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SALUS POPULI SUPREMA LEX ESTO

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

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

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

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

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

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

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

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

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

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

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

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the executive director hereby terminates an emergency amendment effective March 7, 2011, as follows:

22 CSR 10-2.010 Definitions **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on February 1, 2011 (36 MoReg 349–356).

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

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is deleting sections (3), (19), (26), (33), (37), (44), (48), (51), (55), (56), (63), (70), (72), (79), (93)–(95), (97), (100), (115), (125), and (129); amending sections (5), (9), (12), (17), (21), (25), (30), (34), (35), (37), (38), (42), (45), (47)–(49), (51), (52), (55), (69), (76)–(78), (80), (83), (87), (89)–(93), (95), (96), (98), (100), (102), (104), (105), (106), (109), (111), (113)–(115), (118), (120), (124), (125), (129), and (132); adding sections (2), (7), (8), (14), (15), (29), (31), (33), (40), (41), (44), (53), (56), (67), (69), (70), (73), (96), (125), (130), (132)–(134); and renumbering as necessary.

PURPOSE: This amendment changes policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to state members.

EMERGENCY STATEMENT: This emergency amendment is being filed to remove previously promulgated changes to section (49) and must become effective as soon as possible. This emergency amendment is in response to concerns raised and comments received. This emergency amendment is necessary to protect Missouri Consolidated Health Care Plan (MCHCP) members, physicians of MCHCP members, and pharmacists filling prescriptions for MCHCP members from confusion and unintended consequences of any uncertainty regarding the meaning of generic drugs covered by the plan. For example, this emergency amendment will avoid the possibility that a pharmacist might interpret this definition as allowing substitution of a therapeutically, rather than chemically, equivalent generic drug in place of a physician prescribed brand medication without the prescriber's instruction. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan.

The other provisions of this emergency amendment were put in place by the original emergency amendment that became effective January 1, 2011. Those changes must be kept in place in accordance with the new plan year effective January 1, 2011. Those provisions are necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, they clarify member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. They may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that those provisions are not disrupted and remain in place in this emergency amendment in order to maintain the integrity of the current health care plan.

*This emergency amendment must become effective as soon as possible, in order that an immediate danger is not imposed on the public welfare. A proposed amendment regarding this rule was previously filed and published in the February 1, 2011, issue of the **Missouri Register**. The changes made to section (49) by this emergency amendment will be reflected in the final order of rulemaking relating to this rule. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed February 25, 2011, becomes effective March 7, 2011, and expires on June 29, 2011.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be

made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(2) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

*[(2)]***(3)** Administrative appeal. A written request submitted by or on behalf of a member involving Missouri Consolidated Health Care Plan (MCHCP) administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

[(3) Administrative guidelines. Instructive interpretation of the plan document developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.]

(5) Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible*[,]* **and** coinsurance*[, or table of allowance included in the program]* **amounts**.

(7) Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

(8) Assignment. When a doctor agrees to accept Medicare's fee as full payment.

*[(7)]***(9)** Benefit period. The three hundred sixty-five (365) days immediately *[following the first date of like services]* **after the first date of services to treat a given condition**.

*[(8)]***(10)** Benefits. Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

*[(9)]***(11)** Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

*[(10)]***(12)** Board. The board of trustees of the Missouri Consolidated Health Care Plan **(MCHCP)**.

*[(11)]***(13)** Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

(14) Cancellation of Coverage. The voluntary cancellation of medical, dental, or vision coverage per a subscriber's request.

(15) Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

*[(12)]***(16)** Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

*[(13)]***(17)** Claims administrator. An organization or group responsible for the processing of claims and associated services for *[the plan's self-insured benefit programs, including but not limited to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans]* **a health plan**.

*[(14)]***(18)** Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

*[(15)]***(19)** Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses**,** such as deductible or coinsurance.

*[(16)]***(20)** Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

*[(17)]***(21)** Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." *[CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.]*

*[(18)]***(22)** Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

[(19) Copay plan. A set of benefits similar to a health maintenance organization option.]

*[(20)]***(23)** Copayment. A set dollar amount that the covered individual must pay for specific services.

*[(21)]***(24)** Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or functions of the body which are lost or impaired due to illness or injury.

*[(22)]***(25)** Covered benefits and charges. *[A schedule of covered services and charges payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.]* **Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.**

*[(23)]***(26)** Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living*[. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services]* that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.

*[(24)]***(27)** Date of service. Date medical services are received or performed.

*[(25)]***(28)** Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

[(26) Dependent-only participation. Participation of certain survivors of subscribers. Dependent participation may be further defined to include the deceased subscriber's:
(A) Spouse only;
(B) Child(ren) only; or
(C) Spouse and child(ren).]

(29) Dependent child. Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:
(A) Stepchild;
(B) Foster child for whom the employee is responsible for health care;
(C) Grandchild for whom the employee has legal guardianship or legal custody and is responsible for providing health care; and
(D) Other child for whom the employee is the court-ordered legal guardian responsible for providing health care.
1. Except for a disabled child as described in 22 CSR 10-2.010(90), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six (26)).

*[(27)]***(30)** Dependents. The lawful spouse of the employee, the employee's *[unemancipated]* child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom *[application]* **enrollment** has been made and has been accepted for participation in the plan.

(31) Diagnostic. Describes a procedure to determine whether a person has a particular illness.

*[(28)]***(32)** Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

(33) Disease management. A program offered to non-Medicare members to help manage certain chronic diseases.

*[(29)]***(34)** Disposable supplies. *[Medical s]***S**upplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

*[(30)]***(35)** Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:
(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychiatrist;
*[(F)]***(G)** Psychologist;
*[(G)]***(H)** Doctor of **dental medicine, including** dental surgery; *[or]*
(I) Doctor of dentistry; or
*[(H)]***(J)** Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

*[(31)]***(36)** Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

*[(32)]***(37)** Eligibility date. *[Refer to]* **As described in** 22 CSR 10-2.020**.** *[for effective date provisions.*
(A) Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.
(B) Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan and their eligible dependents who were covered by the other medical care plan are eligible for participation immediately.
(C) Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.
(D) Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation or at the employee's choice, on the first day of the month following the employee's date of rehire.]

[(33) Emancipated child(ren). A child(ren) who is:
(A) Employed on a full-time basis;
(B) Eligible for group health benefits in his/her own behalf;
(C) Maintaining a residence separate from his/her parents or guardian, except for full-time students in an accredited school or institution of higher learning; or
(D) Married.]

*[(34)]***(38)** Emergency **medical condition**. *[Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:]* **A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—**
(A) Conditions placing a person's health in significant jeopardy;
(B) Serious impairment to a bodily function;
(C) Serious dysfunction of any bodily organ or part;
(D) Inadequately controlled pain; or
(E) Situations when the health of a pregnant woman or her unborn child are threatened.

*[(35)]***(39)** Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

(40) Emergency Services. With respect to an emergency medical condition—
(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and
(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient.

The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

(41) Employee. A person employed by the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by law.

*[(36)]***(42)** Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is *[not]* eligible as a dependent **up to the age of twenty-six (26)**, except as noted in 22 CSR 10-2.020(1)(A)3. *[Dependent participation may be further defined to include the participating employee's:*

(A) Spouse only;

(B) Child(ren) only; or

(C) Spouse and child(ren).]

[(37) Employees. Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law.]

*[(38)]***(43)** Employer. The state department or agency that employs the eligible employee as defined above.

(44) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care/palliative services;

(H) Laboratory services—lab and x-ray;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.

*[(39)]***(45)** Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board **of trustees**.

*[(40)]***(46)** Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below is considered experimental/investigational/unproven and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion*[:]*—

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

*[(41)]***(47)** First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first *[eligible]* **eligibility** period is the first thirty-one (31) days from the date *[the dependent meets the eligibility requirements for coverage under the plan]* **of the life event**.

*[(42)]***(48)** Formulary. A list of drugs covered by the pharmacy *[program claims administrator]* **benefit manager** and as allowed by the plan administrator.

*[(43)]***(49)** Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

[(44) Grievance. A written complaint submitted by or on behalf of a member regarding either:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling, or reimbursement for health care services.]

*[(45)]***(50)** Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

*[(46)]***(51)** Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference *[will be made]* **is** available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, *[2010]* **2011** State Member Handbook (*[January 1, 2010]* **January 10, 2011**) **or online at www.mchcp.org**. It does not include any later amendments or additions.

*[(47)]***(52)** Health assessment **(HA)**. A questionnaire about a member's health and lifestyle habits *[which qualifies the member]* **required** for participation in the *[Lifestyle Ladder program to earn the incentive premium]* **wellness program**.

(53) Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.

[(48) Health maintenance organization (HMO). A plan that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment.]

*[(49)]***(54)** Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

*[(50)]***(55)** High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

[(51) Home health agency. An agency certified by Medicare and the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.]

(56) Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.

*[(52)]***(57)** Hospice. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.

*[(53)]***(58)** Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

*[(54)]***(59)** Hospital.

(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

(B) An institution not meeting all the requirements of *[(54)(A)]* **subsection (59)(A)** above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

(E) A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.

[(55) Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.]

[(56) Hospital room charges. The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of room available or if a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.]

*[(57)]***(60)** Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

*[(58)]***(61)** Incident. A definite and separate occurrence of a condition.

*[(59)]***(62)** Infertility. Any medical condition causing the inability or diminished ability to reproduce.

*[(60)]***(63)** Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

*[(61)]***(64)** Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

*[(62)]***(65)** Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.

[(63) Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.]

*[(64)]***(66)** Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

(67) Lifestyle Ladder. MCHCP's wellness program.

*[(65)]***(68)** Lifetime. The period of time a member or the member's eligible dependents participate in the plan.

*[(66)]***(69)** Lifetime maximum. The *[maximum]* amount payable by a medical plan during a covered member's life **for specific nonessential benefits**.

(70) MCHCPid. An individual MCHCP member identifier used for member verification and validation.

(71) myMCHCP. A secure MCHCP member website that includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites.

*[(67)]***(72)** Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.

*[(68)]***(73)** Medically necessary. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion*[:]***—**

(A) Are expected to be of clear clinical benefit to the patient; and

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

(74) Medicare approved amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or provider.

*[(69)]***(75)** Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

[(70) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.]

*[(71)]***(76)** Network provider. A physician, hospital, pharmacy, *[etc.,]* **or other health provider** that is contracted with the plan **or its designee**.

[(72) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.]

*[(73)]***(77)** Non-formulary. A drug not contained on the pharmacy *[program's formulary]* **benefit manager's** list *[but may be covered under the terms and conditions of the plan]* **of covered drugs**.

*[(74)]***(78)** Non-network provider or non-participating provider. A*[ny]* physician, hospital, pharmacy, *[etc.,]* **or other health provider** that does not have a contract with the plan **or its designee**.

*[(75)]***(79)** Nurse. A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

*[(76)]***(80)** Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients *[convalescing]* **recovering** from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations *[which]* **that** are recognized under Medicare.

*[(77)]***(81)** Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

*[(78)]***(82)** Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

[(79) Out-of-network. Providers that do not participate in the member's health or pharmacy plan.]

*[(80)]***(83)** Out-of-pocket maximum. *[The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.]* **The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.**

*[(81)]***(84)** Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

*[(82)]***(85)** Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

*[(83)]***(86)** Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and *[impeccable]* assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

*[(84)]***(87)** Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; *[psychiatric]* nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions *[for therapeutic purposes]*.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

*[(85)]***(88)** Participant. Any employee or dependent accepted for membership in the plan.

*[(86)]***(89)** Pharmacy benefit manager (PBM). *[Acts as a link between the parties involved in the delivery of prescription drugs to health plan members.]* The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.

*[(87)]***(90)** Physically or mentally disabled. *[The inability of a person]* **A person's inability** to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.

*[(88)]***(91)** Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice**,** as licensed under section 334.021, RSMo.

*[(89)]***(92)** Plan. The program of health care benefits established by the **board of** trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(90)]***(93)** Plan administrator. The **board of** trustees of the Missouri Consolidated Health Care Plan*[. As such, the board]***, which** is the sole fiduciary of the plan*[,]***. The board** has all discretionary authority to interpret its provisions and to control the operation and administration of the plan*[,]* and whose decisions are final and binding on all parties.

*[(91)]***(94)** Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

*[(92)]***(95)** Plan year. *[Same as]* **The** calendar year **beginning January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year**.

[(93) Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.]

[(94) Pre-certification. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).]

[(95) Pre-existing condition. A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.]

(96) Preferred provider organization (PPO). An arrangement with providers where**by** discounted rates are given to **plan** members *[of the plan who, in turn, are offered a financial incentive to use these providers]*. **Benefits are paid at a higher level when network providers are used.**

[(97) Prevailing fee. The fee charged by the majority of dentists.]

(97) Preventive service. A procedure intended for avoidance or early detection of an illness.

(98) Primary care physician (PCP). A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with *[and been approved by]* a medical plan.

(99) Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.

[(100) Prior plan. The terms and conditions of a plan in effect for the period preceding coverage in the plan.]

*[(101)]***(100)** Private duty nursing. *[Private duty nursing services, n]*Nursing care on a full-time basis in the member's home*[,]* or home health aides.

*[(102)]***(101)** Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

*[(103)]***(102)** Proof of **prior group** insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

*[(104)]***(103)** Proof of prior group coverage. If a member or his/her dependents enroll in the plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

(A) Date coverage was or will be terminated;

(B) Reason for coverage termination; and

(C) List of dependents covered.

*[(105)]***(104)** Prostheses. An artificial extension that replaces a missing part of the body*[. Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital)]* or *[to]* supplement**s** defective parts.

*[(106)]***(105)** Protected health information **(PHI)**. Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

*[(107)]***(106)** Provider. *[Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.]* **A physician, hospital, medical agency, specialist, or other duly-licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(35). Other providers include but are not limited to:**

(A) Audiologist (AUD or PhD);

(B) Certified Addiction Counselor for Substance Abuse (CAC);

(C) Certified Nurse Midwife (CNM)—when acting within the scope of their license in the state in which they practice and performing a service which would be payable under this plan when performed by a physician;

(D) Certified Social Worker or Masters in Social Work (MSW);

(E) Licensed Clinical Social Worker;

(F) Licensed Professional Counselor (LPC);

(G) Licensed Psychologist (LP);

(H) Nurse Practitioner (NP);

(I) Physicians Assistant (PA);

(J) Qualified Occupational Therapist;

(K) Qualified Physical Therapist;

(L) Qualified Speech Therapist;

(M) Registered Nurse Anesthetist (CRNA);

(N) Registered Nurse Practitioner (ARNP); or

(O) Therapist with a PhD or Master's Degree in Psychiatry or related field.

*[(108)]***(107)** Provider directory. A listing of network providers within a health plan.

*[(109)]***(108)** Prudent layperson. An individual possessing an average knowledge of health and medicine.

*[(110)]***(109)** Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or *[an enrollee]* **member** if the plan normally provides coverage for dependent children.

*[(111)]***(110)** Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

*[(112)]***(111)** Refractions. A record of the patient's preference for the focusing of the eyes that *[can]* **may** then be used to purchase eyeglasses **or contact lenses**. It is the *[portion of the eye]* **part of the** exam that determines what prescription lens *[provides]* **gives** the patient *[with]* the best possible vision.

*[(113)]***(112)** Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed,

certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

*[(114)]***(113)** Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020*[(5)(B)]***(7)(B)** and is currently receiving a monthly retirement benefit from *[one (1) of the]* **a** retirement system*[s]* listed in such rule.

[(115) Second opinion program. A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.]

*[(116)]***(114)** Skilled nursing care. *[Care which]* **Services that** must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

*[(117)]***(115)** Skilled nursing facility (SNF). *[An institution which meets fully each of the following requirements:*

(A) It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board, and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

(B) It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).] **A public or private facility licensed and operated according to the law that provides—**

(A) Permanent and full-time facilities for ten (10) or more resident patients;

(B) A registered nurse or physician on full-time duty in charge of patient care;

(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;

(D) A daily medical record for each patient;

(E) Transfer arrangements with a hospital; and

(F) A utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.

*[(118)]***(116)** Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

*[(119)]***(117)** Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(120)]***(118)** Specialty medications. High cost drugs that are primarily self-injectible**;** *[but]* sometimes oral medications.

*[(121)]***(119)** State. Missouri.

