or after July 1, 2019.

(1) Direct Medicaid Qualifying Criteria.

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

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

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

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

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

or

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

(I) Total 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. As determined from the fourth prior year desk-reviewed cost report, the hospital—

A. Has an unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in paragraph (1)(A)2.; or

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

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

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

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

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

C. The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo, or their successors; or

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

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

(B) Those hospitals which meet the criteria established in paragraphs (1)(A)1., (1)(A)2., and (1)(A)4. shall be deemed safety net hospitals. Those hospitals which meet the criteria established in paragraphs (1)(A)1. and (1)(A)3. shall be deemed first tier Disproportionate Share Hospitals (DSH). Those hospitals which meet only the criteria established in paragraphs (1)(A)1. and (1)(A)2. or (1)(A)1. and (1)(A)5. shall be deemed second tier DSH.

(2) Direct Medicaid Payments.

(A) Direct Medicaid Payments. Direct Medicaid payments will be made to hospitals for the following allowable MO HealthNet costs

not included in the per diem rate as calculated in 13 CSR 70-15.010 (3):

1. The increased MO HealthNet costs resulting from the Federal Reimbursement Allowance (FRA) assessment becoming an allowable cost on January 1, 1999;

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

3. The unreimbursed MO HealthNet costs for capital and medical education not included in the trended per diem cost as a result of the application of the sixty percent (60%) minimum utilization adjustment in 13 CSR 70-15.010(3)(A)4.;

4. The increased cost per day resulting from the utilization adjustment. The increased cost per day results from lower utilization of inpatient hospital services by MO HealthNet participants now covered by a managed care health plan;

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

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

(B) The MO HealthNet Division will calculate the Direct Medicaid payment as follows:

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

A. Effective for payments made on or after May 1, 2017, only the Fee-for-Service and Out-of-State components of the MO HealthNet share of both the inpatient and outpatient FRA assessment will be included in the Direct Medicaid add-on payment.

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective for payments made on or after May 1, 2017, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2017, second prior CY would be 2015) by—

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY; and

(II) The days estimated to shift from FFS to managed care effective May 1, 2017. The estimated managed care days for populations added to managed care beginning May 1, 2017 will be subtracted from the trended FFS days to yield the estimated MO HealthNet patient days.

B. Effective for payments made on or after July 1, 2018, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2019, second prior CY would be 2017) by—

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY;

(II) A percentage adjustment shall be applied to the regression due to statewide managed care;

(III) The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report to yield the estimated MO HealthNet patient days; and

(IV) From the total estimated MO HealthNet patient days, remove the SFY 2019 estimated managed care days to yield the estimated MO HealthNet FFS patient days.

C. Effective for payments made on or after July 1, 2019, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2020, second prior CY would be 2018) by—

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY;

(II) A percentage adjustment shall be applied to the regression due to statewide managed care;

(III) The FFS days are factored up by one (1) of the following:

(a) For hospitals that are in a managed care extension region or a psychiatric hospital, the lower of the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report or from the hospital's second prior year cost report to yield the estimated MO HealthNet patient days; or

(b) For hospitals that are not in a managed care extension region or a psychiatric hospital, the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report to yield the estimated MO HealthNet patient days; and

(IV) The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

D. Effective for payments made on or after July 1, 2020, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2021, second prior CY would be 2019) by—

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY;

(II) A percentage adjustment shall be applied to the regression due to statewide managed care;

(III) The FFS days are factored up by one (1) of the following:

(a) For hospitals that are in a managed care extension region or a psychiatric hospital, the lower of the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report or from the hospital's third prior year cost report to yield the estimated MO HealthNet patient days; or

(b) For hospitals that are not in a managed care extension region or a psychiatric hospital, the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report to yield the estimated MO HealthNet patient days; and

(IV) The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

E. The trended cost per day is calculated by trending the base year costs per day by the trend indices as defined in 13 CSR 70-15.010(3)(B)1., using the rate calculation in 13 CSR 70-15.010(3)(A).

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

G. The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (2)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization, as identified in 13 CSR 70-15.010(5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

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

A. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (1)(B), children's hospitals as defined in 13 CSR 70-15.010(2)(Q), and specialty pediatric hospitals as defined in 13 CSR 70-15.010(2)(O). Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (2)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (2)(B)4.;

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

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

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

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

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

3. The number of beds for the new hospital without the base cost report shall be multiplied by the average Direct Medicaid

Payment per bed to determine the hospital's estimated Direct Medicaid Payment for the current state fiscal year; and

4. For a new hospital licensed after February 1, 2007, estimated total Direct Medicaid Payments for the current state fiscal year shall be divided by the estimated MO HealthNet patient days for the new hospital's quartile to obtain the estimated Direct Medicaid adjustment per patient day. This adjustment per day shall be added to the new hospital's MO HealthNet rate as determined in 13 CSR 70-15.010(4), so that the hospital's Direct Medicaid Payment per day is included in its per diem rate, rather than as a separate Add-On Payment. When the hospital's per diem rate is determined from its first full year cost report in accordance with 13 CSR 70-15.010(1)-(3), the facility's Direct Medicaid Payment will be calculated in accordance with subsection (2)(B) of this rule and reimbursed as an Add-On Payment rather than as part of the per diem rate. If the hospital is defined as a critical access hospital, its MO HealthNet per diem rate and Direct Medicaid Payment will be determined in accordance with 13 CSR 70-15.010 (5)(F).

5. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, shall have its Direct Medicaid Payments determined in accordance with 13 CSR 70-15.010(3)(B)4.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2019. This rule was previously filed as part of 13 CSR 70-15.010. Emergency rule filed April 30, 2020, effective May 15, 2020, expires Feb. 24, 2021. Original rule filed April 30, 2020.

PUBLIC COST: For SFY 2020, this proposed rule will cost the state approximately \$44.4 million (State Share: \$15.3 million FRA & eighty-two thousand dollars (\$82,000) IGT for DMH). For SFY 2021, this proposed rule may save the state approximately \$42.4 million (State Share: \$14.1 million FRA & six hundred ninety-one thousand dollars (\$691,000) IGT for DMH). For SFY 2021, this proposed rule may cost public entities \$4.3 million.

PRIVATE COST: For SFY 2020, this proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate. For SFY 2021, this proposed rule may cost private entities \$38.1 million.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**FISCAL NOTE
PUBLIC COST**

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

Rule Number and Title:	13 CSR 70-15.015 Direct Medicaid Payments
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<p>Department of Social Services, MO HealthNet Division</p>	<p>SFY 2020 Impact: Total Cost = \$44.4 million; State Share (FRA Fund) = \$15.3 million State Share (IGT Fund for DMH) = (\$82) thousand</p> <p>SFY 2021 Impact: Total Cost – (\$42.4) million State Share (FRA Fund) – (\$14.1) million State Share (IGT Fund for DMH) = (\$691) thousand</p>
<p>Other Government (Public) & State Hospitals enrolled in MO HealthNet (40)</p>	<p>The estimated cost for SFY 2020 - \$0 million</p> <p>The estimated cost for SFY 2021 - \$4.3 million</p>

III. WORKSHEET

Department of Social Services, MO HealthNet Division Cost:

Estimated Cost for SFY 2020:

	FRA Fund	IGT Fund for DMH	Total
Estimated Payments with days change	\$903,858,641	\$13,275,243	\$917,133,884
Estimated Payments without days change	\$859,256,227	\$13,513,231	\$872,769,458
Estimated Impact of days change	\$44,602,414	(\$237,988)	\$44,364,426
State Share Percentage	34.412%	34.412%	34.412%
State Share	\$15,348,583	(\$81,896)	\$15,266,686

Department of Social Services, MO HealthNet Division Savings:**Estimated Savings for SFY 2021:**

	FRA Fund	IGT Fund for DMH	Total
Estimated Payments with days change	\$863,410,903	\$11,292,731	\$874,703,634
Estimated Payments without days change	\$903,858,641	\$13,275,243	\$917,133,884
Estimated Impact of days change	(\$40,447,738)	(\$1,982,512)	(\$42,430,250)
State Share Percentage	34.868%	34.868%	34.868%
State Share	(\$14,103,115)	(\$691,252)	(\$14,794,367)

Other Government (Public) & State Hospitals:**Estimated Costs for SFY 2021:**

	FRA Fund	IGT Fund for DMH	Total
Estimated Payments with days change	\$130,879,413	\$11,292,731	\$142,172,144
Estimated Payments without days change	\$133,252,842	\$13,275,243	\$146,528,085
Estimated Impact of days change	(\$2,373,429)	(\$1,982,512)	(\$4,355,941)
State Share Percentage	34.868%	34.868%	34.868%
State Share	(\$827,555)	(\$691,252)	(\$1,518,808)

IV. ASSUMPTIONS

The estimated cost is based upon the data in FRA Schedule 20-3. The base year for the SFY 2020 fee for service (FFS) days used for the SFY 2020 Direct Medicaid payments are calendar year 2018 days from the MMIS system. The percentage of managed care (MC) days to the total of FFS days plus MC days is from either the 2016 or 2018 cost report based on whether the hospital was in a MC extension region or a psychiatric hospital. These assumptions create a negative impact to the state for SFY 2020 but results in a positive impact to the public entities for SFY 2020.

The estimated cost is based upon the data in FRA Schedule 20-3 with adjustments to the base days. The base year for the SFY 2021 fee for service (FFS) days used for the SFY 2021 Direct Medicaid payments are calendar year 2019 days from the MMIS system. The percentage of managed care (MC) days to the total of FFS days plus MC days is from either the 2017 or 2018 cost report based on whether the hospital was in a MC extension region or a psychiatric hospital. However, these assumptions result in no fiscal impact to the state for SFY 2021 but results in a negative impact to the public entities for SFY 2021. These assumptions are subject to change for SFY 2021 due to revenue and cost factors that are unknown at the time this regulation was filed.

**FISCAL NOTE
PRIVATE COST**

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

Rule Number and Title:	13 CSR 70-15.015 Direct Medicaid Payments
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
In-state hospitals - 100	Private Hospitals enrolled in MO HealthNet	The estimated cost for SFY 2020 - \$0 million The estimated cost for SFY 2021 - \$38.1 million

III. WORKSHEET

**Private In-State Hospitals:
Estimated Costs for SFY 2021:**

	FRA Fund	IGT Fund for DMH	Total
Estimated Payments with days change	\$732,531,490	\$0	\$732,531,490
Estimated Payments without days change	\$770,605,799	\$0	\$770,605,799
Estimated Impact of days change	(\$38,074,309)	\$0	(\$38,074,309)
State Share Percentage	34.868%	34.868%	34.868%
State Share	(\$13,275,560)	\$0	(\$13,275,560)

IV. ASSUMPTIONS

The estimated cost is based upon the data in FRA Schedule 20-3. The base year for the SFY 2020 fee for service (FFS) days used for the SFY 2020 Direct Medicaid payments are calendar year 2018 days from the MMIS system. The percentage of managed care (MC) days to the total of FFS days plus MC days is from either the 2016 or 2018 cost report based on whether the hospital was in a MC extension region or a psychiatric hospital. These assumptions create a negative impact to the state for SFY 2020 but results in a positive impact to the public entities for SFY 2020.

The estimated cost is based upon the data in FRA Schedule 20-3 with adjustments to the base days. The base year for the SFY 2021 fee for service (FFS) days used for the SFY 2021 Direct Medicaid payments are calendar year 2019 days from the MMIS system. The percentage of managed care (MC) days to the total of FFS days plus MC days is from either the 2017 or 2018 cost report based on whether the hospital was in a MC extension region or a psychiatric hospital. However, these assumptions result in no fiscal impact to the state for SFY 2021 but results in a negative impact to the public entities for SFY 2021. These assumptions are subject to change for SFY 2021 due to revenue and cost factors that are unknown at the time this regulation was filed.

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

PROPOSED AMENDMENT

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA). The division is amending subsection (1)(A), deleting sections (2)-(18), renumbering sections (19)-(22), and adding a new section (6).

PURPOSE: This amendment provides for the methodology used to determine the trend factor to be applied to the inpatient and outpatient adjusted net revenues determined from the Federal Reimbursement Allowance (FRA) fiscal year cost report to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment. Additionally, this amendment is removing outdated language regarding the FRA Assessment.

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

(A) Definitions.

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

2. Base cost report—Desk-reviewed Medicare/Medicaid cost report. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010. When a hospital has more than one (1) cost report with periods ending in the base year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of months reflected in the base cost report, to a twelve- (12-) month period.

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

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

5. Department—Department of Social Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Obtain "Gross Outpatient Charges" from Worksheet G-2, Line 25, Column 2 from CMS 2552-96, or Worksheet G-2, Line 28,

Column 2 from CMS 2552-10, of the most recent cost report that is available for a hospital;

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

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

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

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

G. The trend indices listed below will be applied to the apportioned inpatient adjusted net revenue and outpatient adjusted net revenue in order to inflate or trend forward the adjusted net revenues from the FRA fiscal year cost report to the current state fiscal year to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment.

(I) SFY 2009 = 5.50%

(II) SFY 2009 Missouri Specific Trend = 1.50%

(III) SFY 2010 = 3.90%

(IV) SFY 2010 Missouri Specific Trend = 1.50%

(V) SFY 2011 = 3.20%

(VI) SFY 2012 = 5.33%

(VII) SFY 2013 = 4.4%

(VIII) SFY 2014 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—3.70%

(IX) SFY 2015 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—4.30%

(X) SFY 2016 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—3.90%

(XI) SFY 2017 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—4.10%

(XII) SFY 2018 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—0%

(XIII) SFY 2019 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—0%

(XXX) SFY 2020 =

(a) Inpatient Adjusted Net Revenues—0%

(b) Outpatient Adjusted Net Revenues—2.9%

(XX) SFY 2021 =

(a) Inpatient Adjusted Net Revenues— The trend index, if greater than 0%, will be determined based on the Health Care Costs index as published in *Healthcare Cost Review* by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher.

(b) Outpatient Adjusted Net Revenues— The trend index, if greater than 0%, will be determined based on the Health Care Costs index as published in *Healthcare Cost Review* by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher.

[14. Net operating revenue—Gross charges less bad debts, less charity care, and less contractual allowances times the trend indices listed in 13 CSR 70-15.010(3)(B).]

15. Other operating revenues—The other operating revenue is total other revenue less government appropriations, less donations, and less income from investments times the trend indices listed in 13 CSR 70-15.010(3)(B).]

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

1. *[The FRA shall be sixty-three dollars and sixty-three*

cents (\$63.63) per inpatient hospital day from the 1991 base cost report for Federal Fiscal Year 1994. For succeeding periods, t]The FRA shall be as described beginning with section (2) and going forward.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

through the state fiscal year for which the assessments are being determined.

[(C)] Each hospital shall submit to the Department of Social Services a statement that accurately reflects if the hospital—

- 1. Is publicly or privately owned;*
- 2. Is operated primarily for the care and treatment of mental disorders;*
- 3. Is operated by the Department of Health and Senior Services; and*

4. Accepts payment for services rendered.]

[(D)](C) The [Department of Social Services] division shall prepare a confirmation schedule of the information from each hospital's third prior year cost report and provide each hospital with this schedule. Each hospital required to pay the FRA shall review the confirmation schedule confirm the information is correct or provide correct information.

