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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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HOW TO CITE RULES AND RSMo

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 11—DEPARTMENT OF PUBLIC SAFETY
Division 30—Office of the Director
Chapter 12—Forensic Examinations for Sexual Assault

EMERGENCY RULE

11 CSR 30-12.010 Payments for Sexual Assault Forensic Examinations

PURPOSE: This emergency rule sets out the reporting and billing procedures for appropriate medical providers who conduct sexual assault forensic examinations, commonly known as SAFE exams. This rule sets out the requirements for the appropriate medical provider in submitting a SAFE exam claim to the Department of Public Safety for payment. This rule also establishes the criteria by which SAFE exam expenses are paid and sets out the maximum payments for SAFE exams performed at an emergency room and the maximum payments for SAFE exams performed at a clinic.

EMERGENCY STATEMENT: This emergency rule sets out the maximum amounts that the Department of Public Safety will pay for a SAFE exam. SS#2 for SCS for SB 320, 96th General Assembly, First Regular Session (2011) specifically authorizes the department to establish maximum reimbursement rates for charges submitted, which shall reflect the reasonable cost of providing the forensic exam. During fiscal year (FY) 2011, the funds allocated for the SAFE exam program were insufficient to pay for the incoming SAFE exam claims. As a result, there were no funds available for payments to appropriate medical providers until the General Assembly approved and the governor signed a supplemental appropriation to allow payments to resume.

Section 14.137 of SS/SCS/HCS/HB 14, 96th General Assembly, First Regular Session, provided seven hundred fifty-two thousand dollars ($752,000) in supplemental appropriations to allow the department to pay pending claims for the remainder of FY 2011. To avoid a similar funding shortfall during FY 2012, which would likely lead to another freeze in payments to appropriate medical providers, this rule sets caps on payments for each SAFE exam.

The department held meetings on May 25, 2011, June 28, 2011, August 30, 2011, and October 21, 2011, with those hospitals, medical providers, and the Child Advocacy Centers that submit SAFE exam bills for payment. During the course of receiving feedback from these meetings, the rule language was revised multiple times to address concerns raised. As a result of this stakeholder process, the department was not able to file the emergency rule when the legislation authorizing rulemaking authority took effect on August 28, 2011.

As of November 30, 2011, the department has paid SAFE provider claims totaling $1,034,634.91. Projecting this payment amount over FY 2012, the department projects that it would pay out $2,483,123.60 for the entire year. While this amount would be within the $2.6 million budgeted for this fiscal year between state and federal funds, it leaves very little margin if there is any type of increase in claims received over the last seven (7) months of this fiscal year. To ensure that all sexual assault victims are able to access SAFE exams and that the state of Missouri is able to reimburse all providers for the remainder of FY 2012, the department takes the position that this emergency rule is critical for the continued and smooth operation of this important public safety program.

The Department of Public Safety believes this emergency rule is fair to all interested parties. This emergency rule was filed December 7, 2011, becomes effective December 17, 2011, and expires June 13, 2012.

(1) For purposes of this section, the following terms mean:

(A) "Appropriate medical provider," any licensed nurse, physician, or physician assistant, and any institution employing licensed nurses, physicians, or physician assistants, provided that such licensed professionals are the only persons at such institution to perform tasks under the provisions of this section;

(B) "Evidentiary collection kit," a kit used during a forensic examination that includes materials necessary for appropriate medical providers to gather evidence in accordance with the forms and procedures developed by the attorney general for forensic examinations;

(C) "Forensic examination" or "Sexual Assault Forensic Examination (SAFE) exam," an examination performed by an appropriate medical provider on a victim of an alleged sexual offense to gather evidence for the evidentiary collection kit or using other collection procedures developed for victims who are minors;

(D) "Medical treatment," the treatment of all injuries and health concerns resulting directly from a patient's sexual assault or victimization; and

(E) "Laboratory fees," those laboratory fees associated with a forensic examination of a child age thirteen (13) or under or those laboratory fees associated with lab tests which the appropriate medical provider deems necessary to determine whether the victim had been drugged.

(2) The victim or the victim's parent or guardian or the requesting agency shall consent in writing to the examination.

(3) Claims for payment of forensic examination expenses shall be submitted to the Missouri Department of Public Safety, Sexual Assault Forensic Examination (SAFE) Program, PO Box 1589, Jefferson City, MO 65102.

(4) Claims shall be made on the Sexual Assault Forensic Examination Program Report form approved by the Missouri attorney general. The appropriate medical provider must ensure that all lines of the report form are completely and legibly filled out. The appropriate medical provider shall sign and date the report. If the report is incomplete, unsigned, or not dated, the claim may be denied.

(5) To qualify for payment, all claims shall include the Sexual Assault Forensic Examination Program Report, the Sexual Assault Forensic Examination Checklist, and an itemized billing statement.