*[(122)]***(120)** Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before *[stepping up to]* **using** more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

*[(123)]***(121)** Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the participant and recover the money directly from the other insurer.

*[(124)]***(122)** Subscriber. The employee or member who elects coverage under the plan.

[(125) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.]

*[(126)]***(123)** Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

*[(127)]***(124)** Surgery center (ambulatory). A hospital**-**based, **hospital-**sponsored, or independently-owned facility that performs surgery.

*[(128)]***(125)** Survivor. A member who meets the requirements of subsection 22 CSR 10-2.020*[(5)(A)]***(7)(A)**.

(126) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[(129) Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

(A) Stepchild(ren);

(B) Foster child(ren) for whom the employee is responsible for health care;

(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; and

(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

1. Except for a disabled child(ren) as described in section (87) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

(E) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan.]

*[(130)]***(127)** Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries

too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

*[(131)]***(128)** Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(132)]***(129)** Usual, Customary, and Reasonable charge.

(A) Usual. The fee a *[physician]* **provider** most frequently charges the majority of his/her patients for the same or similar services.

(B) Customary. The range of fees charged in a geographic area by *[physicians]* **providers** of comparable skills and qualifications for the same performance of similar service.

(C) Reasonable. The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the *[doctors]* **providers** for ninety percent (90%) of the procedures reported.

*[(133)]***(130)** Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

(131) Vendor. The current applicable third-party administrator of MCHCP benefits.

*[(134)]***(132)** Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020*[(5)(B)]***(7)(B)**.

(133) Wellness participation year. Year in which members may participate in the wellness program per plan year: October 1–September 25.

(134) Wellness program. A voluntary program focusing on awareness, health education, and behavior change.

(135) Wellness premium. The monthly medical premium applied to members who successfully complete all requirements of the Lifestyle Ladder program.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated March 7, 2011. Emergency amendment filed Feb. 25, 2011, effective March 7, 2011, expires June 29, 2011.*

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

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the executive director hereby terminates an emergency amendment effective March 7, 2011, as follows:

22 CSR 10-3.010 Definitions **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on February 1, 2011 (36 MoReg 400–408).

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

EMERGENCY AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is deleting sections (3), (19), (26), (33), (37), (44), (49), (53), (54), (61), (68), (70), (77), (91)–(93), (95), (98), (114), (124), and (128); amending sections (5), (7), (10), (13), (17), (22)–(24), (27), (29), (30), (32), (34), (36), (39), (41)–(43), (46), (52), (64), (69), (71), (72), (74), (78), (81), (82), (84), (85)–(88), (90), (94), (96), (99), (101), (103)–(105), (109), (111), (113), (115), (116), (121), (126), and (131); adding new sections (2), (7), (8), (14), (15), (29), (31), (33), (40), (41), (44), (52), (55), (68), (69), (72), (95), (125), and (130); and renumbering as necessary.

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.

EMERGENCY STATEMENT: This emergency amendment is being filed to remove previously promulgated changes to section (49) and must become effective as soon as possible. This emergency amendment is in response to concerns raised and comments received. This emergency amendment is necessary to protect Missouri Consolidated Health Care Plan (MCHCP) members, physicians of MCHCP members, and pharmacists filling prescriptions for MCHCP members from confusion and unintended consequences of any uncertainty regarding the meaning of generic drugs covered by the plan. For example, this emergency amendment will avoid the possibility that a pharmacist might interpret this definition as allowing substitution of a therapeutically, rather than chemically, equivalent generic drug in place of a physician prescribed brand medication without the prescriber's instruction. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan.

The other provisions of this emergency amendment were put in place by the original emergency amendment that became effective January 1, 2011. Those changes must be kept in place in accordance with the new plan year effective January 1, 2011. Those provisions are necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, they clarify member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. They may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that those provisions are not disrupted and remain in place in this emergency amendment in order to maintain the integrity of the current health care plan.

This emergency amendment must become effective as soon as possible, in order that an immediate danger is not imposed on the public welfare. A proposed amendment regarding this rule was previously filed and published in the February 1, 2011 issue of the ***Missouri Register****. The changes made to section (49) by this emergency amendment will be reflected in the final order of rulemaking relating to this*

*rule. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed February 25, 2011, becomes effective March 7, 2011, and expires on June 29, 2011.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(2) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

*[(2)]***(3)** Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

[(3) Administrative guidelines. Instructive interpretation of the plan document developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.]

(5) Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible*[,]* **and** coinsurance*[, or table of allowance included in the program]* **amounts**.

(7) Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

(8) Assignment. When a doctor agrees to accept Medicare's fee as full payment.

*[(7)]***(9)** Benefit period. The three hundred sixty-five (365) days immediately *[following the first date of like services]* **after the first date of the services to treat a given condition**.

*[(8)]***(10)** Benefits. Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

*[(9)]***(11)** Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

*[(10)]***(12)** Board. The board of trustees of the Missouri Consolidated Health Care Plan **(MCHCP)**.

*[(11)]***(13)** Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

(14) Cancellation of coverage. The voluntary cancellation of medical, dental, or vision coverage per a subscriber's request.

(15) Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

*[(12)]***(16)** Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

*[(13)]***(17)** Claims administrator. An organization or group responsible for the processing of claims and associated services for *[the plan's self-insured benefit programs, including but not limited to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans]* **a health plan**.

*[(14)]***(18)** Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

*[(15)]***(19)** Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses**,** such as deductible or coinsurance.

*[(16)]***(20)** Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

*[(17)]***(21)** Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." *[CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.]*

*[(18)]***(22)** Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

[(19) Copay plan. A set of benefits similar to a health maintenance organization option.]

*[(20)]***(23)** Copayment. A set dollar amount that the covered individual must pay for specific services.

*[(21)]***(24)** Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury.

*[(22)]***(25)** Covered benefits and charges. *[A schedule of covered services and charges payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.]* **Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.**

*[(23)]***(26)** Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living*[. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services]* that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.

*[(24)]***(27)** Date of service. Date medical services are received *[or performed]*.

*[(25)]***(28)** Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

[(26) Dependent-only participation. Participation of certain survivors of subscribers. Dependent participation may be further defined to include the deceased subscriber's:
(A) Spouse only;
(B) Child(ren) only; or
(C) Spouse and child(ren).]

(29) Dependent child. Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:
(A) Stepchild;
(B) Foster child for whom the employee is responsible for health care;
(C) Grandchild for whom the employee has legal guardianship or legal custody and is responsible for providing health care; and
(D) Other child for whom the employee is court-ordered legal guardian responsible for providing health care.
1. Except for a disabled child as described in 22 CSR 10-2.010(88), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six (26)).

*[(27)]***(30)** Dependents. The lawful spouse of the employee, the employee's *[unemancipated]* child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom *[application]* **enrollment** has been made and has been accepted for participation in the plan.

(31) Diagnostic. Describes a procedure to determine whether a person has a particular illness.

*[(28)]***(32)** Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

(33) Disease management. A program offered to non-Medicare members to help manage certain chronic diseases.

*[(29)]***(34)** Disposable supplies. *[Medical s]***S**upplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

*[(30)]***(35)** Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:
(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychiatrist;
*[(F)]***(G)** Psychologist;
*[(G)]***(H)** Doctor of **dental medicine, including** dental surgery; *[or]*
(I) Doctor of dentistry; or
*[(H)]***(J)** Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

*[(31)]***(36)** Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

*[(32)]***(37)** Eligibility date. *[Refer to]* **As described in** 22 CSR 10-3.020**.** *[for effective date provisions. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of eligibility as determined by the employer.]*

[(33) Emancipated child(ren). A child(ren) who is—
(A) Employed on a full-time basis;
(B) Eligible for group health benefits in his/her own behalf;
(C) Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; or
(D) Married.]

*[(34)]***(38)** Emergency **medical condition**. *[Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:]* **A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—**
(A) Conditions placing a person's health in significant jeopardy;
(B) Serious impairment to a bodily function;
(C) Serious dysfunction of any bodily organ or part;
(D) Inadequately controlled pain; or
(E) Situations when the health of a pregnant woman or her unborn child are threatened.

*[(35)]***(39)** Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

(40) Emergency Services. With respect to an emergency medical condition—
(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and
(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

(41) Employee. A person employed by a participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity.

*[(36)]***(42)** Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is *[not]* eligible as a dependent **up to the age of twenty-six (26)**, except as noted in 22 CSR 10-3.030(1)(A)7. *[Dependent participation may be further defined to include the participating employee's:*

(A) Spouse only;

(B) Child(ren) only; or

(C) Spouse and child(ren).]

[(37) Employees. Employees of the participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity.]

*[(38)]***(43)** Employer. The public entity that employs the eligible employee as defined above.

(44) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care/palliative services;

(H) Laboratory services—lab and x-ray;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.

*[(39)]***(45)** Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board **of trustees**.

*[(40)]***(46)** Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below is considered experimental/investigational/unproven and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion*[:]***—**

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

*[(41)]***(47)** First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first *[eligible]* **eligibility** period is the first thirty-one (31) days from the date *[the dependent meets the eligibility requirements for coverage under the plan]* **of the life event**.

*[(42)]***(48)** Formulary. A list of drugs covered by the pharmacy *[program claims administrator]* **benefit manager** and as allowed by the plan administrator.

*[(43)]***(49)** Generic drug. A chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

[(44) Grievance. A written complaint submitted by or on behalf of a member regarding either:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling, or reimbursement for health care services.]

*[(45)]***(50)** Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

*[(46)]***(51)** Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference *[will be made]* **is** available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, *[2010]* **2011** State Member Handbook (*[January 1, 2010]* **January 10, 2011**) **or online at www.mchcp.org**. It does not include any later amendments or additions.

(52) Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.

*[(47)]***(53)** Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

*[(48)]***(54)** High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

[(49) Home health agency. An agency certified by Medicare and the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.]

(55) Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.

*[(50)]***(56)** Hospice. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.

*[(51)]***(57)** Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility, or part thereof, which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

*[(52)]***(58)** Hospital.

(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

(B) An institution not meeting all the requirements of *[(52)(A)]* **subsection (58)(A)** above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

(E) A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution, or part thereof, which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.

[(53) Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.]

[(54) Hospital room charges. The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of room available or if a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.]

*[(55)]***(59)** Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

*[(56)]***(60)** Incident. A definite and separate occurrence of a condition.

*[(57)]***(61)** Infertility. Any medical condition causing the inability or diminished ability to reproduce.

*[(58)]***(62)** Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

*[(59)]***(63)** Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

*[(60)]***(64)** Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.

[(61) Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.]

*[(62)]***(65)** Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

*[(63)]***(66)** Lifetime. The period of time a member or the member's eligible dependents participate in the plan.

*[(64)]***(67)** Lifetime maximum. The *[maximum]* amount payable by a medical plan during a covered member's life **for specific nonessential benefits**.

(68) MCHCPid. An individual MCHCP member identifier used for member verification and validation.

(69) myMCHCP. A secure MCHCP member website that includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites.

*[(65)]***(70)** Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.

*[(66)]***(71)** Medically necessary. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion*[:]***—**

(A) Are expected to be of clear clinical benefit to the patient;

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

(72) Medicare allowed amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or provider.

*[(67)]***(73)** Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

[(68) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five

(35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.]

*[(69)]***(74)** Network provider. A physician, hospital, pharmacy, *[etc.,]* **or other health provider** that is contracted with the plan **or its designee**.

[(70) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.]

*[(71)]***(75)** Non-formulary. A drug not contained on the pharmacy *[program's formulary]* **benefit manager's** list *[but may be covered under the terms and conditions of the plan]* **of covered drugs**.

*[(72)]***(76)** Non-network provider or non-participating provider. Any physician, hospital, pharmacy, *[etc.,]* **or other health provider** that does not have a contract with the plan **or its designee**.

*[(73)]***(77)** Nurse. A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

*[(74)]***(78)** Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients *[convalescing]* **recovering** from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations *[which]* **that** are recognized under Medicare.

*[(75)]***(79)** Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

*[(76)]***(80)** Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

[(77) Out-of-network. Providers that do not participate in the member's health or pharmacy plan.]

*[(78)]***(81)** Out-of-pocket maximum. *[The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.]* **The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.**

*[(79)]***(82)** Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

*[(80)]***(83)** Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

*[(81)]***(84)** Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and *[impeccable]* assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

*[(82)]***(85)** Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; *[psychiatric]* nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions *[for therapeutic purposes]*.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

*[(83)]***(86)** Participant. Any employee or dependent accepted for membership in the plan.

*[(84)]***(87)** Pharmacy benefit manager (PBM). *[Acts as a link between the parties involved in the delivery of prescription drugs to health plan members.]* The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.

*[(85)]***(88)** Physically or mentally disabled. *[The inability of a person]* **A person's inability** to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.

*[(86)]***(89)** Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice**,** as licensed under section 334.021, RSMo.

*[(87)]***(90)** Plan. The program of health care benefits established by the **board of** trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(88)]***(91)** Plan administrator. The **board of** trustees of the Missouri Consolidated Health Care Plan*[. As such, the board]***, which** is the sole fiduciary of the plan*[,]***. The board** has all discretionary authority to interpret its provisions and to control the operation and administration of the plan*[,]* and whose decisions are final and binding on all parties.

*[(89)]***(92)** Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

*[(90)]***(93)** Plan year. *[Same as]* **The** calendar year **beginning January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year**.

[(91) Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.]

[(92) Pre-certification. Also known as pre-admission certification, pre-admission review, and pre-certification. The

process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).]

[(93) Pre-existing condition. A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.]

(94) Preferred provider organization (PPO). An arrangement with providers where**by** discounted rates are given to **plan** members**.** *[of the plan who, in turn, are offered a financial incentive to use these providers]* **Benefits are paid at a higher level when network providers are used**.

[(95) Prevailing fee. The fee charged by the majority of dentists.]

(95) Preventive service. A procedure intended for avoidance or early detection of an illness.

(96) Primary care physician (PCP). A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with *[and been approved by]* a medical plan.

(97) Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.

[(98) Prior plan. The terms and conditions of a plan in effect for the period preceding coverage in the plan.]

*[(99)]***(98)** Private duty nursing. *[Private duty nursing services, n]***N**ursing care on a full-time basis in the member's home*[,]* or home health aides.

*[(100)]***(99)** Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

*[(101)]***(100)** Proof of **prior group** insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

*[(102)]***(101)** Proof of prior coverage. If a member or his/her dependents enroll in an MCHCP plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

(A) Date coverage was or will be terminated;

(B) Reason for coverage termination; and

(C) List of dependents covered.

*[(103)]***(102)** Prostheses. An artificial extension that replaces a missing part of the body*[. Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital)]* or *[to]* supplement**s** defective parts.

*[(104)]***(103)** Protected health information **(PHI)**. Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

*[(105)]***(104)** Provider. *[Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.]* **A physician, hospital, medical agency, specialist, or other duly-licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010(35). Other providers include but are not limited to:**

(A) Audiologist (AUD or PhD);

(B) Certified Addiction Counselor for Substance Abuse (CAC);

(C) Certified Nurse Midwife (CNM)—when acting within the scope of their license in the state in which they practice and performing a service which would be payable under this plan when performed by a physician;

(D) Certified Social Worker or Masters in Social Work (MSW);

(E) Licensed Clinical Social Worker;

(F) Licensed Professional Counselor (LPC);

(G) Licensed Psychologist (LP);

(H) Nurse Practitioner (NP);

(I) Physicians Assistant (PA);

(J) Qualified Occupational Therapist;

(K) Qualified Physical Therapist;

(L) Qualified Speech Therapist;

(M) Registered Nurse Anesthetist (CRNA);

(N) Registered Nurse Practitioner (ARNP); or

(O) Therapist with a PhD or Master's Degree in Psychiatry or related field.

*[(106)]***(105)** Provider directory. A listing of network providers within a health plan.

*[(107)]***(106)** Prudent layperson. An individual possessing an average knowledge of health and medicine.

*[(108)]***(107)** Public entity. A state-sponsored institution of higher learning, political subdivision, or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board.

*[(109)]***(108)** Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or *[an enrollee]* **member** if the plan normally provides coverage for dependent children.

*[(110)]***(109)** Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

*[(111)]***(110)** Refractions. A record of the patient's preference for the focusing of the eyes that *[can]* **may** then be used to purchase eyeglasses **or contact lenses**. It is the *[portion of the eye]* **part of the** exam that determines what prescription lens *[provides]* **gives** the patient *[with]* the best possible vision.