[1. The schedule shall include:

- A. Provider name;*
- B. Provider number;*
- C. Fiscal period;*
- D. Total number of licensed beds;*
- E. Total inpatient days;*
- F. Total cost of contractual allowance for Medicare;*
- G. Total cost of contractual allowance for Medicaid;*
- H. Gross charges;*
- I. Charity care; and*
- J. Bad debts.*

2. Each hospital required to pay the FRA shall review this information and provide the Department of Social Services with correct information, if the information supplied by the Department of Social Services is incorrect, or affirm the information is correct within fifteen (15) days of receiving the confirmation schedule. If the hospital fails to submit the corrected data within the fifteen- (15-) day time period, the hospital shall be barred from submitting corrected data later to have its FRA assessment or the add-on payments from 13 CSR 70-15.010 adjusted.]

[3.1. [Each hospital may request that its] The FRA will be offset against any Missouri Medicaid payment due the hospital. The FRA Assessments shall be allocated and deducted over the applicable period.

[4.2. [The FRA owed or, if an offset has been requested, the balance due, if any, after that offset shall be remitted by the hospital to the Department of Social Services on a twice monthly basis, on the first and fifteenth of each month beginning October 15, 1992. The remittance shall be made payable to the director of the Department of Revenue. The amount remitted shall be deposited in the state treasury to the credit of the Federal Reimbursement Allowance Fund.] A letter will be sent to the hospital indicating the FRA balance due after offset, if any, at the end of each state fiscal quarter. The FRA balance due shall be remitted by the hospital to the MO HealthNet Division as stated in the letter.

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

[(2) Federal Reimbursement Allowance (FRA) subsequent to Federal Fiscal Year 1994.

(A) The FRA shall continue at the Federal Fiscal Year 1994 prorated assessment level for the nine (9) Medicaid payrolls from October 1, 1994, through February 19, 1995.

(B) The FRA shall be seventy-two dollars and seventy-five cents (\$72.75) per inpatient hospital day from the 1992 base cost report multiplied by nine twenty-fourths (9/24) for the period February 20, 1995, through June 30, 1995.

(3) FRA for State Fiscal Year (SFY) 1996.

(A) The FRA for SFY 96 shall be seventy-five dollars and eighty-seven cents (\$75.87) per inpatient hospital day from the 1993 base cost report.

(4) FRA for State Fiscal Year 1997.

(A) The FRA assessment for State Fiscal Year 1997 shall be determined at the rate of five and sixty-three hundredths percent (5.63%) of the hospital net operating revenues as determined from information reported on the hospital's 1994 base cost report.

(5) Federal Reimbursement Allowance (FRA) for State Fiscal Year 1998.

(A) The FRA assessment for State Fiscal Year 1998 shall be determined at the rate of five and forty-six hundredths percent (5.46%) of the hospital's net operating revenue as determined from information reported in the hospital's 1995 base year cost report.

(6) Federal Reimbursement Allowance (FRA) for State Fiscal Year 1999. The FRA assessment for State Fiscal Year 1999 shall be determined at the rate of five and thirty hundredths percent (5.30%) of the hospital's net operating revenues and other operating revenues defined in paragraphs (1)(A)12. and 13., as determined from information reported in the hospital's 1995 base year cost report. The State Fiscal Year 1999 assessment rate of five and thirty hundredths percent (5.30%) shall continue as an estimate of the FRA assessment percentage until such time as the State Fiscal Year 2000 assessment rate is established.

(7) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2000. The FRA assessment for State Fiscal Year 2000 shall be determined at the rate of five and two hundredths percent (5.02%) of the hospital's net operating revenues and other operating revenues defined in paragraphs (1)(A)12., and 13., as determined from information reported in the hospital's 1996 base year cost report.

(8) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2001. The FRA assessment for State Fiscal Year 2001 shall be determined at the rate of five and fifty hundredths percent (5.50%) of the hospital's net operating revenues and other operating revenues defined in paragraphs (1)(A)12. and 13., as determined from information reported in the hospital's 1997 base year cost report. The State Fiscal Year (SFY) 2001 FRA Assessment shall be used as an estimate of the SFY 2002 FRA Assessment until such time as the regulation establishing the SFY 2002 FRA Assessment is effective.

(9) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2002. The FRA assessment for State Fiscal Year (SFY) 2002 shall be determined at the rate of five and zero hundredths percent (5.00%) of the hospital's total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health, State Center for Health Statistics in the Missouri Hospital Revenues 1995–2000 manual, which is incorporated by reference in this rule. The base financial data for 1998 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year. The financial data that is submitted by the hospitals to the Missouri Department of Health and Senior Services is required as part of 19 CSR 10-33.030 Reporting Financial Data by Hospitals. If the pertinent information is not available

through the Department of Health and Senior Services' hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report that is required to be submitted pursuant to 13 CSR 70-15.010(5)(A).

(10) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2003. The FRA assessment for State Fiscal Year (SFY) 2003 shall be determined at the rate of five and seventy hundredths percent (5.70%) of the hospital's total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics. The base financial data for 1999 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year. The financial data that is submitted by the hospitals to the Missouri Department of Health and Senior Services is required as part of 19 CSR 10-33.030 Reporting Financial Data by Hospitals. If the pertinent information is not available through the Department of Health and Senior Services' hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report that is required to be submitted pursuant to 13 CSR 70-15.010(5)(A).

(11) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2004. The FRA assessment for State Fiscal Year (SFY) 2004 shall be determined at the rate of five and thirty-two hundredths percent (5.32%) of the hospital's total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics. The base financial data for 2000 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year. The financial data that is submitted by the hospitals to the Missouri Department of Health and Senior Services is required as part of 19 CSR 10-33.030 Reporting Financial Data by Hospitals. If the pertinent information is not available through the Department of Health and Senior Services' hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report that is required to be submitted pursuant to 13 CSR 70-15.010 (5)(A).

(12) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2005. The FRA assessment for State Fiscal Year (SFY) 2005 shall be determined at the rate of five and fifty-three hundredths percent (5.53%) of the hospital's total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics. The base financial data for 2001 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year. The financial data that is submitted by the hospitals to the Missouri Department of Health and Senior Services is required as part of 19 CSR 10-33.030 Reporting Financial Data by Hospitals. If the pertinent information is not available through the Department of Health and Senior Services' hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report that is required to be submitted pursuant to 13 CSR 70-15.010(5)(A).

(13) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2006. The FRA assessment for State Fiscal Year (SFY) 2006 shall be determined at the rate of five and ninety-seven hundredths percent (5.97%) of the hospital's total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics. The base financial data for 2002 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year. The financial data that is submitted by the hospitals to the Missouri Department of Health and Senior Services is required as part of 19 CSR 10-33.030 Reporting Financial Data by Hospitals. If the pertinent information is not available through the Department of Health and Senior Services' hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report that is required to be submitted pursuant to 13 CSR 70-15.010(5)(A).

(14) Federal Reimbursement Allowance (FRA) for State Fiscal Year (SFY) 2007. The FRA assessment for SFY 2007 shall be determined at the rate of five and eighty-three hundredths percent (5.83%) of the hospital's total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics. The base financial data for 2003 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year. The financial data that is submitted by the hospitals to the Missouri Department of Health and Senior Services is required as part of 19 CSR 10-33.030 Reporting Financial Data by Hospitals. If the pertinent information is not available through the Department of Health and Senior Services' hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report that is required to be submitted pursuant to 13 CSR 70-15.010(5)(A).

(15) Federal Reimbursement Allowance (FRA) for State Fiscal Year (SFY) 2008. The FRA assessment for SFY 2008 shall be determined at the rate of five and ninety-nine hundredths percent (5.99%) for July 1 through December 31, 2007, and five and forty-nine hundredths percent (5.49%) for January 1 through June 30, 2008, of the hospital's total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics. The base financial data for 2004 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year. The financial data that is submitted by the hospitals to the Missouri Department of Health and Senior Services is required as part of 19 CSR 10-33.030 Reporting Financial Data by Hospitals. If the pertinent information is not available through the Department of Health and Senior Services' hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report that is required to be submitted pursuant to 13 CSR 70-15.010(5)(A).

(16) Federal Reimbursement Allowance (FRA) for State Fiscal Year (SFY) 2009. The FRA assessment shall be determined at the rate of five and forty hundredths percent (5.40%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues from the hospital's 2006 Medicare/Medicaid cost report. The FRA assessment

rate of five and forty hundredths percent (5.40%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment for SFY 2009 is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(17) Beginning July 1, 2009, the Federal Reimbursement Allowance (FRA) assessment shall be determined at the rate of five and forty hundredths percent (5.40%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues from the hospital's 2007 Medicare/Medicaid cost report. The FRA assessment rate of five and forty hundredths percent (5.40%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment beginning July 1, 2009, is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(18) Beginning January 1, 2010, the Federal Reimbursement Allowance (FRA) assessment shall be determined at the rate of five and forty-five hundredths percent (5.45%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues from the hospital's 2007 Medicare/Medicaid cost report. The FRA assessment rate of five and forty-five hundredths percent (5.45%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment, beginning January 1, 2010, is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

[(19)](2) Beginning July 1, 2010, the FRA assessment shall be determined at the rate of five and forty-five hundredths percent (5.45%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and forty-five hundredths percent (5.45%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

[(20)](3) Beginning October 1, 2011, the FRA assessment shall be determined at the rate of five and ninety-five hundredths percent (5.95%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and ninety-five hundredths percent (5.95%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

[(21)](4) Beginning July 1, 2017, the FRA assessment shall be determined at the rate of five and seventy hundredths percent (5.70%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and seventy hundredths percent (5.70%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(A) If the reduction of disproportionate share hospital allotments

for federal fiscal year 2018 is implemented as provided in section 1923(f)(7) of the Social Security Act, the FRA assessment shall be set, effective on the date of such reduction, at the rate of five and fifty hundredths percent (5.50%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and fifty hundredths percent (5.50%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

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

(6) Beginning July 1, 2020, the FRA assessment shall be determined at a rate no greater than five and ninety-five hundredths percent (5.95%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

AUTHORITY: sections 208.201, 208.453, 208.455, and 660.017, RSMo 2016. Emergency rule filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency rule filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Original rule filed Sept. 21, 1992, effective June 7, 1993. For intervening history, please consult the Code of State Regulations. Amended: Filed April 30, 2020.

PUBLIC COST: For SFY 2021, this proposed amendment will result in FRA Assessment cost to state agencies or political subdivisions of approximately \$6.2 million.

PRIVATE COST: For SFY 2021, this proposed amendment will result in FRA Assessment cost to private entities of approximately \$17.3 million.

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, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**FISCAL NOTE
PUBLIC COST**

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

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

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) & State Hospitals - 40	Estimated cost for: SFY 2021 - \$6.2 million

III. WORKSHEET

Estimated Assessment at 5.70% for SFY 2021:

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Public Facilities Revenues - SFY 2020	40	\$1,591,550,607	\$1,747,750,768	\$3,339,301,375
FRA Assessment Rate		5.60%	5.60%	5.60%
Total Assessment - SFY 2020		\$89,126,834	\$97,874,043	\$187,000,877
Public Facilities Revenues - SFY 2021		\$1,591,550,607	\$1,798,435,540	\$3,389,986,147
FRA Assessment Rate		5.70%	5.70%	5.70%
Total Assessment - SFY 2021		\$90,718,385	\$102,510,826	\$193,229,210
Impact of Tax Rate (Assessment - SFY 2020 less Assessment - SFY 2021)				\$6,228,333
Prior SFY Total Assessment using Prior Year Methodology				\$187,000,877
Increase of Total Assessment over Prior SFY				\$6,228,333

IV. ASSUMPTIONS

This fiscal note reflects the total FRA Assessment of 5.70% for July 1, 2020, through June 30, 2021. The FRA Assessment to be collected during SFY 2021 is estimated at approximately \$193.2 million, which is an FRA Assessment to the public facilities of approximately \$6.2 million. The FRA assessment rate is levied upon Missouri hospitals' trended inpatient and outpatient net adjusted revenues in accordance with the Missouri Partnership Plan. However, these assumptions will change for SFY 2021 due to taxable revenues that are unknown at the time this regulation was filed.

**FISCAL NOTE
PRIVATE COST**

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

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

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
100	Hospitals	Estimated cost for: SFY 2021 - \$17.3 million

III. WORKSHEET

Estimated Assessment at 5.70% for SFY 2021:

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Private Facilities Revenues - SFY 2020	100	\$8,116,767,919	\$9,190,928,086	\$17,307,696,005
FRA Assessment Rate		5.60%	5.60%	5.60%
Total Assessment - SFY 2020		\$454,539,003	\$514,691,973	\$969,230,976
Private Facilities Revenues - SFY 2021		\$8,116,767,919	\$9,190,928,086	\$17,307,696,005
FRA Assessment Rate		5.70%	5.70%	5.70%
Total Assessment - SFY 2021		\$462,655,771	\$523,882,901	\$986,538,672
Impact of Tax Rate (Assessment - SFY 2020 less Assessment - SFY 2021)				\$17,307,696
Prior SFY Total Assessment using Prior Year Methodology				\$969,230,976
Increase of Total Assessment over Prior SFY				\$17,307,696

IV. ASSUMPTIONS

This fiscal note reflects the total FRA Assessment of 5.70% for July 1, 2020 through June 30, 2021. The FRA Assessment to be collected during SFY 2021 is estimated at approximately \$986.5 million, which is an FRA Assessment to the private facilities of approximately \$17.3 million. The FRA assessment rate is levied upon Missouri hospitals' trended inpatient and outpatient net adjusted revenues in accordance with the Missouri Partnership Plan. However, these assumptions will change for SFY 2021 due to taxable revenues that are unknown at the time this regulation was filed.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 95—Private Duty Nursing Care Under the
Healthy Children and Youth Program

PROPOSED AMENDMENT

13 CSR 70-95.010 Private Duty Nursing. The MO HealthNet Division is amending sections (1), (3), (4), (5), (6), (7), (8), and (10) and adding paragraphs 2. and 3. to subsection (9)(B).

PURPOSE: This amendment updates outdated language throughout the rule, adds practitioners who can approve a plan of care, adds graduate nurses as individuals who may provide nursing services, removes language included in the provider manual, adds language to define member, and allows nursing services to be provided by a family member or legal guardian.

(1) Service Definition. Private duty nursing (PDN) is the provision of individual and continuous care (in contrast to part-time or intermittent care) provided according to an individual plan of care approved by a physician, **nurse practitioner, physician assistant or assistant physician**, by licensed nurses acting within the scope of the Missouri Nurse Practice Act. Services within the MO HealthNet private duty nursing program include:

(A) Shift care by a registered nurse (RN); *and*

(B) Shift care by a licensed practical nurse (LPN); *and*

(C) **Shift care by a graduate LPN or graduate RN. A graduate LPN or graduate RN may provide nursing services until receipt of the results of the first licensure examination taken by the graduate nurse or until ninety (90) days after graduation, whichever comes first, unless the time requirements have been temporarily suspended or extended by the Board of Nursing.**

(3) Criteria for Providers of Private Duty Nursing Care for Children.