(6) For billing purposes, all appropriate charges for the sexual assault forensic examination shall be itemized with each billable procedure, service, or supply described, including the accompanying International Classification of Disease (ICD-9) and Current Procedural Terminology (CPT) code(s). Written explanation and reasoning may be required to justify certain codes.

(7) Payment shall not exceed—

(A) Nine hundred dollars ($900) for forensic exams performed in an emergency room, including all costs associated with the facility and the appropriate medical provider fee. Payment shall not exceed—

1. Five hundred and forty dollars ($540) for the emergency room fee if submitted separately; and

2. Three hundred and sixty dollars ($360) for the appropriate medical provider fee if submitted separately;

(B) Six hundred and fifty dollars ($650) for forensic exams performed in a clinic, including all costs associated with the facility and the appropriate medical provider. When the exam is performed by a physician, payment shall not exceed—

1. Two hundred and ninety dollars ($290) for the clinic fee if submitted separately;

2. Three hundred and sixty dollars ($360) for the appropriate medical provider fee if submitted separately; and

3. When the exam is performed in a clinic by an appropriate medical provider other than a physician, payment shall not exceed—

A. Three hundred and ninety dollars ($390) for the clinic fee if submitted separately; and

B. Two hundred and sixty dollars ($260) for the appropriate medical provider fee if submitted separately; and

(C) Two hundred dollars ($200) for any laboratory fees associated with the forensic examination, whether the forensic examination is conducted at an emergency room or clinic.

(8) The billing statement must include an itemization of the charges incurred while conducting the forensic examination, including, if applicable, the itemized laboratory fees.

(9) For the purposes of billing the Sexual Assault Forensic Examination Program, claims shall not include charges for medical procedures that are not part of the SAFE exam. The SAFE Program shall not pay for any portions of the itemized bill that are not part of the SAFE exam. The SAFE Program shall not pay for any laboratory fees associated with a SAFE exam except for qualified laboratory fees.

(10) All claims for sexual assault forensic examination charges must be submitted to the department within ninety (90) days from the date of the forensic examination.

(11) Only one (1) forensic examination per victim per sexual offense may be reimbursed.

(12) For a forensic examination to be eligible for reimbursement by the SAFE Program—

(A) The victim of the alleged sexual offense must be a Missouri resident; or

(B) The alleged sexual offense must have occurred in Missouri.

(13) The department, at its discretion, may require additional information regarding the forensic examination for auditing purposes.

AUTHORITY: section 595.220, RSMo Supp. 2011. Emergency rule filed Dec. 7, 2011, effective Dec. 17, 2011, expires June 13, 2012. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2011.

EXECUTIVE ORDER
11-25

WHEREAS, a State of Emergency was declared on April 22, 2011 pursuant to Executive Order 11-06 and extended by Executive Order 11-09, Executive Order 11-19 and Executive Order 11-23; and

WHEREAS, the State of Emergency will expire on December 15, 2011; and

WHEREAS, the tornadoes, floods and severe storms that have impacted the State caused catastrophic damage and significant loss of life and continue to cause distress and hazards to citizens and communities across the state; and

WHEREAS, the magnitude of the ongoing recovery efforts exceeds the capabilities of local jurisdictions and other established agencies and will necessitate the continued assistance of state emergency resources, including the Missouri National Guard; and

WHEREAS, there is still a need for replacement driver licenses, nondriver licenses, vehicle titles, license plates, tabs and other documents lost or destroyed during the devastating tornado that impacted the Joplin area; and

WHEREAS, cleanup efforts from the various natural disasters continue and it remains necessary for the Department of Natural Resources to be authorized to temporarily waive or suspend certain administrative or statutory rules or regulations to assist in the recovery effort; and

WHEREAS, several executive orders have been issued pursuant to the emergency powers contained in Chapter 44, RSMo, to aid in the response to these disasters and relieve the distress and hardship experienced by the affected citizens and communities.

NOW THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by the power vested in me by the Constitution and laws of the State of Missouri, including Chapter 44, RSMo, do hereby extend the declaration of emergency contained in Executive Order 11-06 (and extended by Executive Order 11-09, Executive Order 11-19 and Executive Order 11-23) until March 15, 2012 unless extended in whole or in part by subsequent order.

It is further ordered that Executive Order 11-07, Executive Order 11-11, and Executive Order 11-14 be extended until March 15, 2012 unless extended in whole or in part by subsequent order.

ATTEST:

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 14th day of December, 2011.

Jeremiah W. (Jay) Nixon
Governor

Robin Carnahan
Secretary of State

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

Entirely new rules are printed without any special symbology under the heading of 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 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 50—Division of School Improvement
Chapter 378—Instructional Grant Programs

PROPOSED RESCISSION

5 CSR 50-378.100 Read to be Ready Grant Program. This rule established procedures for the Read to be Ready Grant Program and for assisting districts with reading instruction and assessment.

PURPOSE: This rule is being rescinded since the Department of Elementary and Secondary Education has discontinued the application of the standards contained in this rule.