*[(112)]***(111)** Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care, and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution

that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

*[(113)]***(112)** Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(6)(B) and is currently receiving a monthly retirement benefit from *[one (1) of the retirement systems listed in such rule]* **a public entity**.

[(114) Second opinion program. A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.]

*[(115)]***(113)** Skilled nursing care. *[Care which]* **Services that** must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

*[(116)]***(114)** Skilled nursing facility (SNF). *[An institution which meets fully each of the following requirements:*

(A) It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board, and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

(B) It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).] **A public or private facility licensed and operated according to the law that provides—**

(A) Permanent and full-time facilities for ten (10) or more resident patients;

(B) A registered nurse or physician on full-time duty in charge of patient care;

(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;

(D) A daily medical record for each patient;

(E) Transfer arrangements with a hospital; and

(F) A utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.

*[(117)]***(115)** Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

*[(118)]***(116)** Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(119)]***(117)** Specialty medications. High cost drugs that are primarily self-injectible but sometimes oral medications.

*[(120)]***(118)** State. Missouri.

*[(121)]***(119)** Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before *[stepping up to]* **using** more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

*[(122)]***(120)** Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the participant and recover the money directly from the other insurer.

*[(123)]***(121)** Subscriber. The employee or member who elects coverage under the plan.

[(124) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.]

*[(125)]***(122)** Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

*[(126)]***(123)** Surgery center (ambulatory). A hospital-based, **hospital-**sponsored, or independently-owned facility that performs surgery.

*[(127)]***(124)** Survivor. A member who meets the requirements of subsection 22 CSR 10-3.020(6)(A).

(125) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[(128) Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

(A) Stepchild(ren);

(B) Foster child(ren) for whom the employee is responsible for health care;

(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; and

(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

(E) Except for a disabled child(ren) as described in section (85) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see paragraph 22 CSR 10-3.020(4)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

(F) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan.]

*[(129)]***(126)** Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a

result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

*[(130)]***(127)** Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(131)]***(128)** Usual, Customary, and Reasonable *[C]***c**harge.

(A) Usual—The fee a *[physician]* **provider** most frequently charges the majority of his/her patients for the same or similar services.

(B) Customary—The range of fees charged in a geographic area by *[physicians]* **providers** of comparable skills and qualifications for the same performance of similar service.

(C) Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the *[doctors]* **providers** for ninety percent (90%) of the procedures reported.

*[(132)]***(129)** Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

(130) Vendor. The current applicable third-party administrator of MCHCP benefits.

*[(133)]***(131)** Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-3.020(6)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated March 7, 2011. Emergency amendment filed Feb. 25, 2011, effective March 7, 2011, expires June 29, 2011.*

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

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

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

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

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

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

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

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 5—Inspections

PROPOSED AMENDMENT

2 CSR 80-5.010 Inspection Fees. The board is amending the purpose and section (1).

PURPOSE: This amendment updates the fiscal year for the inspection fee.

PURPOSE: This rule complies with section 196.945, RSMo, to set inspection fees for Fiscal Year [1996] 2012 for milk produced on farms inspected by the State Milk Board and milk imported from points beyond the limits of routine inspection.

(1) The inspection fee for Fiscal Year *[2008]* **2012** (July 1, *[2007]* **2011**–June 30, *[2008]* **2012**) shall be four and a half cents (4.5¢) per hundred weight on milk produced on farms inspected by the State Milk Board or its contracted local authority and four cents (4¢) per hundred weight on milk imported from areas beyond the points of routine inspection.

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 12, 1977, effective Sept. 11, 1977. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Feb. 24, 2011.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Program

PROPOSED RULE

6 CSR 10-2.180 Minority and Underrepresented Environmental Literacy Program

PURPOSE: This rule sets forth the policies of the Coordinating Board for Higher Education regarding student eligibility and application procedures for student financial assistance under the Minority and Underrepresented Environmental Literacy Program.

(1) Definitions.

(A) Academic year shall be from July 1 of any year through June 30 of the following year.

(B) Advisory committee shall be the Minority Environmental Literacy Advisory Committee created under section 173.240, RSMo.

(C) Applicant means a student who has filed a complete and accurate application to receive a Minority and Underrepresented Environmental Literacy Program award as prescribed by the department and who qualifies to receive such award under section 173.240, RSMo.

(D) Approved institution means any institution located in the state of Missouri that meets the requirements set forth in section 173.1102(2) or (3), RSMo, that has been approved under 6 CSR 10-2.140.

(E) Award year shall be from July 1 of any year through June 30 of the following year, excluding summer terms.

(F) Completed secondary coursework or completion of secondary coursework shall be graduation from high school or the virtual public school established in section 161.670, RSMo, receipt of a general education development (GED) diploma, completion of a program of study through homeschooling, or any other program of academic instruction that satisfies the compulsory attendance requirement under section 167.031, RSMo.

(G) Consortium agreement means a written agreement between two (2) or more approved institutions that allows students to take courses at a school other than the home school and have those courses count toward the degree or certificate at the home school and that complies with United States Department of Education requirements

for federal student financial assistance.

(H) Department means the Department of Higher Education created by section 173.005, RSMo.

(I) Expenses mean any educational-related expenses including, but not limited to, tuition, fees, and room and board.

(J) Full-time student means a student who is enrolled in at least twelve (12) semester hours, eight (8) quarter hours, or the equivalent in another measurement system, but not less than the respective number sufficient to secure the certificate or degree toward which the student is working in no more than the number of semesters, or their equivalent, normally required by the institution for the program in which the student is enrolled. Provided, however, that an otherwise eligible student having a disability as defined by Title II of the Americans with Disabilities Act (42 U.S.C. 12101-12213) who, because of his or her disability, is unable to satisfy the statutory minimum requirements for full-time status under Title IV student aid programs shall be considered by the approved institution to be a full-time student and shall be considered to be making satisfactory academic progress, as defined in subsection (1)(P) of this rule, while carrying a minimum of six (6) credit hours or their equivalent at the approved institution.

(K) His, him, or he shall apply equally to the female as well as the male sex where applicable in this rule.

(L) Initial recipient means a student who qualifies under section 173.240, RSMo, has filed an accurate and complete application by the deadline established by the department for the Minority and Underrepresented Environmental Literacy Program, has been selected to receive an award by the advisory committee, and has not received a Minority and Underrepresented Environmental Literacy Program award in any prior academic year.

(M) Program shall mean the Minority and Underrepresented Environmental Literacy Program created under section 173.240, RSMo.

(N) Renewal recipient means a student who received a Minority and Underrepresented Environmental Literacy Program award in any prior academic year, who meets the requirements set forth in section 173.240, RSMo, and who has filed an accurate and complete application by the deadline established by the department for the Minority and Underrepresented Environmental Literacy Program, and has been selected to receive an award by the advisory committee.

(O) Residency, for the purpose of this rule, shall be determined by reference to the standards set forth in the determination of student residency rule, 6 CSR 10-3.010.

(P) Satisfactory academic progress shall be a cumulative grade point average (CGPA) of at least two and one-half (2.5) on a four-point (4.0) scale, or the equivalent on another scale, and, with the exception of grade point average, as otherwise determined by the approved institution's policies as applied to other students at the approved institution receiving assistance under Title IV financial aid programs included in the Higher Education Act of 1965. The calculation of CGPA shall be based on the approved institution's policies as applied to other students in similar circumstances.

(Q) Severely underrepresented minority ethnic group means African Americans, Hispanic or Latino Americans, Native Americans and Alaska Natives, and Native Hawaiians and Pacific Islanders as referenced in the 2011 publication of *Expanding Underrepresented Minority Participation: America's Science and Technology at the Crossroads* authored by the Committee on Underrepresented Groups and the Expansion of the Science and Engineering Workforce Pipeline; Committee on Science, Engineering, and Public Policy; Policy and Global Affairs; National Academy of Sciences, National Academy of Engineering, and Institute of Medicine.

(2) Responsibilities of Institutions of Postsecondary Education. Institutions participating in the program must meet the institutional responsibilities set forth in 6 CSR 10-2.140(5).

(3) Responsibilities of Advisory Committee. The advisory committee shall meet at least annually to select initial and renewal recipients.

(4) Basic Eligibility Policy. To qualify for a Minority and Underrepresented Environmental Literacy Program award, an initial or a renewal recipient, at the time of his application and throughout the period during which he receives the award, must meet the following requirements:

(A) Be a Missouri resident;

(B) Have completed secondary coursework;

(C) Have maintained a cumulative grade point average of at least three (3.0) on a four-point (4.0) scale in high school or, if currently enrolled in college, have maintained a cumulative grade point average of at least two and one-half (2.5) on a four point (4.0) scale; and

(D) Be enrolled full-time in one (1) of the areas of study indicated in subsection 6. of 173.240, RSMo.

(5) Application and Evaluation Policy.

(A) The department shall annually prescribe the time and method for filing applications for financial assistance under the Minority and Underrepresented Environmental Literacy Program. It shall make announcement of its action in these respects.

(B) Students shall apply annually for financial assistance under the Minority and Underrepresented Environmental Literacy Program by completing and submitting the application prescribed by the department by the deadline established by the department.

(C) The department will verify each student's application for a Minority and Underrepresented Environmental Literacy Program award meets the eligibility criteria established in this rule.

(D) The department will provide applications for all eligible students to the advisory committee for review and selection of recipients.

(6) Award Policy.

(A) Minority and Underrepresented Environmental Literacy Program awards shall be allotted and issued for one (1) award year, unless otherwise specified on the application.

(B) A renewal recipient may continue to receive an award under the Minority and Underrepresented Environmental Literacy Program so long as the applicant—

1. Maintains satisfactory academic progress;

2. Otherwise meets the criteria of the Minority and Underrepresented Environmental Literacy Program; and

3. Continues to be selected as a recipient by the advisory committee.

(C) The department shall establish the amount of the award annually and shall make announcement of its action in this respect.

(D) The department shall make awards in the rank order established by the advisory committee until all available funding has been expended to the nearest whole award amount for the timeframe specified on the application.

(E) Renewal students shall have priority when establishing the rank order for awards.

(F) After renewal students, initial students who are members of a severely underrepresented minority ethnic group shall receive priority over members of other minority ethnic groups or students who are otherwise underrepresented in environmental fields when establishing the rank order for awards.

(G) Students who remain unfunded after awards have been made may be considered for an award in accordance with their rank order if funding becomes available.

(H) A student who has been denied a Minority and Underrepresented Environmental Literacy Program award for lack of satisfactory academic progress may not receive another Minority and Underrepresented Environmental Literacy Program award until the enrollment period after the applicable standard has once again been met.

(I) Minority and Underrepresented Environmental Literacy Program awards will be made for use during the normal academic year, but no funds for Minority and Underrepresented Environmental Literacy Program awards will be granted for use for summer terms.

(J) No Minority and Underrepresented Environmental Literacy Program award will be made retroactive to a previous academic year. A Minority and Underrepresented Environmental Literacy Program award will be made retroactive to a previous semester only upon the sole discretion of the department.

(K) Minority and Underrepresented Environmental Literacy Program awards will be issued only after certification of full-time attendance of the student by the institution. For a student enrolled as part of a consortium agreement, the student must be considered to be enrolled full-time under the provisions of the consortium agreement to be certified.

(L) Only one-half (½) the annual Minority and Underrepresented Environmental Literacy Program award will be issued in a semester of that award year.

(M) The applicant's award will be sent to the approved institution to be delivered to the student's account. The institution shall retain the portion of the award that the student owes for expenses and promptly give the applicant any remaining funds.

(N) An applicant's failure to provide information requested by the department by the established deadlines may prevent the applicant from being considered for a Minority and Underrepresented Environmental Literacy Program award.

(O) The department has the discretion to withhold payments of any Minority and Underrepresented Environmental Literacy Program awards after initiating an inquiry into the eligibility or the continued eligibility of a student or into the approved status of an institution.

(P) A student may transfer the Minority and Underrepresented Environmental Literacy Program award from one approved public or private institution to another without losing eligibility for assistance. The student must notify the department of the transfer.

(7) Information Sharing Policy. All information on an individual's Minority and Underrepresented Environmental Literacy Program application will be shared with the financial aid office of the institution to which the individual has applied, or is attending, to permit verification of data submitted. Information may be shared with federal financial aid offices if necessary to verify data furnished by the state or federal governments as provided for in the Privacy Act of 1974, 5 U.S.C. sections 552, 552a.

AUTHORITY: section 173.240, RSMo Supp. 2010. Original rule filed Feb. 17, 2011.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Department of Higher Education, Financial Assistance, Outreach, and Proprietary School Certification, Kelli Reed, Student Assistance Associate, PO Box 1469, Jefferson City, MO 65102-1469. 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 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Program

PROPOSED RULE

6 CSR 10-2.190 A+ Scholarship Program

PURPOSE: This rule sets forth the policies of the Coordinating Board for Higher Education regarding institutional and student eligibility for student financial assistance under the A+ Scholarship program.

(1) Definitions.

(A) Academic year shall be twenty-four (24) semester or trimester credit hours, thirty-six (36) quarter credit hours, or nine hundred (900) clock hours, and at least thirty (30) weeks of instructional time for a credit hour program or at least twenty-six (26) weeks of instructional time for a clock hour program.

(B) A+ Scholarship shall mean the tuition reimbursement program set forth in subsections 7 through 9 of section 160.545, RSMo.

(C) A+ tuition reimbursement shall mean an amount of money paid by the state of Missouri to a qualified student under the A+ Scholarship for costs related to tuition, general fees, and up to fifty percent (50%) of book costs, subject to state appropriations, after federal sources of funding have been applied.

(D) Award year shall be from July 1 of any year through June 30 of the following year.

(E) CBHE shall mean the Coordinating Board for Higher Education created by section 173.005.2, RSMo.

(F) Department shall mean the Department of Higher Education created by section 173.005.1, RSMo.

(G) Federal sources of funding shall mean grant funds made available directly to students by the federal government and shall not include any funds that must be repaid or work-study funds.

(H) Full-time student shall mean a student who, regardless of the course delivery method, is enrolled in at least twelve (12) semester hours, eight (8) quarter hours, or the equivalent in another measurement system, but not less than the respective number sufficient to secure the certificate or degree toward which the student is working in no more than the number of semesters or their equivalent normally required by the institution for the program in which the student is enrolled. Provided, however, that an otherwise eligible student having a disability as defined by Title II of the Americans with Disabilities Act (42 U.S.C. 12101-12213) who, because of his or her disability, is unable to satisfy the statutory minimum requirements for full-time status under federal student financial aid programs included in Title IV of the Higher Education Act of 1965 shall be considered to be making satisfactory academic progress, as defined in subsection (1)(P) of this rule, while carrying a minimum of six (6) credit hours or their equivalent at the approved institution.

(I) Good-faith effort to secure all federal sources of funding that could be applied to tuition reimbursement shall mean, by the deadline established by the department, being eligible to complete and completing the federal need-based aid application form as prescribed by the United States Department of Education (USDE). For students whose parents refuse to provide financial information, the application form must, at a minimum, include the dependent student's financial information. For students attending institutions that do not participate in the federal Title IV student financial aid programs, completion of the predictor tool for federal Title IV student financial aid eligibility approved by the USDE is acceptable.

(J) His, him, or he shall apply equally to the female as well as the male sex where applicable in this rule.

(K) Initial recipient shall mean a student who qualifies under subsection 7 of section 160.545, RSMo, and this rule, and who has made a good faith effort to secure all federal sources of funding that could be applied to tuition reimbursement, and has not received A+ tuition reimbursement in any prior award year.

(L) Participating institution shall mean a Missouri public community college, a public vocational or technical school, or a two (2)-year private vocational or technical school meeting the requirements set forth in subsection 9 of section 160.545, RSMo, that has entered into a participation agreement for the A+ Scholarship program with the department.

(M) Partnership shall mean a written agreement between two (2)

or more institutions, at least one (1) of which must be an A+ participating institution, providing for the processing and delivery of A+ tuition reimbursement.

(N) Renewal recipient shall mean a student who received A+ tuition reimbursement in a prior award year, qualifies under subsection 7 of section 160.545, RSMo, and who has made a good faith effort to secure all federal sources of funding that could be applied to tuition reimbursement.