(A) A provider of private duty nursing care must have a valid MO HealthNet Private Duty Nursing Provider Agreement in effect with the Department of Social Services, *[MO HealthNet Division] Missouri Medicaid Audit and Compliance Unit (MMAC)*. To enroll, the applicant must either submit a written proposal, or be a Medicare-certified and MO HealthNet-enrolled home health agency, or be accredited by Joint Commission for Accreditation of Health Organization (JCAHO), or be accredited by Community Health Accreditation Program (CHAPS). *[The written proposal (required by agencies who are not Medicare certified, or accredited by JCAHO or CHAPS), must describe the agency and its service delivery system, assure understanding of and compliance with the standards of the Private Duty Nursing Care Program and document the agency's administrative and fiscal ability to provide the services in accordance with these standards. Proposals will be reviewed by qualified medical staff or designees of the Department of Social Services (DSS).*

(B) *All applicants to provide MO HealthNet private duty nursing care, enrolling on the basis of a written proposal, may be subject to on-site reviews, performed at the discretion of the department, by DSS staff or designees prior to enrollment. These reviews will monitor compliance with the administrative requirements of the program and service delivery.*

(C) *On-site reviews to monitor compliance with these standards will be conducted at the discretion of the department subsequent to MO HealthNet enrollment, when MO HealthNet has reimbursed for services.*

(D) *Agencies found to be out of compliance with the standards set forth in this rule may have a penalty imposed. Penalties may be as follows:*

1. *The agency will be required to submit a written plan*

of correction, with a follow-up monitoring by DSS staff within ninety (90) days;

2. *New prior authorization requests will not be approved for a specified period of time; and*

3. *The MO HealthNet provider enrollment agreement will be terminated.]*

(4) Administrative Requirements for Private Duty Nursing Providers.

(A) The provider shall immediately notify the *[provider enrollment section unit of the MO HealthNet Division] MMAC* of any change in location, telephone number, or administrative or corporate status. A thirty- (30-)/- day written notice to the *[MO HealthNet Division] MMAC* will be required of the provider prior to the voluntary termination of the provider agreement.

(E) The provider shall have a written statement of the participant's Bill of Rights, which shall be given to the caretaker (if the participant is a minor) at the time the service is initiated. *[At a minimum, the statement should say that the participant has the right to the following:*

1. *Be treated with respect and dignity;*

2. *Have all personal and medical information kept confidential;*

3. *Have direction over the services provided, to the degree possible, within the service plan approved by the Bureau of Special Health Care Needs;*

4. *Know the provider's established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution;*

5. *Receive services without regard to race, creed, color, age, sex, or national origin; and*

6. *Receive a copy of this Bill of Rights.]*

(F) The provider shall have a written grievance policy which shall be provided to each participant or caretaker upon initiation of services. The grievance policy must also include the phone number of the Bureau of Special Health Care Needs and the MO HealthNet Division, *[participant services unit]*.

(5) Qualification Requirements for Private Duty Nursing Direct Care Staff and Supervisors.

(A) For nursing staff, the provider agency shall show evidence in the personnel record that the employee's licensure status with the Missouri Board of Nursing is current, **and a graduate nurse meets the requirements as stated in subsection (1)(C) of this rule.**

(C) The provider will be responsible for assuring and documenting that the nurse's health permits performance of the required activities and does not pose a health hazard. Service delivery shall be prohibited when the employee has a communicable condition. *[Before contact with clients, all employees who will be delivering services in the home must pass a health assessment or physical examination, including tuberculosis (TB) testing, conducted by a physician or a nurse. Self assessment will not be accepted for LPN and RN staff. Health assessments or physical exams shall be repeated at two (2)-year intervals and the results shall be maintained on-site by the provider. Annual TB testing is required, with documentation to be maintained by the provider.]*

(6) Requirements for Training for Private Duty Staff.

(A) All direct care staff (LPNs *and*), RNs, **and graduate nurses** must have at least four (4) hours of orientation training prior to service provision. Orientation training should include general information about the MO HealthNet Private Duty Nursing Program, the HCY program, relationship of the provider agency with the MO HealthNet Division and the Bureau of Special Health Care Needs, the prior authorization process, child abuse/neglect indicators and reporting, participant rights, participant grievance procedures, internal agency policy, and a review of universal precaution procedures as

defined by the Center for Disease Control.

(B) Prior to delivering services, LPNs and graduate LPNs must demonstrate competency in each task required by the plan of care. The competency demonstration must be conducted by an RN and must be documented in the LPN's or graduate LPN's personnel file.

(C) All direct care staff must have [certification] a certificate in either cardiopulmonary resuscitation (CPR) or basic certified life-support (BCL).

(7) Requirements for Supervision of Private Duty Nursing Staff.

(A) Each agency shall employ an RN, with three (3) years' nursing (RN and/or LPN) experience, to act as supervisor to all other nursing staff. One (1) year of experience must either be in supervisory position or in the field of pediatric nursing. The RN supervisor will be responsible for case conferences with staff nurses and documenting the conferences, assuring the competency of staff, training and orientation, and evaluation of direct care staff. **An LPN with three (3) years' experience may act as the assistant supervisor under the RN supervisor. One (1) year of experience must be in high acuity pediatric nursing care in a hospital, home care agency or residential setting. The assistant nursing supervisor may be responsible for case conferences with staff nurses, documenting the conferences, developing plan of care after the initial plan of care has been established by an RN, orientation, training, and evaluation of direct care staff and other duties delegated by the Nursing Supervisor.**

(B) All nursing staff providing direct care shall have an annual performance evaluation completed by [an RN] a licensed nurse supervisor, maintained in the personnel record. [The evaluation must be based on a minimum of two (2) on-site visits with the staff person present.]

(C) Frequency of Supervisory Visits.

1. Participants of private duty nursing care shall have a personal visit with assessment by a [supervisory RN] licensed nurse supervisor at least once every sixty (60) days if the participant is authorized for LPN, graduate LPN or graduate RN service. Supervisory visits by [an RN] a nurse will not be separately reimbursed.

2. Patients who have received RN shift care through the Private Duty Nurse Program or intermittent visits by an RN under the home health program (if those services were provided by an agency affiliated with the private duty provider) are not required to have a separate supervisory visit.

3. Supervisory visits, or explanation of why there are no separate supervisory visits for the month (that is, RN shifts were delivered), are to be documented in the participant record.

(8) Requirements for the Contents of Medical Records. Appropriate medical records for each MO HealthNet participant served must be maintained at the private duty nursing agency. Records [should] shall be kept confidential and access [should] shall be limited to private duty nursing staff and representatives of the Departments of Social Services and Health and Senior Services.

(A) Medical records shall contain the following:

1. Identifying information about the participant, such as name, birthdate, MO HealthNet participant identification number, caretaker, and emergency contact person;

2. All forms or correspondence to and from the Bureau of Special Health Care Needs regarding the services which have been prior authorized;

3. Signed physician orders prior to service delivery which must be updated each time the prior authorization is due for approval by the Bureau of Special Health Care Needs;

4. Consent from the child's legal custodian for treatment prior to service delivery;

5. The plan of care, documenting the amount, duration, and scope of the service. The level of care indicated in the plan of care (RN or LPN) must be based on acceptable standards of nursing practice. Reimbursement is based on the prior authorization approved by the Bureau of Special Health Care Needs, with that prior authorization based upon the plan of care, specifying the number of [hours/units] and the skill level of the service, for periods of up to six (6) months;

6. [Weekly] Daily documentation of all services provided and any supervisory visits;

7. Documentation of the LPN's or graduate LPN's competency demonstration before an RN when the plan of care includes the services of an LPN or graduate LPN as required in subsection (6)(C); and

8. Documentation that a copy of the participant's Bill of Rights was given to the participant, parent, or guardian.

(9) Reimbursement.

(B) Conditions for Reimbursement.

1. Services will be authorized by the Bureau of Special Health Care Needs prior to delivery, in accordance with a private duty nursing care plan, specifying the amount, duration, and scope of services. The prior authorization will be the basis for reimbursement.

2. A MO HealthNet Division enrolled PDN agency may be reimbursed for PDN services rendered by a legal guardian or family member. A family member is defined as a parent; sibling; child by blood, adoption, or marriage; spouse; grandparent or grandchild. The PDN caregiver who delivers the direct care must have a valid RN or LPN license in the State of Missouri and be employed by the MO HealthNet Division enrolled PDN provider.

3. PDN services provided by a family member or legal guardian for a single participant or multiple participants with the same residence may not exceed twelve (12) hours per day up to a maximum of forty (40) hours per week. A family member or legal guardian shall not provide more than forty (40) hours of service in a seven- (7-) day period. For a family member or legal guardian, forty (40) hours is the total amount allowed regardless of the number of children who receive services.

(10) MO HealthNet Private Duty Nursing Provider Manual. [A private duty nursing provider manual shall be produced by the MO HealthNet Division and shall be distributed to all private duty nursing providers participating in the Missouri MO HealthNet Program at its website at www.dss.mo.gov/mhd. The MO HealthNet Private Duty Nursing Provider Manual and bulletins, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/mhd, September 15, 2009, shall contain information about MO HealthNet eligibility, third party liability, procedures for requesting prior authorization, claim filing instructions, instructions for filing adjustments, reimbursement methodology, and current MO HealthNet maximum rates of reimbursement for services, benefits and limitations of services, and other applicable information about the program. The rule does not incorporate any subsequent amendments or additions.] The Department of Social Services, MO HealthNet Division shall administer the MO HealthNet Private Duty Nursing program. The services covered and not covered, the program limitations, and the maximum allowable fees for all covered services shall be included in the Private Duty Nursing provider manual, which is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at http://manuals.momed.com/collections/collection_pdn/print.pdf, April 21, 2020. This rule does not incorporate any subsequent amendments or additions.

AUTHORITY: sections [208.152,] 208.153, [and] 208.201, and 660.017, RSMo [Supp. 2008] 2016, and section 208.152, RSMo Supp. 2019. Original rule filed Sept. 2, 1993, effective April 9, 1994. For intervening history, please consult the Code of State Regulations. Amended: Filed April 21, 2020.

PUBLIC COST: The proposed amendment will cost state agencies or political subdivisions \$1,076,638.18 annually.

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, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE
PUBLIC COST**

- I. Department Title:** Department of Social Services
- Division Title:** Division 70 - MO HealthNet Division
- Chapter Title:** Chapter 95 – Private Duty Nursing Care Under the Healthy Children and Youth Program

Rule Number and Name:	13 CSR 70-95.010 Private Duty Nursing
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Department of Social Services- MO HealthNet Division	\$1,076,638.18

III. WORKSHEET

FY 17 expenditures	\$60,425,796.07
FY 18 expenditures	\$51,831,417.38
FY 19 expenditures	\$49,238,514.06
Total expenditures for FY17-FY19	\$161,495,727.51
Average expenditures (Total divided by 3 years)	\$53,831,909.17
2% increase (2% of Average expenditures)	\$1,076,638.18

IV. ASSUMPTIONS

MHD has engaged the Private Duty Nursing (PDN) industry throughout the process of drafting this proposed regulation amendment, in order to keep stakeholders involved and to solicit feedback. One way in which MHD achieves stakeholder engagement is by hosting stakeholder meetings throughout the amendment process, as well as follow-up calls and emails to discuss the proposed changes.

This feedback is what drives the MHD assumptions when determining fiscal impact. It is expected that there will be a minimal impact (increase of 2%) in utilization of services due to changes that would allow graduate nurses and qualified family members to provide PDN services.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**Division 20—Division of Community and Public Health
Chapter 2—Protection of Drugs and Cosmetics****PROPOSED RESCISSION**

19 CSR 20-2.020 Inspection of the Manufacture and Sale of Cosmetics. This rule established manufacturing and labeling standards for cosmetics as these products relate to public health.

PURPOSE: This rule is being rescinded as it is outdated and no longer necessary.

AUTHORITY: section 196.045, RSMo 1986. This rule previously filed as 13 CSR 50-72.010. Original rule entitled Missouri Division of Health E 1.20 was filed on Nov. 17, 1949, effective Nov. 27, 1949. Rescinded: Filed April 23, 2020.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission to PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**Division 20—Division of Community and Public Health
Chapter 3—General Sanitation****PROPOSED RESCISSION**

19 CSR 20-3.040 Environmental Health Standards for the Control of Communicable Diseases. This rule provided general sanitation rules which helped assure conditions were not injurious to the health of the people.

PURPOSE: This rule is being rescinded as it is outdated and no longer necessary.

AUTHORITY: section 192.020, RSMo 1986. This rule previously filed as 13 CSR 50-83.010. Original rule filed May 12, 1949, effective May 22, 1949. Rescinded: Filed April 23, 2020.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission to PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**Division 40—Division of Maternal, Child and Family Health
Chapter 4—Early Periodic Screening, Diagnosis and Treatment (EPSDT)****PROPOSED RESCISSION**

19 CSR 40-4.010 Basis for Provisions of EPSDT. This rule established basis and criteria for provision of EPSDT services.

PURPOSE: This rule is being rescinded as the EPSDT program resides with the Department of Social Services and DSS has promulgated rules for provision of services through EPSDT as 13 CSR 40-37.010. Therefore, this rule is unnecessary.

AUTHORITY: sections 191.420 and 192.020, RSMo 1986. This rule was previously filed as 13 CSR 50-157.010. Original rule filed Dec.30, 1975, effective Jan. 9, 1976. Amended: Filed May 10, 1978, effective Aug. 11, 1978. Emergency amendment filed Aug. 16, 1979, effective Oct. 1, 1979, expired Nov. 10, 1979. Amended: Filed Aug. 16, 1979, effective Nov. 11, 1979. Amended: Filed Jan. 15, 1985, effective April 11, 1985. Rescinded: Filed April 23, 2020.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission to PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**Division 40—Division of Maternal, Child and Family Health
Chapter 7—Metabolic Formula Program****PROPOSED RESCISSION**

19 CSR 40-7.010 Definitions. This rule defined the terms used in this chapter.

PURPOSE: This rule is being rescinded as the rule has expired and 19 CSR 40-7.040 now defines the terms used in this chapter.

AUTHORITY: sections 191.300-191.380, RSMo (1994 and Supp. 1995). Emergency rule filed Aug. 19, 1996, effective Aug. 29, 1996, expired Feb. 24, 1997. Original rule filed Aug. 15, 1996, effective Jan. 30, 1997. Rescinded: Filed April 23, 2020.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission to PO Box 570, Jefferson City, MO 65102-0570. 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.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission to PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

Division 40—Division of Maternal, Child and Family Health

Chapter 7—Metabolic Formula Program

PROPOSED RESCISSION

19 CSR 40-7.020 Program Eligibility. The Department of Health (DOH) provides low-protein formula, a special dietary product, to individuals diagnosed as having phenylketonuria (PKU), maple syrup urine disease (MSUD) and other metabolic conditions as approved by the Newborn Screening Standing Committee. This rule established the criteria by which the Formula Distribution Program accepts clients for service.

PURPOSE: This rule is being rescinded as the rule has expired and 19 CSR 40-7.050 establishes the criteria for acceptance of clients for service by the Metabolic Formula Program.

AUTHORITY: sections 191.300-191.380, RSMo (1994 and Supp. 1995). Original rule filed Aug. 15, 1996, effective Jan. 30, 1997. Rescinded: Filed April 23, 2020.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission to PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

Division 40—Division of Maternal, Child and Family Health

Chapter 7—Metabolic Formula Program

PROPOSED RESCISSION

19 CSR 40-7.030 Client Responsibilities. This rule established how clients maintain program eligibility.

PURPOSE: This rule is being rescinded as the rule has expired and 19 CSR 40-7.050 and 19 CSR 40-7.060 addresses eligibility and the process for participation in the Metabolic Formula Program.

AUTHORITY: sections 191.300-191.380, RSMo (1994 and Supp. 1995). Emergency rule filed Aug. 19, 1996, effective Aug. 29, 1996, expired Feb. 24, 1997. Original rule filed Aug. 15, 1996, effective Jan. 30, 1997. Rescinded: Filed April 23, 2020.