*AUTHORITY: section[s] 161.092, RSMo 1994, and **sections** 160.514, 167.340, 167.343, and 167.346, RSMo Supp. 1999. Original rule filed Sept. 27, 2000, effective May 30, 2001. Rescinded: Filed Dec. 12, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Elementary and Secondary Education, Office of General Counsel and Governmental Affairs, PO Box 480, Jefferson City, MO 65102-0480 or by email at counsel@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 50—Division of School Improvement
Chapter 380—Technology Grants

PROPOSED RESCISSION

5 CSR 50-380.010 General Provisions. This rule established procedures for implementing section 11 of the Outstanding Schools Act, pertaining to grants to schools for the acquisition of equipment to promote the use of technology.

PURPOSE: This rule is being rescinded since the Department of Elementary and Secondary Education has discontinued the application of the standards contained in this rule.

AUTHORITY: section 170.254, RSMo Supp. 1993. Original rule filed Dec. 21, 1993, effective July 10, 1994. Rescinded: Filed Dec. 12, 2011.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Elementary and Secondary Education, Office of General Counsel and Governmental Affairs, PO Box 480, Jefferson City, MO 65102-0480 or by email at counsel@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 50—Division of School Improvement
Chapter 390—Children At Risk

PROPOSED RESCISSION

5 CSR 50-390.010 Reductions of Pupil/Teacher Ratio for Children at Risk. This rule established criteria for pupil/teacher ratio reduction in schools containing high concentrations of children

who are least advantaged or who have specially identified educational needs, as authorized in section 166.260 of the Outstanding Schools Act and pursuant to section 163.011(6) and Line 14 of subsection 6 of section 163.031, RSMo.

PURPOSE: This rule is being rescinded since the Department of Elementary and Secondary Education has discontinued the application of the standards contained in this rule.

AUTHORITY: sections 163.011(6), 163.031, and 166.260, RSMo Supp. 1993. Original rule filed March 25, 1994, effective Oct. 30, 1994. Rescinded: Filed Dec. 12, 2011.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Elementary and Secondary Education, Office of General Counsel and Governmental Affairs, PO Box 480, Jefferson City, MO 65102-0480 or by email at counsel@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 30—Office of the Director
Chapter 12—Forensic Examinations for Sexual Assault

PROPOSED RULE

11 CSR 30-12.010 Payments for Sexual Assault Forensic Examinations

PURPOSE: This rule sets out the reporting and billing procedures for appropriate medical providers who conduct sexual assault forensic examinations, commonly known as SAFE exams. This rule sets out the requirements for the appropriate medical provider in submitting a SAFE exam claim to the Department of Public Safety for payment. This rule also establishes the criteria by which SAFE exam expenses are paid and sets out the maximum payments for SAFE exams performed at an emergency room and the maximum payments for SAFE exams performed at a clinic.

(1) For purposes of this section, the following terms mean:

(A) "Appropriate medical provider," any licensed nurse, physician, or physician assistant, and any institution employing licensed nurses, physicians, or physician assistants, provided that such licensed professionals are the only persons at such institution to perform tasks under the provisions of this section;

(B) "Evidentiary collection kit," a kit used during a forensic examination that includes materials necessary for appropriate medical providers to gather evidence in accordance with the forms and procedures developed by the attorney general for forensic examinations;

(C) "Forensic examination" or "Sexual Assault Forensic Examination (SAFE) exam," an examination performed by an appropriate medical provider on a victim of an alleged sexual offense to gather evidence for the evidentiary collection kit or using other collection procedures developed for victims who are minors;

(D) "Medical treatment," the treatment of all injuries and health concerns resulting directly from a patient's sexual assault or victimization; and

(E) "Laboratory fees," those laboratory fees associated with a forensic examination of a child age thirteen (13) or under or those laboratory fees associated with lab tests which the appropriate medical provider deems necessary to determine whether the victim had been drugged.

(2) The victim or the victim's parent or guardian or the requesting agency shall consent in writing to the examination.

(3) Claims for payment of forensic examination expenses shall be submitted to the Missouri Department of Public Safety, Sexual Assault Forensic Examination (SAFE) Program, PO Box 1589, Jefferson City, MO 65102.

(4) Claims shall be made on the Sexual Assault Forensic Examination Program Report form approved by the Missouri attorney general. The appropriate medical provider must ensure that all lines of the report form are completely and legibly filled out. The appropriate medical provider shall sign and date the report. If the report is incomplete, unsigned, or not dated, the claim may be denied.

(5) To qualify for payment, all claims shall include the Sexual Assault Forensic Examination Program Report, the Sexual Assault Forensic Examination Checklist, and an itemized billing statement.

(6) For billing purposes, all appropriate charges for the sexual assault forensic examination shall be itemized with each billable procedure, service, or supply described, including the accompanying International Classification of Disease (ICD-9) and Current Procedural Terminology (CPT) code(s). Written explanation and reasoning may be required to justify certain codes.