(O) Repeat coursework shall be any coursework for which the student has been assigned a grade under the institution's standard grading policy, excluding coursework for which the student was placed in an incomplete or withdrawn status, in a previous term.

(P) Satisfactory academic progress shall be a cumulative grade point average (CGPA) of at least two and one-half (2.5) on a four-point (4.0) scale, or the equivalent on another scale, and, with the exception of grade point average, as otherwise determined by the participating institution's policies as applied to other students at the participating institution receiving assistance under federal Title IV student financial aid programs. The calculation of CGPA shall be based on the participating institution's policies as applied to other students in similar circumstances.

(Q) Tuition and fees shall mean any charges to students classified as tuition and any institutional fees charged to all students, excluding program-specific fees.

(R) USDE shall mean the United States Department of Education.

(2) Responsibilities of Participating Institutions.

(A) Only institutions who have entered into a participation agreement with the department may receive reimbursement under the A+ Scholarship program.

(B) Participating institutions shall meet the following requirements:

1. Before requesting reimbursement for an initial recipient, verify the following:

A. The student has met the eligibility requirements listed in section (3) of this rule through collection of a high school transcript bearing the official A+ seal;

B. The eligible student is enrolled as a full-time student, except as provided in subsection (1)(H) of this rule; and

C. The student has made a good faith effort to secure all federal sources of funding that could be applied to tuition reimbursement, except as provided in subsection (1)(I) of this rule;

2. Before requesting reimbursement for a renewal recipient, verify the following:

A. The eligible student is enrolled as a full-time student, except as provided in subsection (1)(H) of this rule;

B. The student has made a good faith effort to secure all federal sources of funding that could be applied to tuition, except as provided in subsection (1)(I) of this rule; and

C. The student is maintaining satisfactory academic progress;

3. Comply with the institutional responsibilities required in 6 CSR 10-2.140(5), with the exception of 6 CSR 10-2.140(5)(A)5.; and

4. Verify federal sources of funding are applied correctly to tuition, general fees, and up to fifty percent (50%) of book costs as specified in subsection (4)(K) of this rule.

(C) Partnerships must comply with the following:

1. Reimbursement will only be made to A+ participating institutions;

2. Reimbursement will only be made for coursework actually delivered by a participating institution;

3. Reimbursement may be requested by only one (1) participating institution as specified in the agreement and must be at a tuition rate consistent with the rate charged to other students enrolled in the course;

4. When a partnership includes only one (1) A+ participating institution, the student must be considered to be enrolled full time at the participating institution;

5. When two (2) or more A+ participating institutions are involved in a partnership, students must be enrolled in sufficient hours at a combination of the participating institutions to be considered to be enrolled full time as defined in this rule; and

6. Institutions entering into partnerships must provide to the department any requested documentation pertaining to the processing and delivery of A+ tuition reimbursements.

(3) Eligibility Policy.

(A) To qualify for A+ tuition reimbursement, an initial recipient must meet the following criteria:

1. Meet the requirements set forth in subsection 7 of section 160.545, RSMo;

2. Be a U.S. citizen, permanent resident, or otherwise lawfully present in the United States, in accordance with section 208.009, RSMo;

3. Enter into a written agreement with the A+ designated high school prior to high school graduation;

4. Graduate from an A+ designated high school with an overall grade point average of at least two and one-half (2.5) on a four-point (4.0) scale, or the equivalent on another scale;

5. Have at least a ninety-five percent (95%) attendance record overall for grades nine through twelve (9-12);

6. Have performed fifty (50) hours of unpaid tutoring or mentoring, of which up to twenty-five percent (25%) may include job shadowing;

7. Beginning with the high school senior class of 2015, have achieved a score of proficient or advanced on the official Algebra I end-of-course exam or complete the first semester at a postsecondary institution with a minimum of twelve (12) hours or the equivalent and a two and one-half (2.5) grade point average prior to receiving A+ tuition reimbursement;

8. Have maintained a record of good citizenship and avoidance of the unlawful use of drugs and/or alcohol;

9. Be admitted as a regular student and enroll in and attend on a full-time basis a participating institution, except that students in the following circumstances may be enrolled less than full time:

A. The student is enrolled in all of the available hours applicable to his program of study in a given term;

B. The student is participating in a required internship; or

C. The student is enrolled in prerequisite courses that do not require full-time enrollment;

10. Not be enrolled or intend to use the award to enroll in a course of study leading to a degree in theology or divinity; and

11. Not have a criminal record preventing receipt of federal Title IV student financial aid.

(B) To qualify for tuition reimbursement under the A+ Scholarship program, a renewal recipient must meet the following criteria:

1. Be admitted as a regular student and enroll in and attend on a full-time basis a participating institution, except that students in the following circumstances may be enrolled less than full time:

A. The student is enrolled in all of the available hours applicable to his program of study in a given term;

B. The student is participating in a required internship; or

C. The student is enrolled in prerequisite courses that do not require full-time enrollment;

2. Maintain satisfactory academic progress; and

3. Make a good-faith effort to secure all federal sources of funding that could be applied to tuition before the award is disbursed but no later than the deadline established by the CBHE.

(C) The department will review written appeals of its eligibility policy in the following circumstances:

1. The student failed to make a good-faith effort to secure all federal sources of funding that could be applied to tuition; or

2. The student failed to meet the grade point average requirement as a result of a documented medical reason.

(4) Award Policy.

(A) A+ tuition reimbursement for institutions with credit-hour programs shall occur each semester within one (1) award year.

(B) A+ tuition reimbursement for institutions with clock-hour programs shall be made in installments determined by the department annually.

(C) Student eligibility for the A+ Scholarship expires at the earliest of the following, except a student who is eligible at the beginning of a term may receive A+ tuition reimbursement for the full term in which the expiration criterion is met:

1. Forty-eight (48) months after completion of high school coursework;

2. Completion of one hundred five percent (105%) of the hours required for the program in which the student is currently enrolled. In instances in which the student is enrolled in a related, higher level certificate, the hours required for both the original and the higher level certificate shall be combined when calculating the percentage. Calculation of the percentage shall include all known hours completed at any institution, regardless of whether those hours are accepted in transfer into the student's current program and whether the student received A+ reimbursement for those hours; or

3. Receipt of an associate's degree.

(D) If an initial recipient is unable to enroll or a renewal recipient ceases attendance for the purpose of providing service in any branch of the armed forces of the United States, the eligibility of the student will be extended for the period of the service as documented on the student's DD214 form and all remaining eligibility will be retained if the student returns to full-time status within twelve (12) months of the end of military service and provides verification to the department that the military service was satisfactorily completed.

(E) Reimbursement will be as specified for the following categories of coursework:

1. Completed coursework, including remedial coursework, for which a grade is assigned under the institution's standard grading policy and that is required by the institution for the completion of a certificate or degree will be reimbursed. The amount of reimbursement paid for coursework for which a standard grade was not assigned, including coursework for which the student was placed in an incomplete or withdrawn status, will be deducted from subsequent reimbursement requests for the student;

2. Repeat coursework will not be reimbursed; and

3. Coursework that is part of a higher level certificate or a degree that is taken after receipt of a certificate will be reimbursed provided that the certificate or degree is in a field related to the original certificate received.

(F) The amount of the A+ tuition reimbursement must be calculated based on the remaining costs of actual tuition and fees after any federal sources of funding have been applied and any deductions have been made for reimbursement of coursework for which a standard grade was not assigned, including coursework for which the student was placed in an incomplete or withdrawn status.

(G) The amount of the A+ tuition reimbursement is subject to legislative appropriation.

(H) If the appropriated funds exceed the amount necessary to fund tuition and fees, up to fifty percent (50%) of book costs may be reimbursed.

(I) If insufficient funds are available to pay all eligible students the full amount of tuition and fees calculated in subsection (4)(F) of this rule, the department may take any of the following measures to address the shortfall in order to ensure the A+ reimbursement does not exceed the appropriation:

1. Reduce the number of hours eligible for reimbursement; or

2. If projections indicate that the measure cited above is inadequate to address the funding shortfall, the department shall, as soon as may practicably be accomplished, make available for public comment a plan containing at least two (2) options to ensure that total A+ reimbursements do not exceed the appropriation. Such plan shall be distributed to all participating institutions and the department shall accept public comments on the plan for no less than thirty (30) days before publication in a CBHE board book. No plan for accommodating the additional shortfall shall be approved before it has been on the agenda of a regularly scheduled CBHE meeting and an opportunity for public comment at the CBHE meeting has been provided.

(J) The hourly tuition rate used to calculate the A+ tuition reimbursement shall not exceed the published standard per credit hour tuition rate charged by Linn State Technical College.

1. Institutions with high need programs that have tuition charges above this limit may apply to the department for a waiver of this requirement on a program-by-program basis.

2. The federal credit hour to clock hour conversion calculation will be applied to institutions with clock hour programs.

(K) Financial aid must be applied to tuition and general fees in the following order:

1. First, all available federal sources of funding; and

2. Second, A+ tuition reimbursement.

(L) Award amounts may be increased or decreased at the department's discretion based on availability of funds for distribution during the award year.

(M) A student who has been denied A+ tuition reimbursement for lack of satisfactory academic progress may not receive another A+ tuition reimbursement until the enrollment period after the applicable standard has once again been met.

(N) No A+ tuition reimbursement will be made retroactive to a previous award year. An A+ tuition reimbursement will be made retroactive to a previous semester or payment period only upon the sole discretion of the department.

(O) A+ tuition reimbursement will be made only after institutional certification of the student's eligibility and the amount of the A+ tuition reimbursement.

(P) An eligible student's failure to provide required information by the established deadlines may result in loss of the A+ Scholarship for the period covered by the deadline.

(Q) The CBHE has the discretion to withhold payments of any A+ tuition reimbursements after initiating an inquiry into the eligibility or continued eligibility of a student or into the participation status of an institution.

(R) An eligible student may transfer the A+ Scholarship from one (1) participating institution to another without losing eligibility for assistance, but the department shall make any necessary adjustments in the amount of the award.

(5) Information Sharing Policy. All information on an individual's A+ Scholarship application will be shared with the financial aid office of the institution to which the individual has applied, or is attending, to permit verification of data submitted. Information may be shared with federal financial aid offices if necessary to verify data furnished by state or federal governments as provided for in the Privacy Act of 1974, 5 U.S.C. sections 552, 552a.

AUTHORITY: sections 160.545, RSMo Supp. 2010 and Executive Order 10-16, dated January 29, 2010. Original rule filed Feb. 17, 2011.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Department of Higher Education, Financial Assistance, Outreach, and Proprietary School Certification, Kelli Reed, Student Assistance Associate, PO Box 1469, Jefferson City, MO 65102-1469. 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 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 2—Air Quality Standards and Air Pollution Control Rules Specific to the Kansas City Metropolitan Area

PROPOSED RESCISSION

10 CSR 10-2.040 Maximum Allowable Emission of Particulate Matter From Fuel Burning Equipment Used for Indirect Heating. This rule restricted the emission of particulate matter from fuel burning equipment used for indirect heating in the Kansas City metropolitan area. This rulemaking will remove a rule that is being replaced with a new statewide rule that restricts the emission of particulate matter from fuel burning equipment used for indirect heating. If the commission adopts this rule action, it will be the department's intention to submit this rule rescission to the U.S. Environmental Protection Agency for removal from the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Environmental Regulatory Agenda website, www.dnr.mo.gov/regs/index.html.

PURPOSE: This rule restricted the emission of particulate matter from fuel burning equipment used for indirect heating. This rulemaking will remove a rule that is being replaced with a new statewide rule that restricts the emission of particulate matter from fuel burning equipment used for indirect heating. The evidence supporting the need for this proposed rulemaking, per section 536.016, RSMo, is a necessity evidence memorandum dated March 5, 2008.

AUTHORITY: section 203.050, RSMo 1986. Original rule filed Dec. 26, 1968, effective Jan. 5, 1969. Amended: Filed March 2, 1972, effective March 12, 1972. Rescinded and readopted: Filed Aug. 11, 1978, effective Feb. 11, 1979. Amended: Filed March 14, 1984, effective Sept. 14, 1984. Rescinded: Filed Feb. 25, 2011.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed rescission will begin at 9:00 a.m., May 26, 2011. The public hearing will be held at the Elm Street Conference Center, 1730 East Elm Street, Lower Level, Bennett Springs Conference Room, Jefferson City, Missouri. Opportunity to be heard at the hearing shall be afforded any interested person. Interested persons, whether or not heard, may submit a written or email statement of their views until 5:00 p.m., June 2, 2011. Written comments shall be sent to Chief, Air Quality Planning Section, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176. Email comments shall be sent to apcprulespn@dnr.mo.gov.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 3—Air Pollution Control Rules Specific to the Outstate Missouri Area

PROPOSED RESCISSION

10 CSR 10-3.060 Maximum Allowable Emissions of Particulate Matter From Fuel Burning Equipment Used for Indirect Heating. This rule restricted the emission of particulate matter from fuel burning equipment used for indirect heating in the outstate Missouri area. This rulemaking will remove a rule that is being replaced with a new statewide rule that restricts the emission of particulate matter from fuel burning equipment used for indirect heating. If the commission adopts this rule action, it will be the department's intention to submit this rule rescission to the U.S. Environmental Protection Agency for removal from the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Environmental Regulatory Agenda website, www.dnr.mo.gov/regs/index.html.

PURPOSE: This rule restricted the emission of particulate matter from fuel burning equipment used for indirect heating. This rulemaking will remove a rule that is being replaced with a new statewide rule that restricts the emission of particulate matter from fuel burning equipment used for indirect heating. The evidence supporting the need for this proposed rulemaking, per section 536.016, RSMo, is a necessity evidence memorandum dated March 5, 2008.

*AUTHORITY: section 643.050, RSMo 1986. Original rule filed March 24, 1971, effective April 3, 1971. For intervening history, please consult the **Code of State Regulations**. Rescinded: Filed Feb. 25, 2011.*

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed rescission will begin at 9:00 a.m., May 26, 2011. The public hearing will be held at the Elm Street Conference Center, 1730 East Elm Street, Lower Level, Bennett Springs Conference Room, Jefferson City, Missouri. Opportunity to be heard at the hearing shall be afforded any interested person. Interested persons, whether or not heard, may submit a written or email statement of their views until 5:00 p.m., June 2, 2011. Written comments shall be sent to Chief, Air Quality Planning Section, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176. Email comments shall be sent to apcprulespn@dnr.mo.gov.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 4—Air Quality Standards and Air Pollution Control Regulations for the Springfield-Greene County Area

PROPOSED RESCISSION

10 CSR 10-4.040 Maximum Allowable Emission of Particulate Matter From Fuel Burning Equipment Used for Indirect Heating. This rule restricted the emission of particulate matter from fuel burning equipment used for indirect heating in the Springfield-Greene County area. This rulemaking will remove a rule that is being replaced with a new statewide rule that restricts the emission of particulate matter from fuel burning equipment used for indirect heating. If the commission adopts this rule action, it will be the department's intention to submit this rule rescission to the U.S.

Environmental Protection Agency for removal from the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Environmental Regulatory Agenda website, www.dnr.mo.gov/regs/index.html.

PURPOSE: This rule restricted the emission of particulate matter from fuel burning equipment used for indirect heating. This rulemaking will remove a rule that is being replaced with a new statewide rule that restricts the emission of particulate matter from fuel burning equipment used for indirect heating. The evidence supporting the need for this proposed rulemaking, per section 536.016, RSMo, is a necessity evidence memorandum dated March 5, 2008.

AUTHORITY: section 643.050, RSMo 2000. Original rule filed Dec. 5, 1969, effective Dec. 15, 1969. For intervening history, please consult the ***Code of State Regulations****. Rescinded: Filed Feb. 25, 2011.*

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed rescission will begin at 9:00 a.m., May 26, 2011. The public hearing will be held at the Elm Street Conference Center, 1730 East Elm Street, Lower Level, Bennett Springs Conference Room, Jefferson City, Missouri. Opportunity to be heard at the hearing shall be afforded any interested person. Interested persons, whether or not heard, may submit a written or email statement of their views until 5:00 p.m., June 2, 2011. Written comments shall be sent to Chief, Air Quality Planning Section, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176. Email comments shall be sent to apcprulespn@dnr.mo.gov.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

PROPOSED RESCISSION

10 CSR 10-5.030 Maximum Allowable Emission of Particulate Matter From Fuel Burning Equipment Used for Indirect Heating. This rule restricted the emission of particulate matter from fuel burning equipment used for indirect heating in the St. Louis metropolitan area. This rulemaking will remove a rule that is being replaced with a new statewide rule that restricts the emission of particulate matter from fuel burning equipment used for indirect heating. If the commission adopts this rule action, it will be the department's intention to submit this rule rescission to the U.S. Environmental Protection Agency for removal from the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Environmental Regulatory Agenda website, www.dnr.mo.gov/regs/index.html.