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

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

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

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

**Title 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 9—Animal Care Facilities
ORDER OF RULEMAKING**

By the authority vested in the Animal Health Division under section 265.020, RSMo 2016, the Animal Health Division amends a rule as follows:

2 CSR 30-9.010 Animal Care Facilities Definitions is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2020 (45 MoReg 9-11). 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 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 9—Animal Care Facilities
ORDER OF RULEMAKING**

By the authority vested in the Animal Health Division under section 265.020, RSMo 2016, the Animal Health Division amends a rule as follows:

2 CSR 30-9.020 Animal Care Facility Rules Governing Licensing, Fees, Reports, Record Keeping, Veterinary Care, Identification, and Holding Period is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2020 (45 MoReg 11-21). 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 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 9—Animal Care Facilities
ORDER OF RULEMAKING**

By the authority vested in the Animal Health Division under section 265.020, RSMo 2016, the Animal Health Division amends a rule as follows:

2 CSR 30-9.030 Animal Care Facilities Minimum Standards of Operation and Transportation is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2020 (45 MoReg 21-24). 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 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle
ORDER OF RULEMAKING**

By the authority vested in the director of revenue under section 32.065, RSMo 2016, the director adopts a rule as follows:

12 CSR 10-23.550 Lease Rental Companies is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on February 3, 2020 (45 MoReg 206-207). 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 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 102—Sales/Use Tax—Taxpayers Rights
ORDER OF RULEMAKING**

By the authority vested in the director of revenue under section 32.065, RSMo 2016, the director amends a rule as follows:

12 CSR 10-102.100 Bad Debts Credit or Refund is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 3, 2020 (45 MoReg 207). 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 30—Division of Regulation and Licensure
Chapter 95—Medical Marijuana

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under Article XIV of the *Missouri Constitution*, the department adopts a rule as follows:

19 CSR 30-95.028 Additional Licensing Procedures is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 2, 2020 (45 MoReg 41). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Health and Senior Services received one (1) comment on the proposed rule.

COMMENT #1: Joe Bednar of Spencer Fane submitted comments on the proposed rule arguing that DHSS' stated purpose for this rule does not fall within the department's rulemaking authority, that the proposed rule perpetuates inequities and unlawfulness of other rules, that other rules should be amended to bring them into compliance with the *Missouri Constitution*, and that the department should determine which applicants who have appealed denial of their application meet the standards for licensure.

RESPONSE: This comment does not contain any specific recommendations regarding any of the language proposed for this rule. Instead, it offers several arguments indicating opposition to other rules, makes claims regarding cases on appeal with the Administrative Hearing Commission, argues the purpose of the proposed rule exceeds the department's rulemaking authority, and concludes the proposed rules should be rescinded.

The claim that the stated purpose for this proposed rule exceeds the department's rulemaking authority is unfounded. First, the comment fails to cite the entire section of rulemaking authority at issue and also fails to cite the entire stated purpose of the proposed rule. The portions the comment omits show how the stated purpose aligns with the rulemaking authority. Specifically, Article XIV says,

"In carrying out the implementation of this section, the Department shall have the authority to . . . Promulgate rules and emergency rules necessary for the proper regulation and control of the cultivation, manufacture, dispensing, and sale of marijuana for medical use and for the enforcement of this section so long as patient access is not restricted unreasonably and such rules are reasonably necessary for patient safety or to restrict access to only licensees and Qualifying Patients." (emphasis added)

The purpose statement for the proposed rules says,

"The Department of Health and Senior Services has the authority to promulgate rules for the enforcement of Article XIV. This rule explains what provisions are necessary for ensuring an efficient facility licensing/certification process after the initial process of scoring and ranking applications is complete." (emphasis added)

The procedural mechanisms established through the proposed rule are necessary for the efficient (proper) regulation and enforcement of Article XIV, and nothing about explaining procedures for accepting a license or for moving to the next applicant in line when a license becomes available would have the effect of restricting patient access. All arguments to the contrary offered by the commenter are related to rules other than the one proposed and to ongoing litigation that is also unrelated to the provisions of the proposed rule. No change has been made to the proposed rule in response to this comment.

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects
Chapter 2—Code of Professional Conduct

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects under section 327.041, RSMo 2016, the board amends a rule as follows:

20 CSR 2030-2.040 Evaluation Criteria for Building Design is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 3, 2020 (45 MoReg 208-209). 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 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2070—State Board of Chiropractic Examiners
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the State Board of Chiropractic Examiners under section 331.100, RSMo 2016, the board rescinds a rule as follows:

20 CSR 2070-2.060 Professional Conduct Rules is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on February 3, 2020 (45 MoReg 209). 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 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2070—State Board of Chiropractic Examiners
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the State Board of Chiropractic Examiners

under section 331.100, RSMo 2016, the board adopts a rule as follows:

20 CSR 2070-2.060 Professional Conduct Rules is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on February 3, 2020 (45 MoReg 209-210). 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 20—DEPARTMENT OF COMMERCE AND
INSURANCE
Division 2220—State Board of Pharmacy
Chapter 7—Licensing**

ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Pharmacy under sections 338.140 and 338.143, RSMo Supp. 2019, the board amends a rule as follows:

20 CSR 2220-7.025 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 3, 2020 (45 MoReg 210-211). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received a comment letter from the St. Louis College of Pharmacy (STLCoP).

COMMENT #1: STLCoP is recommending the board amend subsection (3)(C) of the proposed amendment to clarify that pharmacists licensed in a U.S. state or territory do not have to be approved as a non-pharmacist preceptor.

RESPONSE AND EXPLANATION OF CHANGE: The board agrees with the recommendation. Non-pharmacist preceptor approval is only required for individuals who do not hold an active pharmacist license from a U.S. state or territory. Subsection (3)(C) has been amended as suggested.

COMMENT #2: The board received a comment from STLCoP requesting that the board modify section (6) of the rule to allow intern pharmacists to renew every four (4) years instead of biennially. STLCoP indicated most students complete their internship hours in four (4) years and the extended renewal period would decrease paperwork for both students, the board office and school staff.

RESPONSE: STLCoP's recommendation would constitute a substantive change that is beyond the authorized scope of a final order of rulemaking under Chapter 536, RSMo. Additionally, renewal dates are statutorily designated by the Division of Professional Registration, pursuant to section 324.001.3, RSMo. Accordingly, the suggested revision would require amendment of division rule 20 CSR 2231-2.010 and cannot be accomplished in the current rule. No changes have been made in response to the comment, however, the board will consider the suggestion during future rule discussions.

20 CSR 2220-7.025 Intern Pharmacist Licensure

(3) Site/Preceptor Approval. After licensure, an intern pharmacist shall only be authorized to earn pharmacy practice experience in a site approved by the board and under the supervision of a board

approved preceptor. Requests for site and preceptor approval shall be submitted on a form provided by the board. The board may request additional information, interview program participants, or complete site inspections before a decision on an application is made. The intern pharmacist will receive confirmation from the board office noting approval of the site and preceptor and a start date after which pharmacy practice experience may be counted. In no event shall an intern pharmacist be credited for hours earned prior to being licensed by the board as an intern pharmacist.

(C) Preceptor Approval. To be eligible for approval, a supervising preceptor shall hold a pharmacist license from a U.S. state or territory and such license must be active and not under disciplinary action in such U.S. state or territory. An individual/entity may petition the board to approve a preceptor that is not licensed as a pharmacist in a U.S. state or territory on a form provided by the board. The board may, in its discretion, approve a non-pharmacist preceptor if the preceptor is sufficiently qualified to train interns in the proposed pharmacy practice experience area(s) and the experience to be earned complies with the provisions of 20 CSR 2220-7.030(1)(A)3. The board may limit the amount of pharmacy practice hours that can be earned with a non-pharmacist preceptor.

**Title 20—DEPARTMENT OF COMMERCE AND
INSURANCE
Division 2220—State Board of Pharmacy
Chapter 7—Licensing**

ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Pharmacy under sections 338.140 and 338.143, RSMo Supp. 2019, the board amends a rule as follows:

20 CSR 2220-7.027 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 3, 2020 (45 MoReg 211-212). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received a comment letter from the St. Louis College of Pharmacy (STLCoP).

COMMENT #1: The board received a comment from the St. Louis College of Pharmacy (STLCoP) recommending that the board amend subsection (1)(C) to clarify that approved Missouri schools/colleges may add and approve preceptors and sites that meet the rule's requirements without prior board review and approval.

RESPONSE AND EXPLANATION OF CHANGE: The intent of the amendment was to grant approved Missouri schools/colleges flexibility to approve intern training sites and pharmacist preceptors for matriculating pharmacy students, subject to statutory and rule requirements. Approved Missouri schools would only have to annually submit to the board the list of sites and pharmacist preceptors used by the school/college in the previous year. Subsection (1)(C) has been amended to clarify this intent.

20 CSR 2220-7.027 Approved Missouri Schools/Colleges of Pharmacy

(1) Upon request, the board may approve a Missouri school/college of pharmacy for purposes of providing pharmacy practice experience to enrolled students. To be eligible for approval, the school/college of pharmacy must be located in Missouri and shall—

(C) Submit a list of all preceptors and sites that were used by the school/college curriculum for pharmacy practice experience within

the previous year. The list must be submitted to the board annually for review; and

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE

**Division 2250—Missouri Real Estate Commission
Chapter 5—Fees**

ORDER OF RULEMAKING

By the authority vested in the Missouri Real Estate Commission under section 339.120, RSMo Supp. 2019, the commission withdraws a proposed amendment as follows:

20 CSR 2250-5.020 Application and License Fees is **withdrawn**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 15, 2020 (45 MoReg 113-115). This proposed amendment is withdrawn.

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE

**Division 4240—Public Service Commission
Chapter 40—Gas Utilities and Gas Safety Standards**

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.250, 386.310, and 393.140, RSMo 2016, the commission amends a rule as follows:

20 CSR 4240-40.020 Incident, Annual, and Safety-Related Condition Reporting Requirements is **amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 15, 2020 (45 MoReg 116-119). 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 public comment period ended February 14, 2020, and the commission held a public hearing on the proposed amendment on February 24, 2020. The commission received a timely written comment from the staff of the commission. Robin Ganahl of Kansas City, Missouri, submitted a written comment on February 20, 2020. Jamie Myers, representing the commission's staff, appeared at the hearing and offered comments.

COMMENT #1: Staff's written comment explains that the proposed amendment adopts corresponding changes to federal pipeline safety standards and includes minor editorial changes to clarify and improve ease of reference. In addition, the amendment updates references within the rules to reflect the commission's move from the Department of Economic Development to the Department of Commerce and Insurance.

RESPONSE: The commission will make no change in response to this comment.

COMMENT #2: Robin Ganahl expressed concern about the prevalence of gas leaks in her neighborhood. She urges the commission to require Missouri gas utilities to put maps of known leaks on their websites. Jamie Myers, speaking on behalf of the commission's staff, indicated staff would look at the concerns expressed by Ms. Ganahl.

Ms. Myers pointed out that before it could require the utilities to put a map of known leaks on their websites, the commission would need to obtain feedback from the utilities and other interested stakeholders about the advisability and costs of such a requirement. Staff indicated it would consider Ms. Ganahl's comment in the next update of the gas safety rules.

RESPONSE: The commission will consider Ms. Ganahl's suggestion, but it is too late in the rulemaking process to obtain the feedback from stakeholders necessary to implement that suggestion in this rulemaking. The commission will make no change in response to this comment.

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE

**Division 4240—Public Service Commission
Chapter 40—Gas Utilities and Gas Safety Standards**

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.250, 386.310, and 393.140, RSMo 2016, the commission amends a rule as follows:

20 CSR 4240-40.030 Safety Standards—Transportation of Gas by Pipeline is **amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 15, 2020 (45 MoReg 119-137). 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 public comment period ended February 14, 2020, and the commission held a public hearing on the proposed amendment on February 24, 2020. The commission received a timely written comment from the staff of the commission. Robin Ganahl of Kansas City, Missouri, submitted a written comment on February 20, 2020. Jamie Myers, representing the commission's staff, appeared at the hearing and offered comments.

COMMENT #1: Staff's written comment explains that the proposed amendment adopts corresponding changes to federal pipeline safety standards and includes minor editorial changes to clarify and improve ease of reference. In addition, the amendment updates references within the rules to reflect the commission's move from the Department of Economic Development to the Department of Commerce and Insurance.

RESPONSE: The commission will make no change in response to this comment.

COMMENT #2: Robin Ganahl expressed concern about the prevalence of gas leaks in her neighborhood. She urges the commission to require Missouri gas utilities to put maps of known leaks on their websites. Jamie Myers, speaking on behalf of the commission's staff, indicated staff would look at the concerns expressed by Ms. Ganahl. Ms. Myers pointed out that before it could require the utilities to put a map of known leaks on their websites, the commission would need to obtain feedback from the utilities and other interested stakeholders about the advisability and costs of such a requirement. Staff indicated it would consider Ms. Ganahl's comment in the next update of the gas safety rules.

RESPONSE: The commission will consider Ms. Ganahl's suggestion, but it is too late in the rulemaking process to obtain the feedback from stakeholders necessary to implement that suggestion in this rulemaking. The commission will make no change in response to this comment.

**Title 20—DEPARTMENT OF COMMERCE AND
INSURANCE
Division 4240—Public Service Commission
Chapter 40—Gas Utilities and Gas Safety Standards**

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.250, 386.310, and 393.140, RSMo 2016, the commission amends a rule as follows:

20 CSR 4240-40.033 Safety Standards—Liquefied Natural Gas Facilities is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 15, 2020 (45 MoReg 137-138). 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 public comment period ended February 14, 2020, and the commission held a public hearing on the proposed amendment on February 24, 2020. The commission received a timely written comment from the staff of the commission. Robin Ganahl of Kansas City, Missouri, submitted a written comment on February 20, 2020. Jamie Myers, representing the commission's staff, appeared at the hearing and offered comments.

COMMENT #1: Staff's written comment explains that the proposed amendment adopts corresponding changes to federal pipeline safety standards and includes minor editorial changes to clarify and improve ease of reference. In addition, the amendment updates references within the rules to reflect the commission's move from the Department of Economic Development to the Department of Commerce and Insurance.

RESPONSE: The commission will make no change in response to this comment.

COMMENT #2: Robin Ganahl expressed concern about the prevalence of gas leaks in her neighborhood. She urges the commission to require Missouri gas utilities to put maps of known leaks on their websites. Jamie Myers, speaking on behalf of the commission's staff, indicated staff would look at the concerns expressed by Ms. Ganahl. Ms. Myers pointed out that before it could require the utilities to put a map of known leaks on their websites, the commission would need to obtain feedback from the utilities and other interested stakeholders about the advisability and costs of such a requirement. Staff indicated it would consider Ms. Ganahl's comment in the next update of the gas safety rules.

RESPONSE: The commission will consider Ms. Ganahl's suggestion, but it is too late in the rulemaking process to obtain the feedback from stakeholders necessary to implement that suggestion in this rulemaking. The commission will make no change in response to this comment.

**Title 20—DEPARTMENT OF COMMERCE AND
INSURANCE
Division 4240—Public Service Commission
Chapter 40—Gas Utilities and Gas Safety Standards**

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.250, 386.310, and 393.140, RSMo 2016, the commission amends a rule as follows:

20 CSR 4240-40.080 Drug and Alcohol Testing is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 15, 2020 (45 MoReg 138-139). 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 public comment period ended February 14, 2020, and the commission held a public hearing on the proposed amendment on February 24, 2020. The commission received a timely written comment from the staff of the commission. Robin Ganahl of Kansas City, Missouri, submitted a written comment on February 20, 2020. Jamie Myers, representing the commission's staff, appeared at the hearing and offered comments.

COMMENT #1: Staff's written comment explains that the proposed amendment adopts corresponding changes to federal pipeline safety standards and includes minor editorial changes to clarify and improve ease of reference. In addition, the amendment updates references within the rules to reflect the commission's move from the Department of Economic Development to the Department of Commerce and Insurance.