(7) Payment shall not exceed—

(A) Nine hundred dollars ($900) for forensic exams performed in an emergency room, including all costs associated with the facility and the appropriate medical provider fee. Payment shall not exceed—

1. Five hundred and forty dollars ($540) for the emergency room fee if submitted separately; and

2. Three hundred and sixty dollars ($360) for the appropriate medical provider fee if submitted separately;

(B) Six hundred and fifty dollars ($650) for forensic exams performed in a clinic, including all costs associated with the facility and the appropriate medical provider. When the exam is performed by a physician, payment shall not exceed—

1. Two hundred and ninety dollars ($290) for the clinic fee if submitted separately;

2. Three hundred and sixty dollars ($360) for the appropriate medical provider fee if submitted separately; and

3. When the exam is performed in a clinic by an appropriate medical provider other than a physician, payment shall not exceed—

A. Three hundred and ninety dollars ($390) for the clinic fee if submitted separately; and

B. Two hundred and sixty dollars ($260) for the appropriate medical provider fee if submitted separately; and

(C) Two hundred dollars ($200) for any laboratory fees associated with the forensic examination, whether the forensic examination is conducted at an emergency room or clinic.

(8) The billing statement must include an itemization of the charges incurred while conducting the forensic examination, including, if applicable, the itemized laboratory fees.

(9) For the purposes of billing the Sexual Assault Forensic Examination Program, claims shall not include charges for medical procedures that are not part of the SAFE exam. The SAFE Program shall not pay for any portions of the itemized bill that are not part of the SAFE exam. The SAFE Program shall not pay for any laboratory fees associated with a SAFE exam except for qualified laboratory fees.

(10) All claims for sexual assault forensic examination charges must be submitted to the department within ninety (90) days from the date of the forensic examination.

(11) Only one (1) forensic examination per victim per sexual offense may be reimbursed.

(12) For a forensic examination to be eligible for reimbursement by the SAFE Program—

(A) The victim of the alleged sexual offense must be a Missouri resident; or

(B) The alleged sexual offense must have occurred in Missouri.

(13) The department, at its discretion, may require additional information regarding the forensic examination for auditing purposes.

AUTHORITY: section 595.220, RSMo Supp. 2011. Emergency rule filed Dec. 7, 2011, effective Dec. 17, 2011, expires June 13, 2012. Original rule filed Dec. 7, 2011.

PUBLIC COST: This proposed rule will result in a savings to the Department of Public Safety of up to three hundred forty-five thousand eight hundred sixty-five dollars and seventy-seven cents ($345,865.77) per year, assuming the number of claims processed in Fiscal Year 2011 remains constant. The proposed rule will result in a cost to public entities of less than five hundred dollars ($500).

PRIVATE COST: This proposed rule will cost private entities up to three hundred forty-five thousand eight hundred sixty-five dollars and seventy-seven cents ($345,865.77) per year, assuming the number of claims processed during FY 2011 is constant and that the average amount per claim also remains constant.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Public Safety, Director's Office, PO Box 749, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. **Department Title:** Department of Public Safety
Division Title: Office of the Director
Chapter Title: 595.220 – Forensic Examinations for Sexual Assault

Rule Number and Name:	11 CSR 30-12.010 – Payments for Sexual Assault Forensic Examinations
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Public Safety	Savings of up to $345,865.77

III. WORKSHEET

IV. ASSUMPTIONS

The Department of Public Safety anticipates a savings of up to $345,865.77 as a result of this proposed rule. Because this proposed rule sets out maximum reimbursement rates for hospitals, clinics and private laboratories that bill the Department of Public Safety for expenses incurred in performing Sexual Assault Forensic Exams (SAFE), and because those maximum rates are less than the average claim received by providers in Fiscal Year 2011. Below is the breakdown of projected savings the Department anticipates by provider type:

Hospital Emergency Rooms:
The Department projects savings of up to $149,892.39 in FY 2012.

In Fiscal Year 2011, the Department processed 1,305 claims for reimbursement from hospital emergency departments. The average amount paid per claim was $1,014.86. Multiplying the number of claims (1,305) and the average paid per claim ($1,014.86) resulted in a total payment to emergency rooms in FY 2011 of $1,324,392.39. Under the proposed rule, the amount that the Department will reimburse an emergency room for a

SAFE exam is capped at $900. Assuming that the new average claim would equal the proposed $900 cap, the resulting reimbursement (based on 1,305 claims) would be $1,174,500. This is a reduction in reimbursement of $149,892.39 as compared to the reimbursement provided in FY 2011 ($1,324,392.39 minus $1,174,500). Because this rule is being filed almost halfway into the current fiscal year, the actual impact may be less than $149,892.39 for FY 12 because there has been no cap in place for the first 5 months of this fiscal year (July – November 2011).

Child Advocacy Centers/Clinics:
The Department projects savings of up to $110,068 in FY 2012.