PURPOSE: This rule restricted the emission of particulate matter from fuel burning equipment used for indirect heating. This rulemaking will remove a rule that is being replaced with a new statewide rule that restricts the emission of particulate matter from fuel burning equipment used for indirect heating. The evidence supporting the need for this proposed rulemaking, per section 536.016, RSMo, is a necessity memorandum dated March 5, 2008.

AUTHORITY: section 643.050, RSMo 1994. Original rule filed March 14, 1967, effective March 24, 1967. Rescinded and readopted: Filed Aug. 11, 1978, effective Feb. 11, 1979. Amended: Filed March 14, 1984, effective Sept. 14, 1984. Rescinded: Filed Feb. 25, 2011.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed rescission will begin at 9:00 a.m., May 26, 2011. The public hearing will be held at the Elm Street Conference Center, 1730 East Elm Street, Lower Level, Bennett Springs Conference Room, Jefferson City, Missouri. Opportunity to be heard at the hearing shall be afforded any interested person. Interested persons, whether or not heard, may submit a written or email statement of their views until 5:00 p.m., June 2, 2011. Written comments shall be sent to Chief, Air Quality Planning Section, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176. Email comments shall be sent to apcprulespn@dnr.mo.gov.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

PROPOSED RULE

10 CSR 10-6.405 Restriction of Particulate Matter Emissions From Fuel Burning Equipment Used For Indirect Heating. If the commission adopts this rule action, it will be the department's intention to submit this new rule to the U.S. Environmental Protection Agency for inclusion in the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Environmental Regulatory Agenda website, www.dnr.mo.gov/regs/index.html.

PURPOSE: This rule restricts the emission of particulate matter from fuel burning equipment used for indirect heating except where 10 CSR 10-6.070 would be applied. The evidence supporting the need for this proposed rulemaking, per section 536.016, RSMo, is a necessity evidence memorandum dated March 5, 2008.

(1) Applicability.

(A) This rule applies throughout the state with additional conditions applicable to the metropolitan areas of Kansas City, Springfield, and St. Louis as found in sections (2) and (3) of this rule.

(B) This rule applies to installations in which fuel is burned for the

primary purpose of producing steam, hot water, or hot air or other indirect heating of liquids, gases, or solids and, in the course of doing so, the products of combustion do not come into direct contact with process materials. Fuels may include but are not limited to coal, tire derived fuel unless more strict standards apply, coke, lignite, coke breeze, gas, fuel oil, and wood but do not include refuse. When any products or byproducts of a manufacturing process are burned for the same purpose or in conjunction with any fuel, the same maximum emission rate limitations shall apply.

(C) An emission unit's compliance with 10 CSR 10-6.070 or an emission unit fueled by landfill gas, propane, natural gas, and/or fuel oils #2 through #6; with less than one and two-tenths percent (1.2 %) sulfur would be deemed in compliance with 10 CSR 10-6.405, however the heat input from such emission unit must be included in the calculation of Q, the installation's total heat input as defined in subsections (3)(D) and (3)(E) of this rule.

(D) An installation is exempt from this rule if all of the installation's applicable units are fueled only by landfill gas, propane, natural gas, and fuel oils #2 through #6; with less than one and two-tenths percent (1.2 %) sulfur, or any combination of these fuels.

(2) Definitions.

(A) Existing—Any source which was in being, installed, or under construction on the date provided in the following table:

Area of State	Contruction date began on or before
Kansas City Metropolitan Area	February 15, 1979*
St. Louis Metropolitan Area	February 15, 1979*
Springfield-Greene County Area	September 24, 1971
Outstate Area	February 24, 1971

*Exception: If any source subsequently is altered, repaired, or rebuilt at a cost of thirty percent (30%) or more of its replacement cost, exclusive of routine maintenance, it shall no longer be existing, but shall be considered as new.

(B) New—Any source which is not an existing source, as defined in subsection (2)(A) of this rule.

(C) Definitions of certain terms specified in this rule, other than those defined in this rule section, may be found in 10 CSR 10-6.020.

(3) General Provisions.

(A) The heat content of solid fuels shall be determined as specified in 10 CSR 10-6.040(2). The heat content of liquid hydrocarbon fuels shall be determined as specified in 10 CSR 10-6.040(3).

(B) For purposes of this rule, the heat input shall be the aggregate heat content of all fuels whose products of combustion pass through a stack(s). The hourly heat input value used shall be the equipment manufacturer's or designer's guaranteed maximum input, whichever is greater, except in the case of boilers of ten (10) million British thermal units (mmBtu) or less the heat input can also be determined by the higher heating value (HHV) of the fuel used at maximum operating conditions. The total heat input of all fuel burning units used for indirect heating at a plant or on a premises shall be used for determining the maximum allowable amount of particulate matter which may be emitted.

(C) Indirect heating sources requiring permits under 10 CSR 10-6.060 that in turn may require particular air pollution control measures to meet more stringent emission rate limitations than in this rule shall meet the requirements of the permits issued under 10 CSR 10-6.060 Construction Permits Required.

(D) Emission Rate Limitations for Existing Indirect Heating Sources. No person may cause, allow, or permit the emission of particulate matter from existing indirect heating sources in excess of that specified in the following table:

Area of State	Heat Input (mmBtu/hour)	Rate Limits for Existing Sources (pounds/mmBtu)
Kansas City & St. Louis Metropolitan	<10	0.60
	$>5{,}000$	0.12
	≥ 10 and $\leq 5{,}000$	$E=1.09Q^{-0.259}$
Springfield-Greene County & Outstate Missouri	≤ 10	0.60
	$\geq 10{,}000$	0.18
	>10 and $<10{,}000$	$E=0.90Q^{-0.174}$

Where:
E = the maximum allowable particulate emission rate limit for existing sources in pounds per mmBtu of heat input, rounded off to two (2) decimal places; and
Q = the installation's existing sources heat input in mmBtu per hour.

(E) Emission Rate Limitations for New Indirect Heating Sources. No person may cause, allow, or permit the emission of particulate matter in excess of that specified in the following table:

Area of State	Heat Input (mmBtu/hour)	Rate Limits for New Sources (pounds/mmBtu)
Kansas City & St. Louis Metropolitan	<10	0.40
	$>1{,}000$	0.10
	≥ 10 and $\leq 1{,}000$	$E=0.80Q^{-0.301}$
Springfield-Greene County & Outstate Missouri	≤ 10	0.60
	$\geq 2{,}000$	0.10
	>10 and $<2{,}000$	$E=1.31Q^{-0.338}$

Where:
E = the maximum allowable particulate emission rate limit for new sources in pounds per mmBtu of heat input, rounded off to two (2) decimal places; and
Q = the installation's new sources heat input in mmBtu per hour.

(F) Alternate Method of Compliance.

1. Compliance with this rule also may be demonstrated if the weighted average emission rate (WAER) of two (2) or more indirect heating sources is less than or equal to the maximum allowable particulate E determined in subsection (3)(D) or (3)(E) of this rule. The WAER for the indirect heating sources to be averaged shall be calculated by the following formula:

$$WAER = \frac{\sum_{i=1}^{n} (Ea_i \times Q_i)}{\sum_{i=1}^{n} Q_i}$$

Where:
WAER = the weighted average emission rate in pounds per mmBtu;
Ea_i = the actual emission rate of the ith indirect heating source in pounds per mmBtu;
Q_i = the rated heat input of the ith indirect heating source in mmBtu per hour; and
n = the number of indirect heating sources in the average.

2. Installations demonstrating compliance with this rule in accordance with the requirements of subsection (3)(F) of this rule shall do so by making written application to the director. The application shall include the calculations performed in paragraph (3)(F)1.

of this rule and all necessary information relative to making this demonstration.

3. Subsection (3)(F) of this rule only shall apply if the WAER determined by paragraph (3)(F)2. of this rule for indirect heating sources does not exceed the maximum allowable particulate E determined for that source from subsection (3)(D) or (3)(E) of this rule when using the rated heat input, Q_i, for the individual indirect heating source as if that individual indirect heating source was the only such source at the installation.

(4) Reporting and Record Keeping. All records must be kept on-site for a period of five (5) years and made available to the department upon request. The owner or operator shall maintain records of the following information for each year the unit is operated:

(A) The identification of each affected unit and the name and address of the plant where the unit is located for each unit subject to this rule;

(B) The calendar date of the record;

(C) The emission rate in pounds per mmBtu for each unit on an annual basis for those units complying with the limit in subsections (3)(D) and (3)(E) of this rule; and

(D) The emission rate in pounds per mmBtu for each facility on an annual basis for those units complying with subsection (3)(F) of this rule.

(5) Test Methods. The following hierarchy of methods shall be used to determine compliance with subsections (3)(D) and (3)(E) of this rule:

(A) Continuous Emission Monitoring System (CEMS);

(B) Stack tests;

(C) AP-42 (Environmental Protection Agency (EPA) *Compilation of Air Pollution Emission Factors*) or FIRE (Factor Information and Retrieval System);

(D) Other EPA documents;

(E) Compliance Assurance Monitoring (CAM) Plans as found in a facility operating permit may be used to provide a reasonable assurance of compliance with subsections (3)(D) and (3)(E) of this rule;

(F) Sound engineering calculations; or

(G) The amount of particulate matter emitted shall be determined as specified in 10 CSR 10-6.030(5). Any other method approved for the source incorporated into a construction or operating permit, settlement agreement, or other federally enforceable document.

AUTHORITY: section 643.050, RSMo 2000. Original rule filed Feb. 25, 2011.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed rule will begin at 9:00 a.m., May 26, 2011. The public hearing will be held at the Elm Street Conference Center, 1730 East Elm Street, Lower Level, Bennett Springs Conference Room, Jefferson City, Missouri. Opportunity to be heard at the hearing shall be afforded any interested person. Interested persons, whether or not heard, may submit a written or email statement of their views until 5:00 p.m., June 2, 2011. Written comments shall be sent to Chief, Air Quality Planning Section, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176. Email comments shall be sent to apcprulespn@dnr.mo.gov.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

PROPOSED AMENDMENT

11 CSR 45-4.030 Application for Class A or Class B License. The commission is amending section (20).

PURPOSE: This amendment clarifies an applicant's responsibility to keep its application current.

(20) The applicant *[or licensee]* shall be responsible to keep the application current at all times. The applicant *[or licensee]* shall notify the commission in writing within ten (10) days of any changes to any response in the application and this responsibility shall continue throughout any period *[of licensure granted]* **during which an application is being considered** by the commission. All updates to applications must be submitted by exhibit so that each affected exhibit is resubmitted with the updated information and with the date of resubmission. If any application update is not made in this manner, the commission may deem the update not to be effective.

*AUTHORITY: sections 313.004[,] and 313.807, RSMo 2000, **and section 313.805, RSMo Supp. 2010**. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Feb. 23, 2011.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for May 18, 2011, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

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

PROPOSED AMENDMENT

11 CSR 45-10.020 Licensee's and Applicant's Duty to Disclose Changes in Information. The commission is amending section (1).

PURPOSE: This amendment clarifies an applicant's and licensee's duty to disclose changes in information.

(1) All licensees and applicants for Class A, Class B, supplier, key person/key person business entity or Level I occupational licenses issued by the commission shall have a continuing duty to disclose in writing, within **ten (10) calendar days for an applicant and** thirty (30) calendar days **for a licensee**, any material change in the information provided in the application forms and requested materials submitted to the commission. Any change in information that is not

material must be disclosed to the commission during the licensee's next subsequent application for license renewal.

*AUTHORITY: sections 313.004[,] and 313.807, RSMo 2000 and sections 313.800[,] **and** 313.805, RSMo Supp. [2007] **2010**. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Feb. 23, 2011.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for May 18, 2011, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 35—Children's Division
Chapter 32—Child Care

PROPOSED RULE

13 CSR 35-32.020 Foster Care Case Management Contracts

PURPOSE: This rule establishes the governing provisions for contracts to provide a comprehensive system of service delivery for children and their families as set forth in section 210.112.8, RSMo.

(1) This rule shall apply to all contracts for the provision of case management services for youth placed in the custody or under the supervision of the Children's Division as provided in section 210.112, RSMo, as well as govern the work of contractors and their officers, agents, and employees pursuant to those contracts.

(2) When providing case management services pursuant to a contract with the Children's Division, the contractor shall fully implement and comply with all requirements of federal and state law which apply to permanency planning and shall fully implement and comply with all written policies and procedures of the Children's Division which do not conflict with those federal and state laws. This includes, but is not limited to, all regulations promulgated by the Children's Division. Any policy of the contractor which conflicts with any regulation, policy, or procedure of the Children's Division shall be void.

(3) Contractors shall provide a range of child welfare services including case management services for children in out-of-home placements, family-centered services for parents and legal guardians from whose care the child was removed, and community resource development. Family-centered services shall be defined as the family-focused intervention method utilized by the Children's Division when working with families to assist them in identifying their strengths and needs and to develop a family plan for change.

(A) Case management services shall include assessments, case planning, placement services, service planning, permanency planning, and concurrent planning. The contractor shall have on-going contact with the child; the child's out-of-home care provider; the parents or the guardian of the child in care, if parental/guardianship rights have not been terminated; the children remaining in the home; the court; and the members of the child's Family Support Team as defined in the Children's Division's written policies and procedures. The contractor must provide case management services that respect the culture, ethnicity, and religious practices of the children and that of his/her family. The contractor shall document all case management services provided in the case record as well as in the automated case management system within the timeframes outlined in the contract and in the policies of the Children's Division.

1. Assessments shall be defined as the consideration of all social, psychological, medical, educational, and other factors to determine diagnostic data to be used as a basis for the case plan.

2. Case planning is a process of negotiation between the family case manager, the parent(s) or guardian(s) from whom the child was removed, and the juvenile officer, which describes the services and activities necessary for the purpose of achieving a permanent familial relationship for the child. The case plan shall include the permanency plan as defined in paragraph (3)(A)5. below, the concurrent plan as defined in paragraph (3)(A)6. below, the service plan as defined in paragraph (3)(A)4. below, the timeframes in which services will be delivered, and the timeframes for obtaining reports from service providers, when applicable.

A. Contractors shall develop a case plan no later than fourteen (14) days after referral of the child's case to the contractor by the Children's Division. The contractor shall submit case plans to the court in accordance with local court procedures.

B. The case plan shall be developed following procedures set forth in the written policies and procedures of the Children's Division and applicable federal and state law. In the event that the policies and procedures of the Children's Division conflict with applicable federal and state law, federal and state law shall prevail.

C. The contractor's case manager shall give careful consideration to the unique needs of each child and family when developing the case plan.

D. As necessary to effectuate the best interests of the subject child, the case plan may be amended from time-to-time throughout the contract period.

3. Placement services is the selection of, and placement with, the most appropriate resource for children in out-of-home care based on the assessment of the child's unique needs and personality and the out-of-home care provider's capacity and skills in meeting those needs.

A. The contractor's case manager must utilize the least restrictive out-of-home placement for a child.

(I) The best interests of the child in care shall govern all placement decisions. When the placement would not be contrary to the best interest of the child, the contractor must give relatives of the child in care preference and first consideration to serve as the child's out-of-home care provider. As required by applicable federal and state law, the contractor must conduct an immediate search to locate, contact, and, where appropriate, to place the child in care with his/her grandparent(s). Therefore, grandparents of the child in care shall be given first consideration for placement before other relatives of the child in care are considered. Whenever the contractor decides that relative placement is contrary to the best interests of the child, the contractor shall document the reasons for this decision in the case plan.