RESPONSE: The commission will make no change in response to this comment.

COMMENT #2: Robin Ganahl expressed concern about the prevalence of gas leaks in her neighborhood. She urges the commission to require Missouri gas utilities to put maps of known leaks on their websites. Jamie Myers, speaking on behalf of the commission's staff, indicated staff would look at the concerns expressed by Ms. Ganahl. Ms. Myers pointed out that before it could require the utilities to put a map of known leaks on their websites, the commission would need to obtain feedback from the utilities and other interested stakeholders about the advisability and costs of such a requirement. Staff indicated it would consider Ms. Ganahl's comment in the next update of the gas safety rules.

RESPONSE: The commission will consider Ms. Ganahl's suggestion, but it is too late in the rulemaking process to obtain the feedback from stakeholders necessary to implement that suggestion in this rulemaking. The commission will make no change in response to this comment.

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.

Notice from the publisher.

Beginning with the May 1, 2020 issue of the *Missouri Register* we began publishing notice of suspension of rules based on section 536.022, RSMo and Executive Order 20-04 and expiring on May 15, 2020. Executive Order 20-10 extended the expiration date until June 15, 2020.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 10—Director, Department of Mental Health
Chapter 7—Core Rules for Psychiatric and Substance Use
Disorder Treatment Programs**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

9 CSR 10-7.030(2)(B) & (4)(A)5. Service Delivery Process and Documentation

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 9 CSR 10-7.030(2)(B) and (4)(A)5. shall be waived to the extent necessary to temporarily ease restrictions on the Psychiatric and Substance Use Disorder Treatment Programs to reduce or eliminate face-to-face provisions and requirements that would violate social distancing principles, and give additional time to comply with time constraints.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 3—Substance Use Disorder Treatment Programs**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

9 CSR 30-3.100(6)(A)2. Service Delivery Process and Documentation

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 9 CSR 30-3.100(6)(A)2 shall be waived to the extent necessary to temporarily ease restrictions on the Substance Use Disorder Treatment Programs to reduce or eliminate face-to-face provisions and requirements that would violate social distancing principles, and give additional time to comply with time constraints.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

9 CSR 30-4.035(3) & (5) Eligibility Determination, Assessment, and Treatment Planning in Community Psychiatric Rehabilitation Programs

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 9 CSR 30-4.035(3) & (5) shall be waived to the extent necessary to temporarily ease restrictions on the Community Psychiatric Rehabilitation Programs to reduce or eliminate face-to-face provisions and requirements that would violate social distancing principles, and give additional time to comply with time constraints.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 45—Division of Developmental Disabilities
Chapter 2—Eligibility for Services**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

9 CSR 45-2.010(4)(I) Eligibility for Services From the Division of Developmental Disabilities

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 9 CSR 45-2.010(4)(I) shall be waived to the extent necessary to temporarily suspend reassessment of eligibility for services at age 22 to prevent the termination of necessary services.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 45—Division of Developmental Disabilities
Chapter 2—Eligibility for Services**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

9 CSR 45-2.017(3)(B)2. Utilization Review Process

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 9 CSR 45-2.017(3)(B)2. shall be waived to the extent necessary to temporarily ease restrictions on the Division of Developmental Disabilities in order to give the Division the ability to streamline the utilization review process and reduce the gap in services caused by the temporary closing of services traditionally provided in congregate settings.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 45—Division of Developmental Disabilities
Chapter 3—Services and Supports**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

9 CSR 45-3.070(4); (10)(A)2.B.; (14)(A) & (B) Certification of Medication Aides Serving Persons with Developmental Disabilities

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 9 CSR 45-3.070(4); (10)(A)2.B., (14)(A) & (B) shall be waived to the extent necessary to temporarily ease restrictions on the certification of Medication Aides in following manner to reduce or eliminate face-to-face provisions and requirements that would violate social distancing principles, and give additional time to comply with time constraints. The waiver will give DMH DD contracted providers the ability to certify and re-certify qualified staff per 9 CSR 10-5.190 to administer medications in any residential setting or day program funded, licensed or certified by the Department of Mental health to provide services to persons with IDD. The division will be posting a memorandum to DMH DD contracted service providers regarding interim guidance to meet this requirement during the COVID-19 pandemic.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 45—Division of Developmental Disabilities
Chapter 3—Services and Supports**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

9 CSR 45-3.080(4)(H) & (7)(D) Self-Directed Supports

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 9 CSR 45-3.080(4)(H) & (7)(D) shall be waived to the extent necessary to temporarily ease restrictions governing Self Directed Supports. Current regulation governing Self Directed Supports for activities of daily living (feeding, hygiene, cleaning, laundry etc.) prohibits family members from providing such assistance over 40 hours per week. Due to the compromised health of some individuals served, unavailability of non-family member support, and the social isolation requirements of the public health crisis, the Division is temporarily suspending this limit.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 20—Clean Water Commission
Chapter 6—Permits**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

10 CSR 20-6.300(2)(B) Concentrated Animal Feeding Operations

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 10 CSR 20-6.300(2)(B) applies to the entirety of subsection (B) for existing facilities only. This rule suspension does not apply to facilities that were not in operation on or before March 18, 2020.

10 CSR 20-6.300(2)(B) requires that owners and operators of concentrated animal feeding operations (CAFOs) obtain a permit prior to operating a waste management system at the facility. This notice temporarily suspends the requirement to obtain a permit; it does not suspend obligations to abide by water-quality protection requirements.

Permit applications and associated permit requirements are based primarily on CAFO class size. The COVID-19 emergency has disrupt-

ed transportation and processing operations, which may prevent certain animal feeding operations (AFOs) and CAFOs from transporting animals out of their facilities at a normal rate. This disruption could result in temporarily elevated numbers of animals remaining on-site despite best efforts to avoid increases. Without the suspension of this rule, certain AFO and CAFO owners and operators would need to apply for a new permit or permit modification based on their temporarily increased class size—a permit or modification that would not be required for their normal, non-emergency operations. This suspension allows owners and operators to adapt to temporarily elevated animal numbers without adding additional paperwork and permitting application requirements during the COVID-19 emergency.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 20—Clean Water Commission
Chapter 6—Permits**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

10 CSR 20-6.300(3)(A)3. Concentrated Animal Feeding Operations

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 10 CSR 20-6.300(3)(A)3. applies to the following rule language only: “If the operation increases animal numbers to the Class I operating size, the owner or operator of the [concentrated animal feeding operation (CAFO)] shall apply for an operating permit.” This specific sentence in 10 CSR 20-6.300(3)(A)3. requires that owners and operators of Class II animal feeding operations (AFOs) apply for a permit if the operation increases in size to Class I animal units. This notice temporarily suspends the requirement to obtain a permit; it does not suspend obligations to abide by water-quality protection requirements.

The COVID-19 emergency has disrupted transportation and processing operations, which may prevent certain AFOs from transporting animals out of their facilities at a normal rate. This disruption could result in temporarily elevated numbers of animals remaining on-site despite best efforts to avoid increases. Without the suspension of this rule, certain AFO owners and operators would need to apply for a permit based on the increased class size—a permit that would not be required for their normal, non-emergency operations. This temporary suspension allows owners and operators to adapt to temporarily elevated animal numbers without adding additional paperwork and permitting application requirements during the COVID-19 emergency.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 20—Clean Water Commission
Chapter 6—Permits**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

10 CSR 20-6.300(3)(B)1. Concentrated Animal Feeding Operations

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 10 CSR 20-6.300(3)(B)1. applies to the following language only and for existing facilities only: "Neighbor notice requirements of subsection (C) of this section shall apply to all existing and proposed confinement buildings and wastewater structures. If the proposed expansion or modification results in an increase to a larger classification size, the buffer distance and neighbor notice requirement of the larger classification size will apply to all existing and proposed confinement buildings and wastewater storage structures unless exempted by paragraph 4. of this subsection." This rule suspension does not apply to confinement buildings that are constructed after March 18, 2020.

10 CSR 20-6.300(3)(B)1. requires that owners and operators of concentrated animal feeding operations (CAFOs) provide neighbor notice and meet buffer-distance requirements whenever the CAFO increases animal numbers to a larger class size. Neighbor notice and buffer distances are established based on CAFO class size. The COVID-19 emergency has disrupted transportation and processing operations, which may prevent certain CAFOs from transporting animals out of their facilities at a normal rate. This disruption could result in temporarily elevated numbers of animals remaining on-site despite best efforts to avoid increases. Without the suspension of this rule, certain CAFO owners and operators would need to notify neighbors and meet new buffer distances based on their temporarily increased class size— actions that would not be required for their normal, non-emergency operations. This temporary suspension allows owners and operators to adapt to temporarily elevated animal numbers without triggering new notification and buffer requirements during the COVID-19 emergency, while continuing to require operational and water quality protection measures at all CAFOs.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 20—Clean Water Commission
Chapter 6—Permits**

10 CSR 20-6.300(4)(A)1. Concentrated Animal Feeding Operations

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 10 CSR 20-6.300(4)(A)1. applies to the entirety of paragraph (4)(A)1. for existing confinement buildings only. This rule suspension does not apply to confinement buildings that are constructed after March 18, 2020.

10 CSR 20-6.300(4)(A)1. requires that owners and operators design and construct new and expanding concentrated animal feeding operations (CAFOs) in accordance with the design standards in 10 CSR 20-8.300. Design standards are based on CAFO class size, intended facility use, anticipated animal numbers, and anticipated animal manure generated. This rule requires an expanding animal feeding operation or CAFO to meet the design and construction standards for the increased animal capacity, often resulting in structural additions and modifications. The COVID-19 emergency has disrupted transportation and processing operations, which may prevent certain CAFOs from transporting animals out of their facilities at a normal rate. This disruption could result in temporarily elevated numbers of animals remaining on-site despite best efforts to avoid increases. Without the suspension of this rule, CAFO owners and operators would need to redesign and possibly construct new lagoons or other structures based on their temporarily increased class size. This temporary suspension allow owners and operators to adapt to temporarily elevated animal numbers without adding additional permitting application requirements during the COVID-19 emergency, while

continuing to require operational and water-quality protection measures at all CAFOs. Increased facility monitoring and additional Department considerations for waste disposal can address any temporarily elevated waste production in lieu of new designs and otherwise unnecessary construction.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 23, 2020 until May 15, 2020.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 20—Clean Water Commission
Chapter 9—Treatment Plant Operations**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

10 CSR 20-9.030(4)(B) Certification of Wastewater Operators

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 10 CSR 20-9.030(4)(B) applies to the entirety of subsection (B) for wastewater operators whose certifications otherwise would expire during the suspension of this rule. 10 CSR 20-9.030(4)(B) requires that before a certificate will be renewed, the wastewater operator must submit suitable documentation that no fewer than thirty hours of department-approved renewal training were completed. Certification classes have been cancelled and postponed due to social-distancing requirements related to the COVID-19 emergency, and many professionals cannot obtain the minimum training hours during this emergency despite their best efforts. This temporary suspension will allow certified wastewater operators to renew their certificates without obtaining the minimum amount of renewal training that otherwise would be required so they can continue providing professional services for wastewater treatment systems.

EMERGENCY STATEMENT: Pursuant to Executive Orders (EOs) 20-04 dated March 18, 2020, and EO 20-09 dated April 24, 2020, the rule is suspended effective April 30, 2020 until June 15, 2020.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 20—Clean Water Commission
Chapter 14—Concentrated Animal Feeding Operation
Waste Management System Operations**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

10 CSR 20-14.020(4)(B) Certification of Concentrated Animal Feeding Operation Waste Management System Operators

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 10 CSR 20-14.020(4)(B) applies to the entirety of subsection (B) for certified operators of waste management systems for concentrated animal-feeding operations (CAFOs) whose certifications otherwise would expire during the suspension of this rule. 10 CSR 20-14.020(4)(B) requires that before a certificate will be renewed, the CAFO operator must submit suitable documentation that no fewer than twelve hours of department-approved renewal training were completed. Certification classes have been cancelled and postponed due to social-distancing requirements related to the COVID-19 emergency, and many professionals cannot obtain the minimum training hours during this emergency despite their best efforts. This temporary suspension will allow certified CAFO operators to renew their certificates without obtaining the minimum amount of renewal training that

otherwise would be required so they can continue providing professional services for CAFOs.

EMERGENCY STATEMENT: Pursuant to Executive Orders (EOs) 20-04 dated March 18, 2020, and EO 20-09 dated April 24, 2020, the rule is suspended effective April 30, 2020 until June 15, 2020.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 60—Safe Drinking Water Commission
Chapter 14—Operator Certification**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

10 CSR 60-14.020(8)(C) Certification of Public Water System Operators

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 10 CSR 60-14.020(8)(C) applies to the entirety of subsection (C) for drinking-water operators whose certifications otherwise would expire during the suspension of this rule. 10 CSR 60-14.020(8)(C) requires that before a certificate will be renewed, the operator must submit documentation of training sufficient to meeting the minimum hours for the certificate level, as indicated in Table 4. Certification classes have been cancelled and postponed due to social-distancing requirements related to the COVID-19 emergency, and many professionals cannot obtain the minimum training hours during this emergency despite their best efforts. This temporary suspension will allow certified operators of public water systems to renew their certificates without obtaining the minimum amount of renewal training that otherwise would be required so they can continue providing professional services for public water systems.

EMERGENCY STATEMENT: Pursuant to Executive Orders (EOs) 20-04 dated March 18, 2020, and EO 20-09 dated April 24, 2020, the rule is suspended effective April 30, 2020 until June 15, 2020.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 3—Fireworks**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

11 CSR 40-3.010 Fireworks—Licensing, Permits, Sales, Inspection, and Penalties

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE suspends requirements that a licensed operator license issued under 11 CSR 40-3.010(2)(A)1.A. or a pyrotechnic or special effects operator license issued under 11 CSR 40-3.010(2)(A)1.B. expire after three years. Such licenses that have expired since the effective date of Executive Order 20-04 will continue to be effective until May 15, 2020.

This NOTICE OF SUSPENSION OF RULE also suspends the requirement that a licensee obtaining recertification pursuant to 11 CSR 40-3.010(9)(B)6.A. provide documentation of continuing education completed within the past three years. Continuing education completed at any time between the issuance of a current license and a timely application for recertification will satisfy this requirement.

This suspension affects the holders of a licensed operator license or a pyrotechnic or special effects operator license that has expired.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 16, 2020 until May 15, 2020.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 7—Blasting**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

11 CSR 40-7.010 Blasting—Licensing, Registration, Notification, Requirements, and Penalties

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE suspends requirements under 11 CSR 40-7.010(3)(G) that a blaster's license expires three years from the date of issuance. Blaster's licenses that have expired since the effective date of Executive Order 20-04 will continue to be effective until May 15, 2020.

This suspension affects the holders of a blaster's license that expires between March 18, 2020 and May 15, 2020.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 16, 2020 until May 15, 2020.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 70—Division of Alcohol and Tobacco Control
Chapter 2—Rules and Regulations**

IN ADDITION

NOTICE OF EMERGENCY SUSPENSION OF RULE

11 CSR 70-2.190 Unlawful Discrimination and Price Scheduling

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE temporarily suspends the portion of 11 CSR 70-2.190(1) that applies the regulation to "spirituous liquor and wine" to the extent necessary to allow licensed retailers to return any product containing alcohol in excess of five percent by weight, including malt beverages, to a licensed wholesaler for merchandise credit.

This NOTICE OF SUSPENSION OF RULE also temporarily suspends 11 CSR 70-2.190(7) to the extent necessary to allow the Supervisor of ATC to grant approval for merchandise returns from a licensed retailer to a licensed wholesaler for merchandise credit at any time and for any reason.