In Fiscal Year 2011, the Department processed 1,481 claims for reimbursement from Child Advocacy Centers and clinics. The average amount paid per claim was $724.32. Multiplying the number of claims (1,481) and the average paid per claim ($724.32) resulted in a total payment to clinics of approximately $1,072,718. Under the proposed rule, the amount the Department will reimburse a clinic for a SAFE exam is capped at $650. Assuming the new average claim would equal the proposed $650 cap, the resulting reimbursement (based on 1,481 claims) would be $110,068 ($1,072,718 minus $962,650). Because this rule is being filed almost halfway into the current fiscal year, the actual impact may be less than $110,068 for FY 12 because there has been no cap in place for the first 5 months of the fiscal year (July – November 2011).

Physicians:
The Department projects savings of up to $77,746.38 in FY 2012.

In Fiscal Year 2011, the Department processed 538 claims for reimbursement from physicians conducting SAFE exams. The average amount paid per claim was $504.51. Multiplying the number of claims (538) and the average paid per claim ($504.51) resulted in a total payment to physicians of approximately $271,426.38. Under the proposed rule, the maximum amount the Department will reimburse a medical provider is $360 whether the SAFE exam is performed at an emergency room or at a clinic. Using the $504.51 average reimbursement as a baseline, the projected reduction in payments to emergency room physicians would be $77,746.38 ($271,426.38 (538 claims x $504.51/claim) minus $193,680 (538 claims x $360/claim).

This projection assumes that clinics and hospitals will continue to bill separately to the extent they have in the past. Because the rule provides for a reduced reimbursement amount for hospitals ($540 vs. $900) and clinics ($390 vs. $650) if the facility bill is submitted separately from the provider bill, the rule may result in fewer separate bills filed by physicians and more "bundled" bills filed by the hospital emergency room or clinic.

Also, as noted above, the actual reductions in reimbursement may be less than $77,746.38 for FY 12 because there has been no cap in place for the current fiscal year (July – November 2011).

Private Laboratories:
The Department projects savings of up to $8,159 in FY 2012.

In Fiscal Year 2011, the Department processed 41 claims for reimbursement from private labs. These labs may receive reimbursement for these fees when the fees are associated with a forensic exam of a child age 13 or under or if the fees are associated with lab tests

which the appropriate medical provider deems necessary to determine whether the victim has been drugged.

The average amount paid per claim was $399. Multiplying the number of claims (41) and the average amount per claim ($399) resulted in a total payment to labs of $16,359 in FY 2011. Under the proposed rule, the amount a lab may receive in reimbursement is capped at $200. Assuming the new average claim would be paid at the new cap, the resulting reimbursement would be reduced by $8,159 ($16,359 minus $8,200 (41 claims x $200/claim). As noted previously, the actual amount of fiscal impact to the labs may be less than $8,159 for FY 12 because there has been no cap in place for the first 5 months of the current fiscal year (July – November 2011).

All of the assumptions are based in the number of claims received in FY 2011. If the number of claims increases in FY 2012, the reduction in total payments for the year will be smaller. If the number of claims decreases in FY 2012, the reduction in total payments for the year will be greater.

Conclusion:
Adding the projected savings from each of the providers above, the Department anticipates that it could save up to $351,265.77 as a result of implementation of the proposed rule:

Savings from reduced reimbursements to hospital emergency rooms ($149,892.39) + savings from reduced reimbursements to child advocacy centers/clinics ($110,068) + savings from reduced reimbursements to physicians ($77,746.38) + savings from reduced reimbursements to private laboratories ($8,159) = $345,865.77

FISCAL NOTE
PRIVATE COST

I. Department Title: Department of Public Safety
Division Title: Office of the Director
Chapter Title: 595.220 – Forensic Examinations for Sexual Assault

Rule Number and Title:	11 CSR 30-12.010 Payments for Sexual Assault Forensic Examinations
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Hospitals - 35	Hospital Emergency Rooms	Up to $149,892.39
Child Advocacy Centers/Clinics - 6	Child Advocacy Centers or medical clinics	Up to $110,068
Physicians – 20	Physicians who bill SAFE Program separately from the hospital or clinic	Up to $77,746.38
Private Laboratories – 3	Labs providing certain tests for sexually transmitted diseases or to determine if a victim of a sexual assault was drugged	Up to $8,159
Total		Up to $345,865.77

III. WORKSHEET

IV. ASSUMPTIONS

The costs set out in Part II reflect the projected lost reimbursement for those appropriate medical providers who submit bills for Sexual Assault Forensic Exams (SAFE). While the proposed rule should not result in any new administrative costs for providers submitting claims for reimbursement, the projected costs reflect the reduction in the average reimbursement for each type of provider, assuming that each provider would submit the maximum amount authorized for reimbursement under the rule. To the extent that a provider's average reimbursement would be less under the proposed rule than the average current reimbursement, that difference is reflected above.