(II) Placements in residential treatment shall be based on an assessment of the child's needs. Such placements shall be considered for children in care who need structured and therapeutic intervention. Placement in a residential treatment facility must be of a limited duration and treatment during this time must be focused on enabling the child in care to transition to family and/or community-based care as soon as possible.

(III) In coordination with the child in care's Family Support Team, the contractor shall periodically reassess the placement of the child to determine whether the placement is consistent with the child's permanency plan and is meeting the child's needs.

(IV) As required by the written policies and procedures of the Children's Division, the contractor shall convene Family Support Team meetings to discuss any change in placement.

B. The contractor shall exercise reasonable and continuing efforts to preserve, foster, and encourage the relationships between siblings of children under case management with the contractor unless it is contrary to the safety or welfare of one (1) or more of the siblings to do so.

(I) Whenever reasonably possible, the contractor shall place a child in out-of-home care with any siblings who are also removed from their home. The contractor shall make reasonable efforts to place siblings in the same placement unless doing so would be contrary to the safety or welfare of any of the siblings.

(II) The contractor must make arrangements for regular, frequent, and continuing visitation between siblings who are not in the same placement unless it is contrary to the safety or welfare of one (1) or more of the siblings to do so.

(III) Unless it is contrary to the safety or welfare of one (1) or more of the siblings to do so, the contractor shall reunite siblings at the earliest time possible when circumstances change and different caregivers are no longer required.

(IV) The contractor shall document in the case file its efforts to place siblings in the same home and, if not placed in the same home, its efforts to maintain the sibling relationship. If the contractor determines that placement of siblings in the same placement or visitation between the siblings is contrary to the safety or welfare of the siblings, the contractor shall document the reasons therefore in the case file.

C. When an appropriate placement is available and it is in the best interests of the child to do so, placements of children in care shall be made in the child's home community.

D. Unless otherwise ordered or authorized by the court, placement of children in care shall be with a licensed out-of-home care provider.

E. The contractor's case manager shall not place a child in a home in which any person residing in the home has been found guilty of, or pled guilty to, any crimes identified in section 210.117, RSMo.

4. Service planning is the provision of any services indicated and identified as needed through an assessment and case plan, or ordered by the juvenile court.

5. Permanency planning is determining the permanent plan which best meets the needs of the child in care and which complies with the applicable requirements of federal law. Contractors shall provide ninety (90) calendar days of services to the child and family after a child is reunified with their parent(s) or guardian(s) to assure a continued successful outcome as defined in the contract. The permanency plan shall consider:

A. The child's need for a continuing relationship with his/her parent(s) or legal guardian(s) prior to the child's removal from the home;

B. The ability and willingness of the child's parent(s) or legal guardian(s) prior to the child's removal from the home to actively perform their functions as the child's caregiver with regards to the needs of the child;

C. The interaction and interrelationship of a child with the child's parent(s) or legal guardian(s) from whom they were removed, the child's out-of-home care provider, siblings, and any other person who may have a significant impact upon the child's best interest;

D. The child's adjustment to his/her out-of-home placement, school, and community; and

E. The mental and physical health of all individuals involved, including any history of abuse of or by any individuals involved.

6. A permanency plan shall include an individualized primary permanency plan and a concurrent permanency plan for each child. Concurrent permanency planning is a process of pursuing a primary permanency goal for a child in care, such as reunification, while simultaneously establishing and implementing an alternative permanency plan for that child. The contractor shall make active, reasonable efforts to finalize the primary and concurrent permanency plan and shall document those efforts in the case file. The permanency plan shall be developed at the earliest possible opportunity and in no case later than fourteen (14) days after case referral. The plan shall be submitted to the court in the manner prescribed by law or as otherwise ordered by the court. As required by Children's Division written policies and procedures, the permanency plan shall be periodically reviewed and, where appropriate, may be modified if modification is in the best interests of the child as determined by the child's Family Support Team or as ordered by the court.

A. Community resource development is the recruitment, assessment, and training of out-of-home care providers. It shall also include the development of those services which best meet the needs of the child and family when they are not readily available in their local community.

(I) The contractor shall conduct community resource development activities to obtain a sufficient number of appropriate out-of-home resource providers to enable the contractor to perform its duties under the contract.

(II) Unless such policies and procedures conflict with applicable state law, the contractor shall ensure background investigations are conducted on all out-of-home care providers as required by the written policies and procedures of the Children's Division.

(III) The contractor shall utilize a training curriculum which meets or exceeds the resource development standards set forth in the written policies and procedures of the Children's Division. The contractor shall obtain approval from the Children's Division designee prior to finalizing the curriculum and content for the training sessions.

B. The contractor may directly provide or contract for the services required by this rule in accordance with the proposal submitted in response to the Request for Proposal or Invitation for Bid for the contract awarded for such services. However, any subcontractors employed by the contractor must comply with all requirements of this regulation.

(4) The contractor shall ensure that all children under the age of ten (10) years old referred to the contractor receive a Healthy Children and Youth assessment within thirty (30) days of entering care and every six (6) months thereafter. Such assessments will be utilized to determine treatment services which will meet the child's psychological and social needs. When the assessment indicates intensive twenty-four (24) hour treatment services, appropriate services will be provided. A written report of the assessments shall be maintained in the case file.

(5) The contractor shall deliver all services through qualified professionals who have substantial and relevant education, experience, and who are competent, as defined by the Council on Accreditation, to deliver case management services. The contractor's personnel must meet or exceed all of the applicable licensing or certification requirements of their profession set by the State of Missouri, if such licensure or certification is required by their profession for the performance of their specific job function. The contractor's personnel must meet the education and experience expectations outlined in the most current Child Placing Rules set forth at 13 CSR 40-73.035.

(A) The contractor shall maintain a personnel file for each employee which shall be accessible to the Children's Division upon request for the purpose of verifying compliance with the requirements of its contract with the Children's Division. At a minimum, the file must include complete and current criminal record checks, background investigations, resumes, degrees or diplomas, date of

employment, training records, performance appraisals, commendations, disciplinary actions, and other related actions. Background checks, including criminal background checks, shall be periodically updated as requested by the Children's Division. Contractors shall immediately notify the Children's Division of any act or occurrence which may impact their employee's ability, qualifications, or certification to provide services under the contract.

(6) The contractors shall deliver all services through professionals who have substantial and relevant training.

(A) The contractor's personnel providing case management services or direct supervision of case management services must successfully complete training which emphasizes:

1. A strengths-based assessment of the family;

2. Engagement of the family throughout a child's out-of-home placement beginning with the assessment;

3. Treatment and service planning for all family members with a commitment to reunifying the child with his/her biological family whenever possible, to preserving a child's connection to his/her family of origin whenever possible, and a commitment to a child's right to belong to a family;

4. Family dynamics, including human growth and development;

5. A team approach to case planning which draws upon the experience of professionals who are familiar to the members of the child in care's family;

6. Advocacy for the families and children served through the child welfare system;

7. The relevant legal and due process rights of children, parents, families, and care providers;

8. A background in the laws and procedures governing the juvenile courts; and

9. Cultural sensitivity.

(B) The contractor's personnel providing case management and direct supervision of case management staff must successfully complete pre-service training either by attending the Children's Division pre-service training, or by directly providing or arranging for another entity to provide pre-service training. The training shall include all of the topics listed in subsection (6)(A) above.

1. When the contractor plans to provide or arrange for another entity to provide pre-service training for its employees, the contractor must submit the curriculum to the Children's Division for prior approval.

A. When the contractor is granted permission to provide the pre-service training, or to arrange for another entity to provide the pre-service training, they shall provide the exclusive training to their employees and/or subcontractors. In such instances, employees and/or subcontractors of the contractor shall not be eligible to attend the pre-service training provided by the Children's Division.

2. The pre-service training for newly hired case managers and direct supervisors must be completed within the first ninety (90) calendar days of employment.

3. Pre-service training must incorporate skill-based instruction and skill building exercises. For the first ninety (90) days of employment, the contractor must provide case managers with on-the-job support which includes experiential learning techniques.

4. Contractor's personnel attending Children's Division pre-service training will be scheduled for the first available session with openings.

5. The pre-service training must:

A. Clearly identify the case management role;

B. Clearly acquaint personnel with federal and state laws relating to child welfare practices; this includes, but is not limited to, the constitutional rights of families and children who are involved in the juvenile justice system, including training on due process, the Fourth Amendment to the U.S. Constitution, the Adoption and Safe Families Act, the requirement that Children's Division exercise reasonable efforts to finalize permanency plans, concurrent planning, termination of parental rights, guardianships, the Missouri Rules of Procedure for Juvenile Courts and federal and state law governing permanency planning.

C. Acquaint personnel with Children's Division's policies relating to out-of-home care, adoption and guardianship subsidy programs, family-centered services, intensive in-home services, and resource development as defined by Children's Division written policies and procedures;

D. Acquaint personnel with record keeping requirements as set forth in the written policies and procedures of the Children's Division;

E. Acquaint personnel with the automated information system utilized by the Children's Division; and

F. Successful completion of pre-service training must be documented in personnel records for all personnel providing case management services and direct supervisors.

(C) The contractor's personnel who recruit, train, and assess foster parents serving children with elevated needs, or who provide ongoing support to such foster parents, must successfully complete specific training which is designed for the elevated needs program. Such training must be provided by the Children's Division or by the contractor's staff utilizing curriculum which has been previously approved by the Children's Division.

(D) The contractor's personnel who train staff who are tasked to recruit, train, and assess foster parents serving children with elevated needs must successfully complete a Train-the-Trainer session provided by the Children's Division, or by another entity approved to provide such training by the Children's Division.

(7) The contractor must submit all required information to the family care safety registry on behalf of all professional personnel assigned to provide services under the contract prior to such personnel providing service to children in care. Such information shall be updated on an annual basis thereafter. Any personnel who reside in another state and work in the state of Missouri, or who have relocated to the state of Missouri within the last five (5) years shall provide documentation of background screening(s) from their state of origin to include, but not limited to, child abuse/neglect and criminal background screening check(s), prior to such personnel providing service. If the employee continues to reside in another state while performing case management services for the contractor, the out-of-state check shall be done annually. The contractor's professional personnel assigned to the contract must have background investigations submitted to the Children's Division via a form provided by the Children's Division prior to such professional personnel providing services under the contract.

(A) The form shall be submitted no later than fifteen (15) calendar days after the effective date of the contract for all professional personnel.

(B) The form shall be submitted for each new or anticipated professional personnel assigned to provide services under the contract prior to such personnel providing services.

(C) When child abuse/neglect or criminal activity is discovered through the background investigation of any professional personnel assigned to provide services under the contract, the contractor must review the information to determine the relevance of such finding to the provision of case management services.

1. The contractor shall not allow individuals to perform case management duties when his/her background investigation reveals that he/she has been found guilty, pled guilty, or has been convicted of—

A. A felony conviction for child abuse or neglect or spousal abuse;

B. A felony or misdemeanor conviction for any crime in which a child was a victim or a crime against children, to include, but not limited to, any offense involving child pornography;

C. Any crime involving violence and/or sexual offenses, including, but not limited to, rape, domestic violence, domestic assault, armed criminal action, sexual assault, or homicide;

D. Failure to report suspected child abuse to the child abuse and neglect hotline as required by section 210.115, RSMo;

E. A felony conviction for physical assault, battery, or a drug-related offense within the past five (5) years; or

F. Any other crime listed in section 210.117, RSMo.

2. The contractor must submit a written request to the Children's Division designee when the contractor desires to hire an individual with a history of child abuse/neglect or criminal activity which does not meet the criteria identified in paragraph (7)(C)1. above. The Children's Division designee shall review the request and provide a written response indicating if the individual may provide case management services.

A. The contractor shall request an administrative review no later than thirty (30) days from the date of Children's Division decision when they dispute such decision.

B. The request for an administrative review shall be in writing and generally set out the reasons for the request.

C. The Children's Division shall schedule an administrative review within three (3) business days of receipt of the request. The administrative review shall take place before the Children's Division designee. The Children's Division shall notify the contractor of the date and time of the review. The review may be continued at the request of the contractor, but the employment exclusion shall remain in effect pending the administrative review.

D. The review shall be informal, the rules of evidence shall not apply, and both the contractor and the Children's Division may submit any information relevant to the appealed decision. The purpose of the review will be to determine the potential employee's suitability for employment under the contract.

(I) The contractor's personnel application must include an authorization for the Children's Division to release information which directly relates the employee's suitability for employment under the contract.

(II) Upon completion of the administrative hearing, the Children's Division designee will submit a recommendation to the director of the Children's Division. The director may affirm or reverse the initial decision. Such decision shall be final.

(D) The contractor must submit a written request to the Children's Division designee when the contractor desires to hire a current or former child welfare employee of the Children's Division. The Children's Division will review the request and provide a written response indicating if the individual may provide the case management services. The administrative review process described in paragraph (8)(C)2. above shall be utilized when the contractor disputes the decision.

1. The administrative review process described in paragraph (8)(C)2. above shall not apply when the contractor does not have a signed, written authorization for the Children's Division to release information to the contractor.

(E) The contractor's personnel may be dismissed at the discretion of the contractor. However, an employee of the contractor shall be dismissed if required pursuant to section 207.085, RSMo.

(8) Contractors shall have a proven record of providing quality child welfare services within the state of Missouri.

(A) Contracts shall be awarded through a competitive bid process to:

1. Children's services providers and agencies contracted with the state of Missouri on or before July 1, 2005, to provide a comprehensive system of service delivery for children and their families; or

2. Public and private not-for-profit or limited liability corporations owned exclusively by not-for-profit children's services providers and agencies with a proven record of providing child welfare services within the state of Missouri.

(B) The contractor and/or contractor's subcontractors performing case management and resource development services must be licensed as a child placing agency by the state of Missouri.

(C) The contractor's case management program must be accredited by one (1) or more of the following national accrediting bodies: the Council on Accreditation; the Joint Commission; or the Commission on Accreditation of Rehabilitation Facilities. The Children's Division shall accept as prima facie evidence of completion of the requirements for licensure under sections 210.481 and 210.511, RSMo, proof that an agency is accredited. The Children's Division shall not require any further evidence of qualification for licensure if such proof of voluntary accreditation is submitted.

(D) The contractor must have personnel available to the Children's Division, out-of-home care providers, juvenile court personnel, guardians ad litems, and children in out-of-home care twenty-four (24) hours a day, seven (7) days a week.

1. The contractor's case manager must provide services after normal working hours and on weekends as necessary.

(E) A case manager's caseload may not exceed Council on Accreditation (COA) standards.

(F) The contractor's supervisor-to-worker ratio may not exceed COA standards.

(9) Children's Division shall award contracts through a competitive bid process, subject to appropriation.

(10) Subject to appropriation, the Children's Division shall continue to offer contracts in areas of the state where eligible providers are capable of providing a broad range of services. Subject to appropriation, the Children's Division may consider expansion of the contracts to areas of the state where caseloads exceed COA standards.

(11) The contract may not result in the loss of federal funding. The contractor shall therefore comply with and implement the requirements of all relevant federal and state laws and policies including, but not limited to, those listed below, which pertain to the child under case management by the contractor. In the event of a discrepancy between the policies of the Children's Division and federal or state law, the contractor shall comply with the federal or state law—

(A) Missouri Rules and Regulations governing child placing agencies;

(B) Missouri laws pertaining to the services described in the contract;

(C) The rules of procedure for the juvenile courts;

(D) Any court order pertaining to an assigned case;

(E) Interstate Compact on the Placement of children/juveniles;

(F) The Indian Child Welfare Act;

(G) Multi-Ethnic Placement Act of 1994;

(H) Children's Division written policies and procedures pertaining to the services described in the contract;

(I) Children's Division policy directives to provide services through best child welfare practices;

(J) Children's Division Federal Program Improvement Plan;

(K) Federal Laws, Rules and Regulations including, but not limited to, the Adoption and Safe Families Act and the Health Insurance Portability and Accountability Act;

(L) All federal and state laws and all policies, resolutions, and procedures of the Missouri Department of Social Services regarding disclosure of confidential information and statements to the public and news media about any case assigned under the terms of the contract.

1. The contractor's policies and procedures shall be open to the public upon request.

2. The contractor is not prohibited from making public statements about the contractor, general policies and procedures of the contractor, and other issues of public importance not otherwise prohibited by law, regulation, or policy; and

(M) Local initiatives pertaining to services which a case manager provides to children in out-of-home placements and their families which have been approved by the Children's Division state office. This shall include, but shall not be limited to, requirements related

to Family-to-Family. Expectations of contractors shall not exceed requirements of Children's Division staff.