This rule affects holders of retail and wholesale licenses issued by the Division of Alcohol and Tobacco Control.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is modified effective April 27, 2020 until June 15, 2020.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Driver License Bureau Rules**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

12 CSR 10-24.030(1), (5), (8), and (9) Hearings

ACTION TAKEN: NOTICE OF SUSPENSION OF 12 CSR 10-24.190(1), (5), (8), and (9).

Sections (1), (5), (8), and (9) of 12 CSR 10-24.030 are suspended to temporarily limit Department of Revenue administrative alcohol hearings to telephone hearings only. Currently, driver licensees subject to administrative alcohol hearings have a choice whether to request in-person hearings or telephonic hearings. This will temporarily eliminate in-person hearings to help minimize the contact between all participants, including law enforcement, the licensee, the administrative hearing officer, and any other witnesses. This suspension only applies to sections (1), (5), (8), and (9) of 12 CSR 10-24.030; and subsection 3 of section 302.530, RSMo.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 16, 2020 until May 15, 2020.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Driver License Bureau Rules**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

12 CSR 10-24.305(1) Commercial Driver License Requirements/Exemptions

ACTION TAKEN: NOTICE OF SUSPENSION OF 12 CSR 10-24.305(1).

12 CSR 10-24.305 (1) is suspended to waive the commercial learner's permit fourteen day waiting period requirement for those preparing to take the commercial driver license skills test. Suspension of the rule will remove unnecessary barriers to commercial drivers who are critical to Missouri's COVID-19 response and economic recovery because they transport needed food, medical supplies, equipment, and other goods to our citizens and businesses. This suspension only applies to section (1) of 12 CSR 10-24.305; subsection 2 of section 302.720, RSMo.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective May 1, 2020 until June 15, 2020.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 26—Dealer Licensure**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

12 CSR 10-26.210(1) Dealer Seminar Certification Requirements

ACTION TAKEN: NOTICE OF SUSPENSION OF 12 CSR 10-26.210(1).

12 CSR 10-26.210(1) is suspended to waive the requirement that motor vehicle dealer applicants complete an approved educational seminar prior to licensure. Due to COVID-19, approved educational seminars have not been offered for several weeks and are not being currently offered by seminar providers. This will allow important Missouri businesses to operate without unnecessary delays beyond their control. This suspension only applies to section (1) of 12 CSR

10-26.210; and subsection 10 of section 301.560, RSMo.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective May 1, 2020 until May 15, 2020.

**Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 91—Personal Care Program**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

13 CSR 70-91.010 Personal Care Program

ACTION TAKEN: NOTICE OF SUSPENSION OF 13 CSR 70-91.010

13 CSR 70-91.010 shall be waived in the following manner:

(1) 13 CSR 70-91.010(1)(B)1. shall be waived to the extent necessary to suspend the physician notification mailing.

(2) 13 CSR 70-91.010(1)(B)3. shall be waived to the extent necessary to allow providers to exceed authorized units and deliver outside of the prior authorization under the direct guidance and limitations from MHD and DHSS.

(3) 13 CSR 70-91.010(1)(C)1.F. shall be waived to the extent necessary to waive the twenty-one (21) day notice requirement for providers during this period.

(4) 13 CSR 70-91.010(3)(E) shall be waived to the extent necessary to suspend requirements for providers to provide written notification that a client's services have been discontinued.

(5) 13 CSR 70-91.010(3)(G) shall be waived to the extent necessary to waive the experience requirements of supervisors.

(6) 13 CSR 70-91.010(3)(H)2. and 3. shall be waived to the extent necessary to suspend monitoring of utilization and annual site visits.

(7) 13 CSR 70-91.010(3)(J)1. shall be waived to the extent necessary to suspend the requirement for providers to conduct monthly on-site visits.

(8) 13 CSR 70-91.010(3)(K)3. shall be waived to the extent necessary to waive the experience requirements for aides.

(9) 13 CSR 70-91.010(3)(K)4. shall be waived to the extent necessary to suspend the prohibition of family members from delivering personal care services to allow an individual who is a member of the participant's family, who does not reside in the same household, to deliver personal care services, if no other caregiver is available.

(10) 13 CSR 70-91.010(4)(A)2.F. shall be waived to the extent necessary to waive the requirement for client signature.

(11) 13 CSR 70-91.010(4)(B)1.-2., (5)(F)2.A.-B. shall be waived to the extent necessary to allow services to only exceed cost cap or be delivered and paid outside of service plan when specific guidance and direction is provided by MHD and DHSS.

(12) 13 CSR 70-91.010(5)(E) shall be waived to the extent necessary to waive the requirements for experience and participant specific training.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 30, 2020 until May 15, 2020.

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

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 15-7.021 In-Home Service Standards

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 15-7.021

19 CSR 15-7.021 shall be waived in the following manner:

(1) 19 CSR 15-7.021(1) shall be waived to the extent necessary to allow for the waiver of prior authorization in limited circumstances. Formal guidance must be released by MHD and the Division in each circumstance that no prior authorization is required.

(2) 19 CSR 15-7.021(4)(A)3. shall be waived to the extent necessary to allow for the waiver of the training requirements beyond task training for the participant for aides.

(3) 19 CSR 15-7.021(6)(C)2. shall be waived to the extent necessary to waive the initial onsite evaluation for new Advanced Respite clients; allow training to be conducted via telephone.

(4) 19 CSR 15-7.021(12) shall be waived to the extent necessary to allow personal care units to be delivered via telephone under defined circumstances and under limitations developed by MHD and DHSS during the emergency period.

(5) 19 CSR 15-7.021(13)(B) shall be waived to the extent necessary to allow NEMT to be provided by the personal care provider if NEMT is documented to be unavailable.

(6) 19 CSR 15-7.021(14)(D) shall be waived to the extent necessary to suspend designated manager trainings.

(7) 19 CSR 15-7.021(18)(B), (H) shall be waived to the extent necessary to suspend the prohibition of family members from providing care to allow an individual who is a member of the participant's family, who does not reside in the same household, to provide care, if no other caregiver is available; and reference checks.

(8) 19 CSR 15-7.021(19)(A)2., (B)4., (C)2.A.-C., and (D)4. shall be waived to the extent necessary to temporarily waive the experience requirements.

(9) 19 CSR 15-7.021(21)(C) shall be waived to the extent necessary to suspend on site evaluations.

(10) 19 CSR 15-7.021(22) shall be waived to the extent necessary to waive orientation and in-service hours.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 30, 2020 until May 15, 2020.

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

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 15-7.021 In-Home Service Standards

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 15-7.021

19 CSR 15-7.021(16)(B) and (D) shall be waived to the extent necessary to temporarily allow vendors to provide notice to DHSS by telephone or in writing.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 30, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 15—Division of Senior and Disability Services
Chapter 8—Consumer-Directed Services

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 15-8.400 Vendors

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 15-8.400

19 CSR 15-8.400 and Section 208.918, RSMo, shall be waived in the following manner:

(1) 19 CSR 15-8.400(4)(A)1., (7)(B) shall be waived to the extent necessary to suspend requirements for background screening and Good Cause Waiver to be returned prior to aides providing care.

(2) 19 CSR 15-8.400(4)(B); §208.918.1(2) shall be waived to the extent necessary to allow training to be in a limited format in order to bring on new staff quickly.

(3) 19 CSR 15-8.400(6)(B) shall be waived to the extent necessary to allow vendors to provide notice to DHSS by telephone, if needed, in lieu of writing.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 30, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 15—Division of Senior and Disability Services
Chapter 9—Electronic Visit Verification

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 15-9.200 Electronic Visit Verification

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 15-9.200

19 CSR 15-9.200 shall be waived to the extent necessary to temporarily suspend the requirement for providers to maintain documentation of client's exception to the use of EVV.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 30, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 26—Home Health Agencies

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-26.010 Home Health Licensure Rule

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-26.010(1)(B)

19 CSR 30-26.010(1)(B) shall be waived to the extent that the provisions require licensed home health agencies to provide dementia-specific training about Alzheimer's disease and related dementias to their employees and those persons working as independent contractors who provide direct care to or may have daily contact with residents, patients, clients, or consumers with Alzheimer's disease or related dementias. This waiver allows the required dementia-specific training about Alzheimer's disease and related dementias to be suspended until the conclusion of the state of emergency.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 22, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 35—Hospices

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-35.010 Hospice Program Operations

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-35.010(2)(M)1.B. (XIII)

19 CSR 30-35.010(2)(M)1.B. (XIII) shall be waived to the extent the provisions require licensed hospice agencies to provide dementia-specific training about Alzheimer's disease and related dementias to their employees and those persons working as independent contractors who provide direct care to or may have daily contact with resident's patients, clients, or consumers with Alzheimer's disease or related dementias. This waiver allows the required dementia-specific training about Alzheimer's disease and related dementias to be suspended until the conclusion of the state of emergency.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions cited in this notice are suspended effective April 22, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services Systems Regulations

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-40.308 Application and Licensure Requirements Standards for the Licensure and Relicensure of Air Ambulance Services

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 19 CSR 30-40.308

19 CSR 30-40.308 is waived in the following manner:

(1) 19 CSR 30-40.308(1)(A) shall be waived to the extent necessary to allow ground ambulance services, air ambulance services, emergency medical response agencies, emergency medical service training entities and stretcher van services an additional (90) days after the state of emergency has concluded to submit their applications to renew their licenses.

(2) 19 CSR 30-40.308(1)(C) shall be waived to the extent the provisions require air ambulance services to be inspected after an initial or relicensure application is received by the Department in order for the Department to verify the air ambulance service meets statutory and regulatory requirements. The Department shall temporarily suspend all air ambulance service licensure inspections. Those licensed air ambulance services expiring during the state of emergency, which have applied to the Department to have their air ambulance service licenses renewed or have indicated that they will be applying to have their air ambulance service licenses renewed, will continue to stay licensed as an air ambulance service until an inspection can be conducted by the Department after the state of emergency has concluded. Those air ambulance services applying with the Department for an initial air ambulance service license will receive an inspection after the state of emergency has concluded.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 29, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services Systems Regulations

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-40.309 Application and Licensure Requirements Standards for the Licensure and Relicensure of Ground Ambulance Services

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 19 CSR 30-40.309

19 CSR 30-40.309 is waived in the following manner:

(1) 19 CSR 30-40.309(1)(A) shall be waived to the extent necessary to allow ground ambulance services, air ambulance services, emergency medical response agencies, emergency medical service training entities and stretcher van services an additional (90) days after the state

of emergency has concluded to submit their applications to renew their licenses.

(2) 19 CSR 30-40.309(1)(C) and (D) shall be waived to the extent the provisions require ground ambulance services to be inspected after an initial or relicensure application is received by the Department in order for the Department to verify the ground ambulance service meets statutory and regulatory requirements. The Department shall temporarily suspend all ground ambulance service licensure inspections. Those licensed ground ambulance services expiring during the state of emergency, which have applied to the Department to have their ground ambulance service license renewed or have indicated that they will be applying to have their ground ambulance service licenses renewed, will continue to stay designated as a ground ambulance service until an inspection can be conducted by the Department after the state of emergency has concluded. Those ground ambulance services applying with the Department for an initial ground ambulance service license will receive an inspection after the state of emergency has concluded.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 29, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

**Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services
Systems Regulations**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-40.331 Application and Accreditation or Certification Requirements for Training Entities that Conduct Training for First Responders, Emergency Medical Dispatchers, Emergency Medical Technicians-Basic, Emergency Medical Technicians-Intermediate, and Emergency Medical Technicians-Paramedic

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 19 CSR 30-40.331

19 CSR 30-40.331 is waived in the following manner:

(1) 19 CSR 30-40.331(1)(A) & (B) shall be waived to the extent necessary to allow ground ambulance services, air ambulance services, emergency medical response agencies, emergency medical service training entities and stretcher van services an additional (90) days after the state of emergency has concluded to submit their applications to renew their licenses.

(2) 19 CSR 30-40.331(1)(B) shall be waived to the extent the provisions require training entities to be inspected after an initial or relicensure application is received by the Department in order for the Department to verify the training entity meets regulatory requirements. The Department shall temporarily suspend all training entity inspections. Those training entities expiring during the state of emergency, which have applied to the Department to have their training entity certification renewed or have indicated that they will be applying to have their training entity certification renewed, will continue to stay certified as a training entity until an inspection can be conducted by the Department after the state of emergency has concluded. Those training entities applying with the Department for an initial training entity certification will receive an inspection after the state of emergency has concluded.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-

04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 29, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

**Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical
Services Systems Regulations**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-40.333 Application and Licensure Requirements for the Licensure and Relicensure of Emergency Medical Response Agencies That Provide Advanced Life Support

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 19 CSR 30-40.333

19 CSR 30-40.333 is waived in the following manner:

(1) 19 CSR 30-40.333(1)(A) shall be waived to the extent necessary to allow ground ambulance services, air ambulance services, emergency medical response agencies, emergency medical service training entities and stretcher van services an additional (90) days after the state of emergency has concluded to submit their applications to renew their licenses.

(2) 19 CSR 30-40.333(1)(C) shall be waived to the extent the provisions require emergency medical response agencies to be inspected after an initial or relicensure application is received by the Department in order for the Department to verify the emergency medical response agency meets statutory and regulatory requirements. The Department shall temporarily suspend all emergency medical response agency licensure inspections. Those licensed emergency medical response agencies expiring during the state of emergency, which have applied to the Department to have their emergency medical response agency licenses renewed or have indicated that they will be applying to have their emergency medical response agency licenses renewed, will continue to stay designated as an emergency medical response agency until an inspection can be conducted by the Department after the state of emergency has concluded. Those emergency medical response agencies applying with the Department for an initial emergency medical response agency license will receive an inspection after the state of emergency has concluded.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 29, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

**Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services
Systems Regulations**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-40.528 Application and Licensure Requirements; Standards for the Licensure and Relicensure of Stretcher Van Services

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 19 CSR 30-40.528

19 CSR 30-40.528 is waived in the following manner:

(1) 19 CSR 30-40.528(1)(A) shall be waived to the extent necessary to allow ground ambulance services, air ambulance services, emergency medical response agencies, emergency medical service training entities and stretcher van services an additional (90) days after the state of emergency has concluded to submit their applications to renew their licenses.