Hospital Emergency Rooms:
In Fiscal Year 2011, the Department processed 1,305 claims for reimbursement from hospital emergency departments. The average amount paid per claim was $1,014.86. Multiplying the number of claims (1,305) and the average paid per claim ($1,014.86) resulted in a total payment to emergency rooms in FY 2011 of $1,324,392.39. Under the proposed rule, the amount that the Department will reimburse an emergency room for a SAFE exam is capped at $900. Assuming that the new average claim would equal the proposed $900 cap, the resulting reimbursement (based on 1,305 claims) would be $1,174,500. This is a reduction of $149,892.39 as compared to the reimbursement provided in FY 2011 ($1,324,392.39 minus $1,174,500). Because this rule is being filed almost halfway into the current fiscal year, the actual impact may be less than $149,892.39 for FY 12 because there has been no cap in place for the first 5 months of this fiscal year (July – November 2011).

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In Fiscal Year 2011, the Department processed 1,481 claims for reimbursement from Child Advocacy Centers and clinics. The average amount paid per claim was $724.32. Multiplying the number of claims (1,481) and the average paid per claim ($724.32) resulted in a total payment to clinics of approximately $1,072,718. Under the proposed rule, the amount the Department will reimburse a clinic for a SAFE exam is capped at $650. Assuming the new average claim would equal the proposed $650 cap, the resulting reimbursement (based on 1,481 claims) would be $110,068 ($1,072,718 minus $962,650). Because this rule is being filed almost halfway into the current fiscal year, the actual impact may be less than $110,068 for FY 12 because there has been no cap in place for the first 5 months of the fiscal year (July – November 2011).

Physicians:
In Fiscal Year 2011, the Department processed 538 claims for reimbursement from physicians conducting SAFE exams. The average amount paid per claim was $504.51. Multiplying the number of claims (538) and the average paid per claim ($504.51) resulted in a total payment to physicians of approximately $271,426.38. Under the proposed rule, the maximum amount the Department will reimburse a medical provider is $360 whether the SAFE exam is performed at an emergency room or at a clinic. Using the 504.51 average reimbursement as a baseline, the projected reduction in payments to emergency room physicians would be $77,746.38 ($271,426.38 (538 claims x $504.51/claim) minus $193,680 (538 claims x $360/claim).

This projection assumes that clinics and hospitals will continue to bill separately to the extent they have in the past. Because the rule provides for a reduced reimbursement amount for hospitals ($540 vs. $900) and clinics ($390 vs. $650) if the facility bill is submitted separately from the provider bill, the rule may result in fewer separate bills filed by physicians and more "bundled" bills filed by the hospital emergency room or clinic.

Also, as noted above, the actual reductions in reimbursement may be less than $77,746.38 for FY 12 because there has been no cap in place for the current fiscal year (July – November 2011).

Private Laboratories:
In Fiscal Year 2011, the Department processed 41 claims for reimbursement from private labs. These labs may receive reimbursement for these fees when the fees are associated with a forensic exam of a child age 13 or under or if the fees are associated with lab tests which the appropriate medical provider deems necessary to determine whether the victim has been drugged.

The average amount paid per claim was $399. Multiplying the number of claims (41) and the average amount per claim ($399) resulted in a total payment to labs of $16,359 in FY 2011. Under the proposed rule, the amount a lab may receive in reimbursement is capped at $200. Assuming the new average claim would be paid at the new cap, the resulting reimbursement would be reduced by $8,159 ($16,359 minus $8,200 (41 claims x $200/claim). As noted previously, the actual amount of fiscal impact to the labs may be less than $8,159 for FY 12 because there has been no cap in place for the first 5 months of the current fiscal year (July – November 2011).

All of the assumptions are based in the number of claims received in FY 2011. If the number of claims increases in FY 2012, the reduction in total payments for the year will be smaller. If the number of claims decreases in FY 2012, the reduction in total payments for the year will be greater.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 9—Internal Control System

PROPOSED AMENDMENT

11 CSR 45-9.118 Minimum Internal Control Standards *(MICS)*—Chapter R. The commission is amending the rule title and section (1).

PURPOSE: This amendment updates minimum internal control standards by adding new forms needed for wire transfers, accounting processes, cards and dice, and poker.

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter R—Forms, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter R does not incorporate any subsequent amendments or additions as adopted by the commission on *[September 29, 2010]* **December 7, 2011**.

AUTHORITY: section 313.004, RSMo 2000, and sections 313.800 and 313.805, RSMo Supp. 2010. Original rule filed June 30, 2010, effective Jan. 30, 2011. Amended: Filed Dec. 8, 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 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 February 29, 2012, 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 70—MO HealthNet Division
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

PROPOSED RULE

13 CSR 70-3.240 MO HealthNet Primary Care Health Homes

PURPOSE: This rule establishes the MO HealthNet Primary Care Health Home program for MO HealthNet participants with chronic conditions.

(1) Definitions.

(A) EMR—Electronic Medical Records, also referred to as Electronic Health Records (EHR).

(B) Health Home—A primary care practice or site that provides comprehensive primary physical and behavioral health care to MHD patients with chronic physical and/or behavioral health conditions, using a partnership or team approach between the Health Home practice's/site's health care staff and patients in order to achieve improved primary care and to avoid preventable hospitalization or emergency department use for conditions treatable by the Health Home.