(12) All contracts and contractors shall be subject to oversight and inspection by the Missouri Department of Social Services and/or the Children's Division to assure compliance with standards which shall be consistent with applicable federal standards, but not less than the standards and policies utilized by the Children's Division. The contractor shall allow reasonable and timely site visits by the Missouri Department of Social Services and/or the Children's Division.

(A) The contractor shall maintain adequate, legible, genuine, current, and complete records of services rendered under the terms of the contract which are not part of the child's record for a period of five (5) calendar years following the expiration of the contract. This shall include, but is not limited to, resource records, expenditures, invoices, and other documentation pertaining to payments made under the terms of the contract.

(B) Adequate and complete documentation shall mean the contractor's records are such that an orderly examination by a reasonable person is possible and can be conducted without the use of information extrinsic to the records and that such an examination can readily determine the contractor's reported services were, in fact, provided; to whom the services were provided; and the extent and duration of such services. At a minimum, the required records shall consist of service authorization forms and copies of invoices submitted to the Children's Division for payment.

(C) The contractor's failure to maintain adequate, legible, genuine, current, and complete records of services rendered under the terms of the contract for a period of five (5) calendar years shall be deemed a material breach of the contract and the contractor shall repay to the Children's Division all amounts received for any services which are not adequately verified and fully documented by the contractor's records.

(D) The contractor shall indemnify and hold harmless the state of Missouri, the Missouri Department of Social Services and its agents, officers, and employees from any and all liability, loss, damages, or expenses which the Missouri Department of Social Services, the Children's Division, or the state of Missouri may sustain, incur, or be required to pay by reason of any person's injury, death, property loss, or damage sustained and/or suffered because of any act or omission by the contractor, its employees, or subcontractors that results from violation of a law, regulation, or policy of the Missouri Department of Social Services or the Children's Division. This includes, but is not limited to, court costs and attorney fees incurred by or charged to the Missouri Department of Social Services or the Children's Division as the result of such act or omission by the contractor, its officers, employees, agents, representatives, or subcontractors.

(E) In the event the court finds the contractor liable for sanctions or otherwise holds the contractor in contempt as a result of the contractor's violation of any law, rule, court order, or procedure or policy of Missouri Department of Social Services or the Children's Division, the contractor shall be solely responsible for the payment of any fines, penalties, or sanctions, including attorney fees and costs, that arise under any such action. Additionally, the contractor shall save, indemnify, and hold the state of Missouri harmless, including its agencies, employees, and assigns, from every expense, liability, or payment arising out of such sanction, fine, or penalty assessed against the contractor or against the Missouri Department of Social Services, the Children's Division, or the department's Division of Legal Services as a result of the actions of the contractor, including court costs, attorney fees, and litigation expenses.

(13) Contractors shall be evaluated by the Children's Division based on objective, consistent, and performance-based criteria as further defined in the contract.

(A) A percentage of children under the jurisdiction of the juvenile court and in the care of the contractor must achieve permanency within a twelve (12)-month period as specified in the contract. For purposes of this section, permanency shall be defined as reunification with the child's parent(s), reunification with the child's guardian(s), a finalized adoption, or the establishment of a legal guardianship for the child.

(B) A percentage of children under the jurisdiction of the juvenile court and in the care of the contractor must not have substantiated child abuse/neglect reports with the out-of-home care provider listed as the perpetrator within a twelve (12)-month period as specified in the contract.

(C) A percentage of children under the jurisdiction of the juvenile court and in the care of the contractor must not reenter Children's Division custody or supervision within twelve (12) months of their previous exit from such custody or within twelve (12) months of the date of reunification as specified in the contract.

(D) The Children's Division may monitor additional outcomes including, but not limited to: the number of placement settings for children in out-of-home care; residential utilization; outcomes for older youth; and the number of resource homes developed by the contractor as identified in the Request for Proposal or Invitation for Bid. The Children's Division may require corrective action when the contractor fails to meet the standards set forth in the Request for Proposal or Invitation for Bid.

(14) The contractor shall participate and cooperate with any program evaluation and improvement plan, including on-going record keeping, evaluation, and reporting in accordance with the program evaluation design, and preparation for, and participation in, the federal Child and Family Service Review, or any other performance initiative required of, or by, the Children's Division. Any program evaluation will include the same outcome measures for the contractors and the Children's Division within a specified region.

(15) If the contractor does not comply with its obligations under this regulation, or breaches its contract with the Children's Division, the Children's Division shall have the discretion to terminate the contract and seek any remedies which may be available in law and equity for breach of contract. If the Children's Division determines that the contractor has failed to meet the outcome measures specified in the contract, the Children's Division may reduce the contractor's caseload or cancel the contract in its entirety. The contractor shall be allowed an opportunity to review the outcomes prior to the development of the final outcomes report. The contractor shall be responsible for any updates in the automated case management system which are necessary to correct the outcomes. The Children's Division shall correct any programming errors identified by the contractor.

(16) In addition to those measures authorized in section (15) above, if the contractor does not meet the outcome goals specified in the contract, or otherwise fails to comply with this regulation or the contract, the Children's Division may elect to require the contractor to implement a practice improvement plan to correct any deficiencies in performance. Failure of the contractor to take action as indicated in the practice improvement plan within ninety (90) calendar days or the number of days specified in the practice improvement plan shall be considered a breach of contract. Thereafter, the Children's Division may terminate the contract or pursue any other remedies in law or equity available to the Children's Division. The written practice improvement plan shall address:

(A) Reasons why the outcome was not achieved;
(B) Steps taken to meet the outcome;
(C) Individual(s) responsible for necessary action; and
(D) Timeframe for meeting the defined outcome.

AUTHORITY: section 207.020, RSMo 2000 and section 210.112, RSMo Supp. 2010 and Young v. Children's Division, State of Missouri Department of Social Services, 284 S.W.3d 553 (Mo. 2009). Original rule filed Feb. 28, 2011.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with Department of Social Services, Children's Division, PO Box 88, Jefferson City, MO 65109.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 35—Children's Division
Chapter 32—Child Care

PROPOSED RULE

13 CSR 35-32.030 Contracted Foster Care Case Management Costs

PURPOSE: This rule establishes the methodology for the provision of reasonable cost for foster care case management services as set forth in section 210.112.4(6), RSMo.

(1) Payment to foster care case management providers contracted by the Children's Division (CD) shall be based on the reasonable cost of services as determined through the competitive procurement process. Providers shall certify their bid covers all reasonable costs.

(A) Upon request by CD, the provider shall submit a written explanation and supporting documentation detailing how the provider calculated the reasonable costs of services. The CD may not award a contract to any provider which fails to submit such information when requested by CD.

(B) CD, in its sole discretion, may reject any bid where CD determines that the bid amount for a service or services exceeds the reasonable cost of the service or services.

(2) The CD may, at its sole discretion, establish a cap on the highest amount that CD will pay for the reasonable cost of services identified in the Request for Proposal (RFP) or Invitation for Bid (IFB). CD will announce the cap for services in the RFP or IFB. Upon request by CD, case management providers or prospective case management providers who submit a proposal or bid for a contractor shall provide CD with cost reports and supporting documentation. CD shall utilize one (1) or more of the following methods to establish the cap as part of the competitive procurement process:

(A) Industry cost reports for the previous three (3) calendar years which demonstrate the costs to the provider to deliver the services identified in the RFP or IFB. Such reports shall include costs for case management services, community resource development, treatment services, special expenses, crisis expenses, administrative costs, and any other cost incurred to provide the services identified in the RFP or IFB.

1. Cost for case management services shall include all costs associated with assessments, case planning, placement services, service planning, permanency planning, and concurrent planning. Such costs shall include salaries and benefits for required staff.

A. Assessments shall be defined as the consideration of all social, psychological, medical, educational, and other factors to determine diagnostic data to be used as a basis for the case plan.

B. Case planning is a process of negotiation between the family case manager, parent(s) or guardian(s) from whom the child was removed, and the juvenile officer which describes the services and activities necessary for the purpose of achieving a permanent familial relationship for the child.

C. Placement services is the selection of the most appropriate placement resource for children in out-of-home care based on the assessment of the child's unique needs and personality and the out-of-home care provider's capacity and skills in meeting those needs.

D. Service planning is the provision of any services indicated and identified as needed through an assessment and case plan, or ordered by the juvenile court.

E. Permanency planning is determining the permanent plan which best meets the needs of the child.

F. Concurrent planning is a process of pursuing a primary permanency goal for children in out-of-home care, such as reunification, while simultaneously establishing and implementing an alternative permanency plan for that child.

2. Cost for community resource development shall include all costs associated with the recruitment, assessment, and training of out-of-home care providers. It shall also include the development of those services which shall best meet the needs of the child and his/her family when they are not readily available in the local community.

3. Cost for treatment services shall include all services designed to meet the service and treatment needs of an individual.

4. Cost for special expenses shall include all costs associated with needs of children which are not designed to meet a service or treatment need. These costs would not be included in the foster care maintenance payment to the placement provider. An example is a clothing allowance.

5. Cost for crisis expenses shall include all costs incurred to address the critical financial and resource needs of families. Crisis funds are utilized to purchase specific items family members need to alleviate a crisis. An example is payment to have utilities restored so that a child may be returned home.

6. Administrative costs are those which are incurred to deliver the case management services defined in the RFP or IFB which are not included above in paragraphs (2)(A)1., (2)(A)2., (2)(A)3., (2)(A)4., or (2)(A)5. Such costs include expenses for general administrative functions and overhead.

7. Provider costs shall be determined and validated by a third party contractor retained by CD or the Department of Social Services for that purpose. The provider shall submit any and all information that CD, the Department of Social Services, or the third party contractor may require to validate the cost report. The provider shall certify such information is truthful, accurate, and complete.

8. Provider costs shall include any applicable credits or payments received through federal or state funding sources or private contributions.

9. Industry cost reports shall include any audited financial statements for the applicable time period under review.

A. Cost to CD for the three (3) previous calendar years for similar services identified in the RFP or IFB.

B. Historical expenditures of agencies contracted to provide the services identified in the RFP or IFB for up to three (3) previous calendar years. These expenditures shall include any payments the contractor has made on behalf of the children and families receiving services identified in the RFP or IFB.

C. Historical expenditures of the CD for up to three (3) previous calendar years for all services identified in the RFP or IFB which have been provided to children placed in out-of-home care in the regions to be served by the foster care case management contractors. CD expenditures shall only be utilized in conjunction with industry cost reports and/or historical expenditures of agencies contracted to provide the services identified in the RFP or IFB.

D. CD shall consider all applicable state and federal laws and regulations when a cap is established.

(3) Awards shall be made to the lowest and best qualified bidder(s), subject to applicable procurement law and available appropriation. A qualified bidder is a provider which meets all of the requirements in law, regulation, and policy related to the services identified in the

RFP or IFB. A qualified bidder must also meet the qualifications outlined in the RFP or IFB.

(4) The number of bids and cases awarded to any given provider are subject to available appropriation.

(5) The contract shall specify the monthly amount which is to be paid based on the number of cases awarded unless payment has been reduced for reasons specified in this regulation. The contract may include a provision that the parties to the contract may amend the contract to increase the rate if specifically authorized by statute or appropriation.

(6) The contract shall provide for the payment of incentives to recognize accomplishment of case goals and corresponding cost savings to the state.

(A) For contracts effective on or before September 30, 2011, incentives shall be provided when contractors exceed the permanency expectations identified in the contract as follows:

1. The contract shall identify the percentage of children who are to achieve permanency in a twelve (12)-month period. Permanency shall be defined as reunification with the child's parent(s) or legal guardian(s), a finalized adoption, or establishment of a legal guardianship;

2. CD shall refer the number of cases in the Notice of Award during the first month of the contract year. CD shall refer additional cases throughout the contract year with the intention of replacing cases which are expected to move to permanency each month based on the percentage of children who are to achieve permanency as identified in the contract; and

3. The contractor shall be paid monthly for the number of cases awarded, regardless of the number they actually serve, except in the following situations:

A. CD shall reduce the payment when CD determines it is in the best interest of a child to reassign the case to CD staff and the case is not replaced. CD shall reduce payment by the number of cases which have been disenrolled and reassigned for case management which were not replaced;

B. CD shall reduce payment when the contractor is placed on referral hold as the result of the contractor's staff involvement with an unacceptable, egregious situation as defined in the contract. Payment shall be reduced by the number of cases which CD is unable to refer while the contractor is on referral hold due to an egregious situation. Egregious situations are defined in this rule to include any situation which seriously impacts the delivery of services to a child or family assigned to the contractor, including a material breach of the contract with the division, and shall include, but is not limited to, the following:

(I) Court contempt order;

(II) Violating the condition(s) of a court order;

(III) Unsafe environments or inappropriate out-of-home provider as evidenced by the following:

(a) Placement in unlicensed foster homes or facilities unless approved by the court;

(b) Placements with a provider without conducting a background screening;

(c) Placements with a provider with a failed background screening as defined in the CD Child Welfare Manual;

(d) Placements without full compliance with the requirements of the Interstate Compact on the Placement of Children (section 210.620, RSMo); and

(e) Placements without court approval where court approval is required;

(IV) Breaches of confidentiality as defined in the contract;

(V) Intentionally, recklessly, knowingly, or negligently entering false data in CD's automated case management system;

(VI) Failure to comply with the requirement to report suspected child abuse and neglect, child injuries, child fatalities, or other critical incidents as required by contract and/or as required by section 210.115, RSMo; and

(VII) Other violations of federal or state law;

C. The contractor shall not invoice for reentries into care within twelve (12) months of previous exit except under those circumstances described below:

(I) The contractor shall be paid for reentries into care during the contract year whereby the number of cases replacing those which are expected to move to permanency each month shall be reduced to correspond with the number of reentries when:

(a) The contractor does not have an opportunity to serve the case or the court terminates jurisdiction and there is clear and convincing documentation to support the contractor was against the release of jurisdiction;

(b) Reunification does not occur; and

(c) The case has been replaced; and

(II) The contractor shall be paid for reentries into care during the next contract year whereby the reentry into care shall count as an active case at the beginning of the contract year when:

(a) The contractor does not have an opportunity to serve the case or the court terminates jurisdiction and there is clear and convincing documentation to support the contractor was against the release of jurisdiction; and

(b) Reunification did occur when the court first terminated jurisdiction after assignment to the contractor; and

D. CD shall reduce the monthly case rate to remove the foster care maintenance payment for those children who have been enrolled in the interdivisional agreement through the MRDD waiver with the Missouri Department of Mental Health.