(2) 19 CSR 30-40.528(1)(C) shall be waived to the extent the provisions require stretcher van services to be inspected after an initial or relicensure application is received by the Department in order for the Department to verify the stretcher van service meets statutory and regulatory requirements. The Department shall temporarily suspend all stretcher van licensure inspections. Those licensed stretcher van services expiring during the state of emergency, which have applied to the Department to have their stretcher van service licenses renewed or have indicated that they will be applying to have their stretcher van service license renewed, will continue to stay designated as a stretcher van service until an inspection can be conducted by the Department after the state of emergency has concluded. Those stretcher van services applying with the Department for an initial stretcher van service license will receive an inspection after the state of emergency has concluded.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 29, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 82—General Licensure Requirements

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-82.010 General Licensure Requirements

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-82.010

19 CSR 30-82.010(4)(A)1.-3. and (4)(B) shall be waived to the extent the regulation requires the owner or operator of a long-term care (LTC) facility to submit a written request to the department for an exception to licensure requirements and the exception, if approved, is only in effect for the time specified in the approval notice, unless the owner or operator requests for a renewal of the exception. This waiver shall allow existing exceptions to continue beyond the time specified in the approval notice. Facilities shall have until two (2) months after the state emergency has ended to submit renewal requests to the department.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 22, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 85—Intermediate Care and Skilled Nursing Facility

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-85.032 Physical Plant Requirements for New and Existing Intermediate Care and Skilled Nursing Facilities

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-85.032(31)(B)

19 CSR 30-85.032(31)(B) shall be waived to the extent that the provisions require new and existing intermediate care and skilled nursing facilities to have a qualified electrician certify in writing, every two (2) years, that the electrical system is being maintained to the appropriate standards. This waiver allows the required written certification by a qualified electrician to be delayed. Facilities have until two (2) months after the state of emergency has concluded to be current with the required maintenance of electrical systems.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 22, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 85—Intermediate Care and Skilled Nursing Facility

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-85.032 Physical Plant Requirements for New and Existing Intermediate Care and Skilled Nursing Facilities

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-85.032(48)(A)

19 CSR 30-85.032(48)(A) shall be waived to the extent the provisions require only activities necessary to the administration of the facility to be contained in any building used as a long-term care facility, except related activities (e.g., home health agencies, physician's office, pharmacy, ambulance service, child day care, food service, and outpatient therapy for the elderly or disabled in the community) may be conducted in buildings subject to prior written approval of these activities by the department and, if approved, remains in effect only for the time specified in the approval notice, unless the owner or operator requests for a renewal to continue to conduct the related activity. This waiver shall allow existing second business approvals to continue beyond the time specified in the approval notice. Facilities shall have until two (2) months after the state emergency has ended to submit renewal requests.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 22, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 85—Intermediate Care and Skilled Nursing Facility

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-85.042 Administration and Resident Care Requirements for New and Existing Intermediate Care and Skilled Nursing Facilities

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-85.042

19 CSR 30-85.042 shall be waived in the following manner:

(1) 19 CSR 30-85.042(7) shall be waived to the extent that the provisions require new and existing intermediate care and skilled nursing facilities to have to enter into written agreements when outside resources are used to provide services to the residents.

(2) 19 CSR 30-85.042(9) shall be waived to the extent that the provisions require new and existing intermediate care and skilled nursing facilities to only care for the number of residents for which the facilities are licensed.

(3) 19 CSR 30-85.042(11) shall be waived to the extent that the provisions require new and existing intermediate care and skilled nursing facilities to provide regular daily visiting hours and allow relatives or guardians and clergy the ability to see critically ill residents at any time, if requested.

(4) 19 CSR 30-85.042(21) shall be waived to the extent that the provisions require new and existing intermediate care and skilled nursing facilities to conduct a comprehensive orientation program within sixty (60) days of employment with nursing assistants who have not successfully completed the state-approved training program. This waiver allows new and existing intermediate care and skilled nursing facilities to conduct a comprehensive orientation program within ninety (90) days of employment with nursing assistants who have not successfully completed the state-approved training program.

(5) 19 CSR 30-85.042(35)(B) shall be waived to allow a registered nurse to be on duty eight consecutive hours each day rather than specifically on the day shift.

(6) 19 CSR 30-85.042(39) and section 198.082, RSMo, shall be waived to the extent that the provisions require nursing assistants employed by new and existing intermediate care and skilled nursing facilities to have successfully completed the nursing assistant training program approved by the Department within one (1) year for licensed-only facilities or within four (4) months of employment with a federally certified facility in order to remain employed in the facility as a nursing assistant.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 16, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 85—Intermediate Care and Skilled Nursing Facility

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-85.042 Administration and Resident Care Requirements for New and Existing Intermediate Care and Skilled Nursing Facilities

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-85.042(27)

19 CSR 30-85.042(27) shall be waived to the extent that the provisions require new and existing intermediate care and skilled nursing facilities to comply with the testing of residents and staff/employees

for tuberculosis as set forth in 19 CSR 20-20.010 through 19 CSR 20-20.100.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 23, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 86—Residential Care Facilities and Assisted Living Facilities

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-86.022 Fire Safety and Emergency Preparedness Standards for Residential Care Facilities and Assisted Living Facilities

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-86.022

19 CSR 30-86.022 shall be waived in the following manner:

(1) 19 CSR 30-86.022(3) shall be waived to the extent that the provisions require fire extinguishers to be maintained in assisted living facilities and residential care facilities. This waiver allows the required maintenance of fires extinguishers by an outside vendor to be delayed. Facilities have until two (2) months after the state of emergency has concluded to be current with the required maintenance of fire extinguishers.

(2) 19 CSR 30-86.022(4)(A) and (C) shall be waived to the extent that the provisions require the range hood extinguishing system to be tested and maintained and the range hood to be certified at least twice annually in assisted living facilities and residential care facilities. This waiver allows the required maintenance and certification by an outside vendor to be delayed. Facilities have until two (2) months after the state of emergency has concluded to be current with the required maintenance and certification of range hood extinguishing systems.

(3) 19 CSR 30-86.022(5)(D) shall be waived to the extent that the provisions require assisted living facilities and residential care facilities to conduct unannounced fire drills and a resident evacuation at least once a year. This waiver allows all fire drills during the state of emergency to be announced. This waiver allows facilities to delay the resident evacuation. Facilities have until two (2) months after the end of the state emergency too be current on the resident evacuation.

(4) 19 CSR 30-86.022(9)(C) and (D) shall be waived to the extent that the provisions require inspections and written certifications of the complete fire alarm system by an approved qualified service representative, at least annually in assisted living facilities and residential care facilities. This waiver allows the required inspections and certifications to be delayed. Facilities have until two (2) months after the end of the state of emergency to be current on the required inspections and written certifications for complete fire alarm systems.

(5) 19 CSR 30-86.022(11)(D), (E) and (F) and §198.074.2-4 RSMo, shall be waived to the extent that the provisions require inspections and written certifications of the sprinkler system by an approved qualified service representative, at least annually in assisted living facilities and residential care facilities. Facilities have until two (2) months after the end of the state of emergency to be current on the required inspections and certifications of the sprinkler system.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 23, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

**Division 30—Division of Regulation and Licensure
Chapter 86—Residential Care Facilities and Assisted Living Facilities**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-86.032 Physical Plant Requirements for Residential Care Facilities and Assisted Living Facilities

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-86.032(3)(A)

19 CSR 30-86.032(3)(A) shall be waived to the extent the provisions require only activities necessary to the administration of the facility to be contained in any building used as a long-term care facility except related activities (e.g., home health agencies, physician's office, pharmacy, ambulance service, child day care and food service for the elderly in the community) may be conducted in buildings subject to prior written approval of these activities by the department and if approved, remains in effect only for the time specified in the approval notice, unless the owner or operator requests for a renewal to continue to conduct the related activity. This waiver shall allow existing second business approvals to remain in effect beyond the time specified in the approval notice. Facilities have until two (2) months after the state of emergency has concluded to submit renewal requests.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 17, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

**Division 30—Division of Regulation and Licensure
Chapter 86—Residential Care Facilities and Assisted Living Facilities**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-86.032 Physical Plant Requirements for Residential Care Facilities and Assisted Living Facilities

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-86.032(13)

19 CSR 30-86.032(13) shall be waived to the extent that the provisions require assisted living facilities and residential care facilities to have a qualified electrician inspect the wiring in the facility every two (2) years. This waiver allows the required inspection by a qualified electrician to be delayed. Facilities have until two (2) months after the state of emergency has concluded to be current with the required inspection of wiring in the facility.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 22, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

**Division 30—Division of Regulation and Licensure
Chapter 86—Residential Care Facilities and Assisted Living Facilities**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-86.042 Administrative, Personnel and Resident Care Requirements for New and Existing Residential Care Facilities

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-86.042

19 CSR 30-86.042 shall be waived in the following manner:

(1) 19 CSR 30-86.042(7) shall be waived to the extent the provisions require residential care facilities to only care for the number of residents for which the facilities are licensed.

(2) 19 CSR 30-86.042(17) shall be waived to the extent the provisions require residential care facilities to comply with the testing of residents and staff/employees for tuberculosis as set forth in 19 CSR 20-20.010 through 19 CSR 20-20.100.

(3) 19 CSR 30-86.042(18) shall be waived to the extent that the provisions require residential care facilities to comply with the screening/testing of residents and staff/employees for tuberculosis as set forth in 19 CSR 20-20.100.

(4) 19 CSR 30-86.042(37) shall be waived to the extent the provisions require residential care facilities to have documentation of the resident's current medical status and any special orders or procedures which should be followed obtained prior to admission be in the resident's file not later than ten (10) days after admission. This waiver allows for residential care facilities to have documentation of the resident's current medical status and any special orders or procedures which should be followed obtained prior to admission be in the resident's file not later than thirty (30) days after admission.

(5) 19 CSR 30-86.042(58) shall be waived to the extent that the provisions require residential care facilities to have a pharmacist or registered nurse review the medication regimen of each resident at least every three (3) months in a residential care facility. This waiver allows the pharmacist or registered nurse the ability to review the medication regimen of each resident at least every three (3) months at a location outside of the residential care facility.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 17, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

**Division 30—Division of Regulation and Licensure
Chapter 86—Residential Care Facilities and Assisted Living Facilities**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-86.043 Administrative, Personnel, and Resident Care Requirements for Facilities Licensed as a Residential Care Facility II on August 27, 2006 that Will Comply with Residential Care Facility II Standards

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-86.043

19 CSR 30-86.043 shall be waived in the following manner:

(1) 19 CSR 30-86.043(8) shall be waived to the extent the provisions require a residential care facility II to only care for the number of residents for which the facility is licensed.

(2) 19 CSR 30-86.043(54) shall be waived to the extent that the provisions require a residential care facility II to have a pharmacist or registered nurse review the medication regimen of each resident at least every other month in a residential care facility II. This waiver allows the pharmacist or registered nurse the ability to review the medication regimen of each resident at least every other month at a location outside of the residential care facility II.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 17, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 86—Residential Care Facilities and Assisted Living Facilities

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-86.047 Administrative, Personnel, and Resident Care Requirements for Assisted Living Facilities

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-86.047

19 CSR 30-86.047 shall be waived in the following manner:

(1) 19 CSR 30-86.047(9) shall be waived to the extent that the provisions require assisted living facilities to only care for the number of residents for which the facilities are licensed.

(2) 19 CSR 30-86.047(18) shall be waived to the extent that the provisions require assisted living facilities to comply with the testing of residents and staff/employees for tuberculosis as set forth in 19 CSR 20-20.010 through 19 CSR 20-20.100.

(3) 19 CSR 30-86.047(19) shall be waived to the extent that the provisions require assisted living facilities to comply with the screening/testing of residents and staff/employees for tuberculosis as set forth in 19 CSR 20-20.100.

(4) 19 CSR 30-86.047(26) shall be waived to the extent that the provisions require assisted living facilities to ensure that any documentation of a physical examination prior to admission be in the resident's file not later than ten (10) days after admission. This waiver allows assisted living facilities to ensure that any documentation of a physical examination prior to admission be in the resident's file not later than thirty (30) days after admission.

(5) 19 CSR 30-86.047(45) shall be waived to the extent that the provisions require injections, other than insulin, to be administered only by a physician or licensed nurse in assisted living facilities. This waiver allows nursing students in those facilities designated as a clinical training site for registered nurses/licensed practical nurses and those individuals, who have completed a nurse education program but have not yet taken the nurse exam, the ability to administer injections, other than insulin. Any injections, other than insulin, administered by a nursing student shall be performed in the presence of and under the direct supervision of a licensed nurse.

(6) 19 CSR 30-86.047(54) shall be waived to the extent that the provisions require assisted living facilities to have a physician, pharmacist or registered nurse review the medication regimen of each resident at least every other month in an assisted living facility. This waiver allows the physician, pharmacist or registered nurse the ability to review the medication regimen of each resident at least every other month at a location outside of the assisted facility.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 17, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 90—Adult Day Care Program Licensure

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-90.040 Staffing Requirements

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-90.040

19 CSR 30-90.040 shall be waived in the following manner:

(1) 19 CSR 30-90.040(6) shall be waived to the extent the provisions require there to be at least two (2) direct care staff persons on duty at all times providing direct care to adult care participants when two (2) through sixteen (16) participants are present and one (1) additional direct care staff person to be present in adult day care centers when any portion of eight (8) additional participants are present. This waiver shall allow for one (1) direct care staff person to be on duty at all times providing direct care to up to eight (8) adult day care participants, as long as their care needs do not exceed the care that one person can provide, and one (1) additional direct care staff person shall be present when any portion of eight (8) additional participants are present in the adult day care center.

(2) 19 CSR 30-90.040(7) shall be waived to the extent the provisions require adult day care programs to comply with the screening/testing of staff/employees for tuberculosis as set forth in 19 CSR 20-20.010 through 19 CSR 20-20.100.

(3) 19 CSR 30-90.040(18) shall be waived to the extent that the provisions require adult day care programs to provide at least quarterly in-service training to staff. This waiver allows adult day care programs thirty (30) days after the conclusion of the state of emergency to conduct necessary in-services.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 22, 2020 until May 15, 2020.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 90—Adult Day Care Program Licensure

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-90.050 Program Policies and Participant Care Requirements and Rights

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-90.050

19 CSR 30-90.050 shall be waived in the following manner:

(1) 19 CSR 30-90.050(3) shall be waived to the extent the provisions require adult day care centers to have a medical assessment by an adult day care participant's physician or that physician's designated agent of the participant's medical condition prior to the first day of participation and signed by the physician or the physician's designated agent within five (5) working days of the first day of participation. This waiver shall allow adult day care centers to receive this medical assessment signed by the physician or the physician's designated agent within thirty (30) days of the first day of participation.

(2) 19 CSR 30-90.050(4) shall be waived to the extent the provisions require adult day care centers to develop a written individual plan of care for each adult day care participant within five (5) contact days following the entry of the participant into the adult day care program. This waiver shall allow adult day care centers to develop a written individual plan of care for each adult day care participant within thirty (30) contact days following the entry of the participant into the adult day care program.

(3) 19 CSR 30-90.050(8)(D)3.C. shall be waived to the extent the provisions require orders concerning treatments and medications to be in effect for a specified number of days as indicated by the physician, which may not exceed sixty (60) days at adult day care centers. This waiver shall allow orders concerning treatments and medications which come due during the state of emergency, to be in effect for an additional thirty (30) days after the conclusion of the state of emergency, if authorized by the physician.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 22, 2020 until May 15, 2020.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 90—Adult Day Care Program Licensure**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

19 CSR 30-90.070 Fire Safety and Facility Physical Requirements

ACTION TAKEN: NOTICE OF SUSPENSION OF 19 CSR 30-90.070

19 CSR 30-90.070 shall be waived in the following manner:

(1) 19 CSR 30-90.070(2)(A) shall be waived to the extent the provisions require adult day care centers to obtain annual written approval from the appropriate local fire safety officials, certifying that the facility complies with local fire codes. This waiver shall allow adult day care centers up to two (2) months after the state of emergency has concluded to obtain the annual written approval from the appropriate local fire safety officials.

(2) 19 CSR 30-90.070(2)(E) shall be waived to the extent the provisions require adult day care centers to conduct fire drills coordinated with local fire safety authorities at least one (1) time per month and with sufficient frequency to familiarize staff and participants with the proper evacuation procedures. Any fire drills coordinated with local fire safety authorities may be delayed under this waiver and shall resume after the state of emergency has concluded.

(3) 19 CSR 30-90.070(2)(C) shall be waived to the extent that the provisions require fire extinguishers to be maintained in adult day care centers. This waiver allows the required maintenance of fire extinguishers by an outside vendor to be delayed. Adult day care centers have until two (2) months after the state of emergency has concluded to be current with the required maintenance of fire extinguishers.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the provisions referenced in this notice are suspended effective April 22, 2020 until May 15, 2020.