(C) Learning Collaborative—Group training sessions that primary care providers must attend if they are chosen to participate in the MO HealthNet Health Home program. The training will include meetings with mandatory attendance by certain officers and medical staff of the Health Home site and monthly conference calls.

(D) Meaningful Use Stage One—The American Recovery and Reinvestment Act (ARRA) of 2009 created the Electronic Health Records (EHR) incentive payments program to provide Medicare or Medicaid incentive payments to eligible professionals in primary care practices. Meaningful use means that the eligible professionals or providers document that they are using certified EHR technology in ways that can be measured significantly in quality and in quantity. Stage one of meaningful use means the eligible professionals meet twenty (20) out of twenty-five (25) meaningful use objectives as specified by the Centers for Medicare and Medicaid Services (CMS).

(E) MHD—MO HealthNet Division, Department of Social Services.

(F) NCQA—National Committee of Quality Assurance, the entity chosen by MHD to certify that a primary care practice has obtained a level of Health Home recognition after the practice achieves specified Health Home standards.

(G) Needy Individuals—Patients whose primary care services are either reimbursed by MHD or the Children's Health Insurance Program (CHIP), or are provided as uncompensated care by the primary care practice, or are furnished at no cost or at reduced cost to patients without insurance.

(H) Patient Panel—The list of patients for whom each provider at the practice site serves as the primary care provider.

(I) CMS—Centers for Medicare and Medicaid Services.

(2) A primary care practice site shall meet the following requirements at the time of the site's application to be considered for selection as a Health Home site by MHD and for participation in a Health Home learning collaborative:

(A) It must have substantial Medicaid utilization in its patient population, with needy individuals comprising no less than twenty-five percent (25%) of its patient population;

(B) It must demonstrate that it has strong engaged leadership committed to, and capable of, leading the practice site through a continuing Health Home transformation process and sustaining transformed practice processes;

(C) It must have patient panels assigned to each primary care clinician;

(D) It must actively utilize MHD's comprehensive electronic health record for care coordination and prescription monitoring for MHD participants;

(E) It must utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning;

(F) It must meet the minimum access requirements of third-next-available appointment within thirty (30) days and same-day urgent care;

(G) It must have completed EMR implementation and have been using EMR at stage one of meaningful use for at least six (6) months prior to the beginning of Health Home services; and

(H) It must comply with established time frames for Health Home applications, inquiry submission, learning collaborative attendance, and any reporting deadlines.

(3) Health Home Responsibilities After Selection.

(A) Health Home practice sites will be physician or nurse practitioner-led and shall form a health team comprised of, at a minimum, a primary care physician (i.e., family practice, internal medicine, or pediatrics) or nurse practitioner, a licensed nurse or medical assistant, a behavioral health consultant, a nurse clinical care manager,

and the practice administrator or office manager. The team will be supported as needed by the care coordinator and Health Home Director. Other team members may include, for example, dietitians, nutritionists, pharmacists, or social workers.

(B) Practice sites selected to be MHD Health Homes shall participate in Health Home learning collaboratives. MHD will announce the dates and locations for learning collaborative meetings.

1. At a minimum, each Health Home practice site shall send to the learning collaborative meetings a team consisting of a senior clinician, another clinician, and a non-clinician member of the practice (site) such as the practice manager or practice administrator.

2. A Health Home will participate in monthly learning collaborative conference calls or webinars.

3. A Health Home will participate in topical work groups as requested by MHD.

4. A practice organization that has more than one (1) of its practice sites recognized by MHD as Health Homes, but not all of its sites selected for learning collaborative participation, shall designate a trainer to participate in a "train the trainer" program. The trainer shall attend the learning collaborative as a member of a practice's core practice team and then train all of the organization's other Health Home practice sites that were not selected for learning collaborative participation. MHD or its designee shall identify content that the practice organization trainer will teach to the Health Home practice sites that do not participate in the learning collaborative.

(C) Health Homes shall convene practice team meetings at regular intervals to assist with the practice's transformation into a Health Home and to support continual Health Home evolution.

(D) A Health Home shall create and maintain a patient registry using EHR software, a stand-alone registry, or a third-party data repository and measures reporting system. The patient registry is the system used to obtain information critical to the management of the health of a primary care practice's patient population, including dates of services, types of services, and laboratory values needed to track chronic conditions. The Health Home's patient registry will be used for—

1. Patient tracking;

2. Patient risk stratification;

3. Analysis of patient population health status and individual patient needs; and

4. Reporting as specified by MHD.

(E) Primary care practice sites must transform how they operate in order to become Health Homes. Transformation involves mastery of thirteen (13) Health Home core competencies to be taught through the learning collaborative. The thirteen (13) core competencies are—