(B) For contracts effective on or after October 1, 2011, subject to available appropriation, CD shall pay an incentive for the sum of the monthly differences between the number of children who are expected to achieve permanency as defined in the contract and the number of children who do achieve permanency. Permanency shall be defined as reunification with the child's parent(s) or legal guardian(s), a finalized adoption, or establishment of a legal guardianship. The following provisions shall apply to the administration of the incentive:

1. The percentage of children which are to achieve permanency in a twelve (12)-month period shall be based on the following percentage, whichever number is higher:

A. The percentage of children who move to permanency within a region, utilizing an average for all counties served within the region; or

B. The percentage of children contractors serve who move to permanency within a region, utilizing an average of the performance of contractors serving the region;

2. The contractor may return cases to CD when children have been placed with their parent(s) or legal guardian(s) for more than ninety (90) days. The contractor may retain management of the case after ninety (90) days only with the prior, written permission of the CD. When permission is granted, the contractor shall understand the permanency expectation will not change. The contractor shall return cases when an adoption has been finalized, the courts have awarded a legal guardianship, and when the juvenile court has terminated jurisdiction over the child. CD shall replace such cases on a one-for-one basis in the following order of preference if cases are available:

A. The next child and any sibling who enter care within ten (10) calendar days in the county where the case was returned;

B. A child and any sibling currently case managed by CD in the county where the case was returned with services being provided by a supervisor or coworker due to the extended absence of the service worker;

C. A child and any sibling which entered care within thirty (30) calendar days in the county where the case was returned which is case managed by CD;

D. A child and any sibling from a county other than the one (1) where the record was returned which is served by the contracted

provider and meets the criteria set forth in subparagraph (6)(B)2.A., (6)(B)2.B., or (6)(B)2.C. above, when agreeable to the contractor;

E. In the event the contractor is assigned more active cases than awarded in an effort to keep one (1) worker assigned to a sibling group, cases shall not be replaced until such a time when the contractor is serving the amount of active cases awarded. Active cases do not include children who have been placed with their parent(s) or legal guardian(s) for more than ninety (90) days unless the CD has granted permission for the contractor to keep the case, children who have been adopted, those situations where the courts have awarded a legal guardianship, situations where the juvenile court has terminated jurisdiction over the child, or reentries into care unless they meet the criteria specified in part (6)(B)3.D.(I) below. The contractor shall not be assigned a sibling group which would increase the number of cases awarded by more than two percent (2%);

3. The contractor shall be paid for the number of cases awarded except in the following situations:

A. Payment shall be reduced in the following and subsequent months during the contract year and subsequent renewal periods to correspond with the number of cases which could not be assigned when the counties have no case which meets any of the criteria identified in subparagraph (6)(B)2.A., (6)(B)2.B., (6)(B)2.C., or (6)(B)2.D. above. CD reserves the right to increase the number of referrals during subsequent renewal periods when the number of children entering CD's custody increases in the geographic region served by the contractor, when the provider is agreeable to such;

B. CD shall reduce the payment when CD determines it is in the best interest of a child to reassign the case to CD staff and the case is not replaced. CD shall reduce payment by the number of cases which have been disenrolled and reassigned for case management which were not replaced;

C. CD shall reduce payment when the contractor is placed on referral hold as the result of the contractor's staff involvement with an unacceptable, egregious situation as defined in the contract. Payment shall be reduced by the number of cases which CD is unable to refer while the contractor is on referral hold;

D. The contractor shall not be paid for re-entries into care within twelve (12) months of previous exit except under the following circumstance:

(I) The reentry into care will count as an active case when CD is able to determine that the contractor did not have an opportunity to serve the case or the court terminated jurisdiction and there is clear and convincing documentation to support the contractor was against the release of the jurisdiction. In the event the contractor is serving more active cases than awarded as the result of the reentry into care they shall not be paid for such. However, cases shall not be replaced until such a time when the contractor is serving the amount of active cases awarded; and

E. The monthly case rate shall be reduced to remove the foster care maintenance when the contract specifies the division shall be responsible for such;

4. CD shall determine the number of children achieving permanency during the contract year while being served by the contractor. The contractor will be paid for the sum of the monthly differences between the number of children who are expected to achieve permanency as defined in the contract and the number of children who do achieve permanency, subject to available appropriation, as follows:

A. Contractors shall be paid the monthly amount bid and awarded for the sum of the monthly differences during the contract year as identified in paragraph (6)(B)4. above subject to available appropriation; and

B. The incentive shall be a one (1)-time payment for the number of children who exceeded the permanency standard during the contract year as identified in paragraph (6)(B)4. above; and

5. CD reserves the right in its sole discretion to reduce the number of cases assigned in subsequent contract years with payment reduced to correspond when the contractor fails to meet the permanency standard defined in the contract. CD also reserves the right to terminate the contract. In the event the contractor fails to meet the permanency standard and the number of cases are reduced in subsequent contract years CD may reduce the number of cases awarded as follows:

A. CD may request the return of active cases;

B. CD may not replace cases which are closed by the contractor; and

C. CD will reduce payment to correspond with the number of active cases served.

AUTHORITY: section 207.020, RSMo 2000 and section 210.112, RSMo Supp. 2010 and Young v. Children's Division, State of Missouri Department of Social Services, 284 S.W.3d 553 (Mo. 2009). Original rule filed Feb. 28, 2011.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with Department of Social Services, Children's Division, PO Box 88, Jefferson City, MO 65109.

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

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

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 3—Filing and Reporting Requirements

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.250 and 392.455, RSMo 2000 and sections 392.450 and 392.451, RSMo Supp. 2010, the commission amends a rule as follows:

4 CSR 240-3.510 Filing Requirements for Telecommunications Company Applications for Certificates of Service Authority to Provide Telecommunications Services, Whether Interexchange, Local Exchange, or Basic Local Exchange **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2010 (35 MoReg 1736–1737). 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 January 3, 2011, and the commission held a public hearing on the proposed amendment on January 4, 2011. The commission received timely written comments from the staff of the Missouri Public Service Commission, William D. Steinmeier (an attorney who regularly practices before the commission), and AT&T Missouri. In addition, the commission's staff offered comments at the hearing. Each comment supported the proposed amendment.

COMMENT #1: The commission's staff offered a written comment explaining that the existing rule requires applicants for authority to provide basic local telephone service to submit detailed financial information to establish their financial ability to offer such services. Staff indicates its experience since promulgating the existing rule has shown that the detailed financial information reporting requirements are not necessary. Staff believes the amended rule will continue to protect the public interest in local phone service provided by economically-stable providers.
RESPONSE: The commission thanks its staff for its comment. The commission has made no changes to the rule because of this comment.

COMMENT #2: William D. Steinmeier offered a written comment indicating he is an attorney who frequently files applications for certificates of service authority on behalf of small competitive telephone companies. Mr. Steinmeier explains that Missouri's current financial reporting criteria are among the most stringent in the nation. As such, those criteria have created a barrier that has discouraged companies from attempting to enter Missouri's competitive market for local telephone service. Mr. Steinmeier supports the proposed amendment as an appropriate streamlining of the certificate application process, while still protecting the public interest. Mr. Steinmeier encourages the commission to adopt the proposed amendment.
RESPONSE: The commission thanks Mr. Steinmeier for his comment. The commission has made no changes to the rule because of this comment.

COMMENT #3: AT&T Missouri filed a written comment indicating its support for the proposed amendment. It explains that new entrants into the competitive local telephone service market frequently seek to provide service by reselling the services of another carrier, such as AT&T Missouri. If the new entrant becomes financially insolvent, the established carrier, whose service is resold, may not be paid for providing that service. As a result, AT&T Missouri has a financial interest in ensuring that new carriers entering the market are financially stable. AT&T Missouri believes that the proposed amendment appropriately streamlines the application process while still protecting the financial interests of established telephone service providers.
RESPONSE: The commission thanks AT&T Missouri for its comment. The commission has made no changes to the rule because of this comment.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 70—Special Education
Chapter 742—Special Education

ORDER OF RULEMAKING

By the authority vested in the State Board of Education under sections 160.900–160.925 and 161.092, RSMo Supp. 2010, the board hereby amends a rule as follows:

5 CSR 70-742.141 is amended.

A notice of proposed rulemaking was not published because state program plans required under federal education acts or regulations are specifically exempt under section 536.021, RSMo. Public hearings were held on October 21 and 28, 2010, in St. Louis and Jefferson City.

This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*. This rule describes Missouri's services for infants and toddlers with disabilities, in accordance with Part C of the Individuals with Disabilities Education

Act (IDEA), Public Law 105-17.

5 CSR 70-742.141 Individuals with Disabilities Education Act, Part C. This order of rulemaking makes changes to section (2) and amends the incorporated by reference material, *Regulations Implementing Part C of the Individuals with Disabilities Education Act First Steps Program.*

(2) The Missouri state plan for the regulations implementing Part C of the Individuals with Disabilities Education Act (IDEA) First Steps Program contains the administrative provisions for the delivery of the state's federally assisted early intervention system. The Missouri state plan for the IDEA, Part C is hereby incorporated by reference and made a part of this rule. A copy of the IDEA, Part C (revised January 2011) is published by and can be obtained from the Department of Elementary and Secondary Education, Special Education Compliance Section, 205 Jefferson Street, PO Box 480, Jefferson City, MO 65102-0480. This rule does not incorporate any subsequent amendments or additions.

AUTHORITY: sections 160.900–160.925 and 161.092, RSMo Supp. 2010, Executive Order 94-22 of the Governor, Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Original rule filed Dec. 29, 1997, effective March 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed March 1, 2011.*

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

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

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.200 Purpose and Structure **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1562). 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: A public hearing on this proposed amendment was held December 1, 2010, and the public comment period ended December 1, 2010. At the public hearing, the department staff explained the proposed amendment and one (1) comment was made.

COMMENT #1: Denise Clemonds, Missouri Association of Homes for the Aging, commented that there is no statutory basis for "negotiating" competing interests and agreed that the purpose statement required clarification.
RESPONSE: This comment is in agreement with the amendment. No changes have been made to the rule as a result of this comment.

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

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.300 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1562–1563). 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: A public hearing on this proposed amendment was held December 1, 2010, and the public comment period ended December 1, 2010. At the public hearing, the department staff explained the proposed amendment and three (3) comments were made.

COMMENT #1: Denise Clemonds, Missouri Association of Homes for the Aging, commented that the proposed definition is necessary to support other proposed rule amendments.
RESPONSE: This comment is in agreement with the amendment. No change has been made to the rule as a result of this comment.

COMMENT #2: Greg Bratcher, BJC HealthCare, commented that any facility which requires a license cannot submit a request for non-applicability review, even if the cost is below the expenditure minimum.
RESPONSE: This comment is outside of the purview of the amendment change and, therefore, cannot be addressed at this point. No change has been made to the rule as a result of this comment.

COMMENT #3: Jon Dolan, Missouri Health Care Association, commented that the new non-applicability procedure for certain types of projects does not provide for an appropriate level of scrutiny or public input and exceeds the regulatory authority of the Missouri Health Facilities Review Committee.
RESPONSE AND EXPLANATION OF CHANGE: The department concurs with this conclusion and has deleted the language regarding expansion and replacement projects being subject to non-applicability review.

19 CSR 60-50.300 Definitions for the Certificate of Need Process

(12) Non-applicability review means a Letter of Intent process to document that a CON is not needed for a proposal when the capital expenditure is less than the minimums in section 197.305(6), RSMo; the proposal is to increase the number of beds by ten (10) or more than ten percent (10%) of total bed capacity, whichever is less, over a two (2)-year period; an exemption or exception is found in accordance with section 197.312, RSMo, or section 197.314(1), RSMo; or the proposal meets the definition of a non-substantive project.

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

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.400 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1563–1564). 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: A public hearing on this proposed amendment was held December 1, 2010, and the public comment period ended December 1, 2010. At the public hearing, the department staff explained the proposed amendment and four (4) comments were made.

COMMENT #1: Denise Clemonds, Missouri Association of Homes for the Aging, commented that the proposed changes will save time, trouble, and money for applicants and relieve Certificate of Need (CON) staff workload.
RESPONSE: This comment is in agreement with the amendment. No change has been made to the rule as a result of this comment.

COMMENT #2: Greg Bratcher, BJC HealthCare, commented that any facility which requires a license is subject to review, even if the cost is below the expenditure minimum, and any new hospital, regardless of cost, is subject to review.
RESPONSE: This comment is outside of the purview of the amendment change and, therefore, cannot be addressed at this point. No change has been made to the rule as a result of this comment.

COMMENT #3: Richard D. Watters, Lashly & Baer, P.C., commented that the provision for testing a Letter of Intent for applicability needs to be more clearly defined.
RESPONSE: The agency believes the current provisions are clear and no additional definitions are needed at this time. No change has been made to the rule as a result of this comment.

COMMENT #4: Jon Dolan, Missouri Health Care Association, commented that the new non-applicability procedure for certain types of projects does not provide for an appropriate level of scrutiny or public input and exceeds the regulatory authority of the Missouri Health Facilities Review Committee.
RESPONSE AND EXPLANATION OF CHANGE: The department concurs with this conclusion and has deleted the language regarding expansion and replacement projects being subject to non-applicability review.

19 CSR 60-50.400 Letter of Intent Process

(3) An LTC bed expansion or replacement sought pursuant to sections 197.318.8 through 197.318.10, RSMo, requires a CON application if the capital expenditure for such bed expansion or replacement exceeds six hundred thousand dollars ($600,000), but allows for shortened information requirements and review time frames.

(6) The CONP staff, as an agent of the Missouri Health Facilities Review Committee (committee), will review LOIs according to the following provisions:

(B) The CONP staff shall test the LOI for applicability in accordance with statutory provisions for expenditure minimums, exemptions, and exceptions;

(C) If the test verifies that a statutory exception or exemption is met on a proposed project, or the proposed cost is below all applicable expenditure minimums, the committee chair may issue a Non-Applicability CON letter indicating the application review process is complete; otherwise, the CONP staff shall add the proposal to a list of Non-Applicability proposals to be considered at the next regularly scheduled committee meeting;

(D) If an exception or exemption is not verified, and if the proposal is above any applicable expenditure minimum, then a CON application will be required for the proposed project;

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

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.410 Letter of Intent Package **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1564–1565). 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.

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Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.420 Review Process **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1565–1566). 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: A public hearing on this proposed amendment was held December 1, 2010, and the public comment period ended December 1, 2010. At the public hearing, the department staff explained the proposed amendment and two (2) comments were made.

COMMENT #1: Denise Clemonds, Missouri Association of Homes for the Aging, commented that the proposed rules relieve the heavy workload of the committee members and staff.
RESPONSE: This comment is in agreement with the amendment. No change has been made to the rule as a result of this comment.

COMMENT #2: Richard D. Watters, Lashly & Baer, P.C., commented that the rule be amended to expand the notification of review for certain applications.
RESPONSE: The agency believes the current notification process is adequate; however, the agency will review for possible future changes. No change has been made to the rule as a result of this comment.

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Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.430 Application Package **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1566–1568). 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.

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Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.440 Criteria and Standards for Equipment and New Hospitals **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1569). 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.

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Division 60—Missouri Health Facilities Review Committee
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ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.450 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1569–1571). 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: A public hearing on this proposed amendment was held December 1, 2010, and the public comment period ended December 1, 2010. At the public hearing, the department staff explained the proposed amendment and three (3) comments were made.

COMMENT #1: Denise Clemonds, Missouri Association of Homes for the Aging, commented that the increase in the bed need methodology will enhance the safety and comfort of Missouri seniors. She also commented that expanding the non-applicability process will save time, trouble, and money for applicants and relieve workload for staff.
RESPONSE: This comment is in agreement with the amendment. No change has been made to the rule as a result of this comment.

COMMENT #2: Richard Watters, Lashly & Baer, P.C., commented that he supports the new assisted living facility methodology and recommends that consideration be given to increasing the need formula for skilled nursing facility beds as well.
RESPONSE: This request goes beyond the scope of the proposed amendment. No change has been made to the rule as a result of this comment.

COMMENT #3: Jon Dolan, Missouri Health Care Association, commented that the current need formulas are too permissive and should instead be more restrictive.
RESPONSE: After considerable study and deliberation, the agency concludes that the proposed methodology is appropriate at this time. Additional study and monitoring of occupancy will be ongoing.

COMMENT #4: Pursuant to comments received on 19 CSR 60-50.300 Definitions for the Certificate of Need Process and 19 CSR 60-50.400 Letter of Intent Process, staff noted similar language in this rule.
RESPONSE AND EXPLANATION OF CHANGE: The department has deleted the language regarding expansion and replacement projects being subject to non-applicability review.

19 CSR 60-50.450 Criteria and Standards for Long-Term Care

(2) Replacement Chapter 198 beds may qualify for an exception to the LTC bed minimum occupancy requirements (MOR) plus shortened information requirements and review time frames if an applicant proposes to—

(3) LTC bed expansions involving a Chapter 198 facility may qualify for an exception to the LTC bed MOR. In addition to the shortened information requirements and review time frames, applicants shall also submit the following information:

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Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.470 Criteria and Standards for Financial Feasibility **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1571). 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.

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Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.500 Additional Information **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1571–1572). 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 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.600 Certificate of Need Decisions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1572). 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 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.700 Post-Decision Activity **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1572–1573). 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
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ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 197.320, RSMo 2000, the department amends a rule as follows:

19 CSR 60-50.800 Meeting Procedures **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1573-1574). 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 INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2234—Board of Private Investigator Examiners
Chapter 1—General Rules

ORDER OF RULEMAKING

By the authority vested in the Board of Private Investigator Examiners under sections 324.1102 and 324.1132, RSMo Supp. 2010, the board amends a rule as follows:

20 CSR 2234-1.050 Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2010 (35 MoReg 1690–1693). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.