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

**NOTIFICATION OF REVIEW:
APPLICATION REVIEW SCHEDULE**

The Missouri Health Facilities Review Committee has initiated review of the CON applications listed below. A decision is tentatively scheduled for June 22, 2020. These applications are available for public inspection at the address shown below.

Date Filed

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

5/11/2020

#5793 HT: CoxHealth
Springfield (Greene County)
\$1,933,410, Replace MRI unit

#5787 HT: Capital Region Medical Center
Jefferson City (Cole County)
\$1,700,475, Replace MRI unit

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by June 11, 2020. All written requests and comments should be sent to—

Chairman

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

For additional information contact Alison Dorge at alison.dorge@health.mo.gov.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2220—State Board of Pharmacy
Chapter 3—Negative Generic Drug Formulary**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2220-3.011 Generic Drug Substitution

ACTION TAKEN: This NOTICE OF SUSPENSION OF 20 CSR 2220-3.011(3).

Section (3) has been waived to allow pharmacists to substitute albuterol inhalers (albuterol sulfate aerosol, metered) with other albuterol inhalers listed in the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) with a different equivalency evaluation code during the State of Emergency if the prescribed albuterol inhaler is not available due to a shortage. This waiver applies only to "albuterol sulfate aerosol, metered" products listed in the Orange book.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 16, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2231—Division of Professional Registration
Chapter 2—Designation of License Renewal Dates and Related Renewal Information**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2231-2.010 Designation of License Renewal Dates and Related Renewal Information

ACTION TAKEN: This NOTICE OF SUSPENSION OF 20 CSR 2231-2.010(2)(BB)5.

Paragraph (2)(BB)5. has been waived to extend the Missouri pharmacy technician registration renewal deadline to July 31, 2020.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, and EO 20-09 dated April 24, 2020, the rule is suspended effective April 24, 2020 until June 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2245—Real Estate Appraisers
Chapter 4—Certificates and Licenses**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2245-4.020 Expiration and Renewal

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2245-4.020.

Real estate appraiser licenses expire on June 30 of even numbered years. Due to the COVID-19 pandemic, education providers were canceling classes and in response the Appraisal Subcommittee issued a memo dated March 31, 2020 indicating that Appraiser Qualifications Board criteria provides for a ninety (90) day deferment for meeting all continuing education requirements for individuals impacted by a federally declared disaster.

Based on this information, the commission, extended the license expiration date and due date of all continuing education to September 28, 2020.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 22, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2245—Real Estate Appraisers
Chapter 8—Continuing Education**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2245-8.010 Requirements

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2245-8.010.

Real estate appraiser licenses expire on June 30 of even numbered years. Due to the COVID-19 pandemic, education providers were canceling classes and in response the Appraisal Subcommittee issued a memo dated March 31, 2020 indicating that Appraiser Qualifications Board criteria provides for a ninety (90) day deferment for meeting all continuing education requirements for individuals impacted by a federally declared disaster.

Based on this information, the commission, extended the license expiration date and due date of all continuing education to September 28, 2020.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 22, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2250—Missouri Real Estate Commission
Chapter 3—Applications for License; License Examinations**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2250-3.010 Applications for License

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2250-3.010

Paragraph (4)(A)1. requires proof of successful completion of the forty-eight- (48-) hour Salesperson Pre-Examination Course prior to the date of the real estate examination and no more than six (6)-months prior to the receipt of the application in the Missouri Real Estate Commission office.

Paragraph (4)(A)2. requires proof of satisfactory completion of both the national and state portions of the required real estate salesperson examination after completion of the forty-eight- (48-) hour Salesperson Pre-Examination Course.

Paragraph (4)(A)3. requires proof of successful completion of the twenty-four- (24-) hour Missouri Real Estate Practice Course for Salesperson applicants after completion of the forty-eight- (48-) hour Salesperson Pre-Examination Course.

Subsection (6)(A)2. requires proof of successful completion of the forty-eight- (48-) hour Broker Pre-Examination Course prior to the date of the real estate examination and no more than six- (6-) months prior to the receipt of the application in the Missouri Real Estate Commission office.

Paragraph (6)(A)3. requires proof of satisfactory completion of both the national and state portions of the required real estate Broker

examination after completion of the 48-hour Broker Pre-Examination Course.

Section (8) stipulates that real estate applicants have six- (6-) months after the required course(s) to pass the required examination and apply for licensure. After the six- (6-) month deadline expires, courses and examinations must be repeated before applying for a real estate license.

Many of the accredited real estate schools canceled in-class courses during March and April, the real estate testing services vendor ceased administering written tests from March 20 until April 21, 2020, and many of the fingerprint vendor sites ceased operations. These measures occurred as a method of eliminating the need for licensee applicants to gather in large crowds or have person-to-person contact (violating the social distance standard) during the State of Emergency related to the novel coronavirus (COVID-19) pandemic. This waiver allows Salesperson and Broker applicants, whose application deadline was March 1, 2020 through April 30, 2020, until June 30, 2020 to complete the application requirements and submit the required application documents to the MREC office.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 17, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2250—Missouri Real Estate Commission
Chapter 3—Applications for License; License Examinations**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2250-3.020 License Examinations

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2250-3.020

Section (1) requires the commission to announce “the date and place of examinations” as far in advance as is practicable.

The commission will allow the testing service to schedule tests with little advance notice to catch up on the backlog that has resulted because of closing for about three (3) weeks due to the COVID-19 epidemic.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 17, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2250—Missouri Real Estate Commission
Chapter 4—Licenses**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2250-4.020 Expiration and Renewal; Name and Address Changes

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2250-4.020

Subsection (1)(A) establishes an expiration date of June 30, of even numbered years, for broker and brokerage real estate licenses and requires these licenses must be renewed before the licenses expire.

Subsection (1)(B) establishes an expiration date of September 30, of even numbered years, for salesperson real estate licenses and requires these licenses must be renewed before the licenses expire.

Subsection (1)(C) permits the commission to mail renewal notices thirty (30) days prior to the license expiration date listed in subsections (1)(A) and (1)(B) above.

Subsection (1)(D) permits the commission to issue a license for each renewal period with a properly completed renewal application, including proof of continuing education, and proper biennial fee as long as the renewal application is received (or postmarked) prior to the expiration date.

Subsection (1)(E) requires the commission to collect a delinquent fee of fifty dollars (\$50) per month (or partial month) that has elapsed since the license expiration date. The delinquency fee shall not exceed two hundred dollars (\$200).

Subsection (1)(F) requires applicants who have not completed the continuing education requirements before the license expiration date must take the twenty-four- (24-) hour Missouri Real Estate Practice Course within six- (6-) months of prior to the renewal is received by the commission.

Section (2) states that until a new license is procured, the holder of an expired license shall not perform any act for which a license is required.

Section (4) states within ten (10) days following a change in name or home address, each licensee shall notify the commission in writing.

The commission will extend the salesperson renewal expiration date by one-month because of the COVID-19 pandemic which caused most of the in-seat continuing education courses to cancel from March 16 through April and the real estate testing company closing all Missouri testing sites until at least April 29, 2020.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 17, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2250—Missouri Real Estate Commission
Chapter 4—Licenses**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2250-4.050 Broker-Salesperson and Salesperson Licenses; Transfers; Inactive Salespersons

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2250-4.050

Section (3) requires a real estate broker to notify the commission within seventy-two (72) hours of a termination of an affiliation of a broker-salesperson or salesperson and return that person’s license to the commission.

Section (4) prohibits the new real estate license applicant and the renewal licensee from engaging in any real estate activity until the license has been received by the broker. Additionally, when a licensee files an application to transfer a real estate license from one brokerage to another brokerage, the transfer is not effective until the

new license is received by the broker.

Section (6) requires an inactive salesperson license be renewed biennially on or before September 30 of each renewal year. An inactive salesperson license cannot be re-activated until the licensee presents a certificate of completion of the twenty-four- (24-) hour Missouri Real Estate Practice Course that was completed within the prior six (6) months.

Broker and brokerage licenses expire June 30, 2020 and salesperson licenses expire September 30, 2020. Inactive licensee wanting to reactivate their licenses are required to complete the 24-hour course before reactivating their licenses. Many of the accredited schools have ceased in-seat courses, which is the majority of real estate courses presented. The commission will extend the six (6-) month deadline within which the course must be completed as well as extend the renewal deadline by up to sixty days.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 17, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND
INSURANCE
Division 2250—Missouri Real Estate Commission
Chapter 4—Licenses**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2250-4.070 Partnership, Association, or Corporation License

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2250-4.070

Section (8) requires that when a broker-partner, broker-association, or broker-officer license is returned to the commission, the licensee has six (6) months in which to change status or reinstate the license. After the six- (6-) month period, the licensee must take the twenty-four- (24-) hour Missouri Real Estate Practice Course and show proof it was satisfactorily completed within six (6) months prior to reinstatement of the license.

Broker type licenses and brokerage licenses expire June 30, 2020. Inactive licensee wanting to reactivate their licenses are required to complete the twenty-four- (24-) hour course before reactivating their licenses. Many of the accredited schools have ceased in-seat courses, which is the majority of real estate courses presented. The commission extending the six- (6-) month deadline within which the course must be completed by up to sixty days.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 17, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND
INSURANCE
Division 2250—Missouri Real Estate Commission
Chapter 7—Schools**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2250-7.020 Application for Accreditation

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2250-7.020(2)(B).

Subsection (2)(B) requires any applicant for real estate school accreditation acknowledge that the school has the means to reasonably capture the average time each student took to complete each distance delivery course.

Under this current regulation, courses are approved as in-seat courses (in-class person to person instruction), on-line courses (distance delivery), or correspondence study courses. Distance delivery (on-line) courses are required to capture the average time it takes students to complete the on-line course. Courses taught as classroom delivery courses (in-seat) are not required to administer tests, nor keep track of test times if one is administered. During the COVID-19 pandemic, the commission will temporarily allow accredited schools to move in-seat courses to on-line (distance delivery) courses and permit WebEx and Zoom type courses via a webinar style platform. As such, the commission will temporarily waive the necessity to capture the average time it takes students to complete the course.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 17, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND
INSURANCE
Division 2250—Missouri Real Estate Commission
Chapter 7—Schools**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2250-7.080 Additional Requirements for Approved Schools Offering Distance Delivered Courses

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2250-7.080(1).

Section (1) requires schools providing distance delivery (on-line) courses submit certain documentations to the commission, such as copies of entire course as offered to students, multiple choice test question items, learning objectives, examinations and key, statement of how examinations are going to be maintained secure, and a statement attesting that the school will provide within ten (10) days certificates of course completion to student who pass with a seventy-five percent (75%) or more.

During the COVID-19 pandemic, the commission temporarily approves in-class courses to be transformed to on-line courses. The commission does not want accredited schools to spend unnecessary time adhering to on-line standards when the course materials have already been submitted and met the in-class required standards.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 17, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND
INSURANCE
Division 2250—Missouri Real Estate Commission
Chapter 8—Business Conduct and Practice**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2250-8.010 Place of Business

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2250-8.010(1).

Section (1) requires Missouri resident brokers to maintain a regularly established place of business and open to the public during usual business hours or at regularly stated intervals.

During the COVID-19 period, the commission will permit real estate companies to modify their "open door" business by considering the waiver of this rule.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 17, 2020 until May 15, 2020.

**Title 20—DEPARTMENT OF COMMERCE AND
INSURANCE
Division 2250—Missouri Real Estate Commission
Chapter 10—Continuing Education**

IN ADDITION

NOTICE OF SUSPENSION OF RULE

20 CSR 2250-10.100 Continuing Education Requirements for Licensees

ACTION TAKEN: This NOTICE OF SUSPENSION OF RULE 20 CSR 2250-10.100

Section (1) requires all licensees who hold an active license to complete at least twelve (12) hours of approved continuing education credit during the two (2) year license period prior to renewal. The regulation prohibits licensees from renewing their licenses without the required twelve (12) continuing education credits.

Most of the in-seat continuing education courses are being canceled from March 16 through mid-April (and maybe beyond), the real estate testing company has closed all Missouri testing sites until at least April 21, and many accredited real estate schools have canceled or postponed in-class courses until further notice. The commission will waive portions of the above requirements in order to extend the renewal period and permit accredited schools to use alternative methods to instruct real estate licensees; thereby, protecting the school staff and real estate licensees to possible COVID-19.

EMERGENCY STATEMENT: Pursuant to Executive Order (EO) 20-04 dated March 18, 2020, the rule is suspended effective April 17, 2020 until May 15, 2020.

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

NOTICE OF DISSOLUTION AND WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS AND CLAIMANTS AGAINST MNA HOLDINGS, LLC

On April 20, 2020, MNA Holdings, LLC, a Missouri limited liability company (the "Company"), filed a Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. The dissolution was effective on that date.

You are hereby notified that if you believe you have a claim against the Company, you must submit a written summary of your claim to the Company in care of Stephanie Chrisman, 1213 East Briggs Drive, PO Box 67, Macon, MO 63552. The summary of your claim must include the following information:

1. The Name, address, and telephone number of the claimant;
2. The amount of the claim;
3. The date on which the claim is based occurred; and
4. A brief description of the nature of the debt or the basis for the claim.

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

NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST VANAB CORP.

Vanab Corp., a Missouri corporation, filed its Articles of Dissolution by Voluntary Action with the Missouri Secretary of State on March 9, 2020. The dissolution was effective on that date.

Any and all claims against Vanab Corp. may be sent to J. Brian Hill, Esq., 2900 Brooktree Lane, Suite 100, Gladstone, Missouri 64119. Each claim should include the following information: the name, address and telephone number of the claimant; the amount of the claim; the basis for the claim; documentation supporting the claim; and the date(s) on which the event(s) on which the claim is based occurred.

Any and all claims against Vanab Corp. will be barred unless a proceeding to enforce such claim is commenced within two (2) years after the date this notice is published.

**NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS
AND CLAIMANTS AGAINST AJT, LLC**

On March 5, 2020, AJT, LLC filed its notice of winding up with Missouri Secretary of State.

Claims against the corporation must be submitted to Marsha Pamperin, 441 Tracker Road, Nixa, Mo 65714. Claims must contain: 1) Claimant name, address, and telephone number; 2) the amount claimed; 3) the date on which the claim arose; & 4) a brief description of the basis of the claim, including supporting documentation.

All claims against AJT, LLC will be barred unless a proceeding to enforce the claim is commenced within three (3) years of the date this notice was published.

**NOTICE OF DISSOLUTION AND WINDING UP
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
TCHFH INVESTMENT FUND, LLC**

On April 27, 2020, TCHFH Investment Fund, LLC (the "Company"), a Missouri limited liability company, filed its Notice of Winding Up with the Missouri Secretary of State.

You are hereby notified that if you believe you have a claim against the Company, you must submit a summary in writing of the circumstances surrounding your claim to Tauseef Khawaja, 1954 University Avenue W., Saint Paul, Minnesota 55104. The summary must include the following information: (1) the name, address, and telephone number of the claimant; (2) amount of claim; (3) basis of the claim; (4) the date on which the claim arose; and (5) documentation supporting the claim.

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

NOTICE OF DISSOLUTION

Metro Lofts, LLC ("Company") was dissolved on March 12, 2020. Company requests that claims against Company be presented by letter to: Dan Manning, Doster Ullom & Boyle, LLC, 16150 Main Circle Drive, Chesterfield, Missouri 63017. Claims against Company must include the following: name, address and telephone number of claimant; amount of claim; a description of the basis and nature of claim; and documentation supporting claim. Claims against Company will be barred unless a proceeding to enforce the claim is commenced within three years after this publication.