1. Patient/family/peer/advocate/caregiver-centeredness or a whole-patient orientation to care;

2. Multi-disciplinary team-based approach to care;

3. Personal patient/primary care clinician relationships;

4. Planned visits and follow-up care;

5. Population-based tracking and analysis with patient-specific reminders;

6. Care coordination across settings, including referral and transition management;

7. Integrated clinical care management services focused on high-risk patients including medication management, such as medication histories, medication care plans, and medication reconciliation;

8. Patient and family education;

9. Self-management support by members of the practice team;

10. Involvement of the patient in goal setting, action planning, problem solving, and follow-up;

11. Evidence-based care delivery, including stepped care protocols;

12. Integration of quality improvement strategies and techniques; and

13. Enhanced access.

(F) By the eighteenth month following the receipt of the first MHD Health Home payment, a practice site participating in the Health Home program shall demonstrate to MHD that the practice site has either—

1. Submitted to the National Committee of Quality Assurance (NCQA) an application for Health Home status and has obtained NCQA recognition of Health Home status at "Level 1 Plus." "Level 1 Plus" recognition is defined for these purposes as meeting 2011 NCQA Level 1 standards, plus recognition for achieving the following 2011 NCQA patient-centered medical home standard at the specified level of performance: Standard 3C at one hundred percent (100%), or at seventy-five percent (75%) with an acceptable plan of correction; or

2. Submitted to NCQA an application for Health Home status and has obtained NCQA recognition of Health Home status at "Level 1 Plus," defined as meeting NCQA 2008 PPC-PCMH Level 1 standards, plus recognition for achieving the following NCQA 2008 PPC-PCMH standards at the specified levels of performance: Standard 3C at seventy-five percent (75%), Standard 3D at one hundred percent (100%), and Standard 4B at fifty percent (50%).

(G) A Health Home shall submit to MHD or its designee the following information, as further specified by MHD or its designee, within the specified time frames:

1. Monthly narrative practice reports that describe the Health Home's efforts and progress toward implementing Health Home practices;

2. Monthly clinical quality indicator reports utilizing clinical data obtained from the Health Home's patient registry or third-party data repository;

3. Periodic submission of Medicaid Home Implementation Quotient (MHIQ) survey scores, as specified by MHD; and

4. Other reports as specified by MHD.

(H) Practices selected to participate in the Health Home program must provide evidence of Health Home practice transformation on an ongoing basis using measures and standards established by MHD. Evidence of Health Home transformation includes:

1. Development of fundamental Health Home functionality at six (6) months and at twelve (12) months of entering the Health Home program, based on an assessment process to be applied by MHD or its designee;

2. Significant improvement on clinical indicators specified by and reported to MHD or its designee; and

3. Development of quality improvement plans to address gaps and opportunities for improvement identified during and after the Health Home application process.

(I) A Health Home must notify MHD within five (5) working days of the following changes:

1. If the employment or contract of a clinical care manager is terminated after the initiation of clinical care management payments;

2. If the Health Home experiences substantive changes in practice ownership or composition, including:

A. Acquisition by another practice;

B. Acquisition of another practice; or

C. Merger with another practice.

(J) Health Homes shall participate in evaluations determined necessary by CMS and/or MHD. Participation in evaluations may require responding to surveys and requests for interviews of Health Home practice staff and patients. Health Homes shall provide all requested information to an evaluator in a timely fashion.

(K) Within three (3) months of selection to be a Health Home, a practice site will develop agreements or memorandums of understanding to formalize traditional care planning with area hospitals, in which the hospitals agree to—

1. Notify the Health Home when Health Home patients are admitted to inpatient hospital departments;

2. Identify for the Health Home individuals seeking emergency department services who might benefit from connection with the Health Home;

3. Notify the Health Home when Health Home patients seek treatment in the hospitals' emergency departments; and

4. Refer patients to the Health Home for follow-up care.

(4) Health Home Patient Requirements.

(A) To become a MO HealthNet Health Home patient, an individual—

1. Must be an MHD participant or a participant enrolled in an MHD managed care health plan; and

2. Must have at least—

A. Two (2) of the following chronic health conditions:

(I) Asthma;

(II) Diabetes;

(III) Cardiovascular disease;

(IV) A developmental disability; or

(V) Be overweight, as evidenced by having a body mass index (BMI) over twenty-five (25); or

B. One (1) chronic health condition and be at risk for a second chronic health condition as defined by MHD. In addition to being a chronic health condition, diabetes shall be a condition that places a patient at risk for a second chronic condition. Smoking or regular tobacco use shall be considered at-risk behavior leading to a second chronic health condition.

(B) A participant eligible for Health Home services and identified by MHD as an existing user of Health Home services will be auto-assigned to a Health Home based on qualifying chronic health conditions. A participant not enrolled in an MHD managed care health plan will be attributed to a Health Home using a standard patient algorithm adopted by MHD. A participant enrolled in an MHD managed care health plan will be attributed to a Health Home practice site that the participant has selected or to which the participant has been assigned by the health plan.

(C) After being assigned to Health Homes, participants will be granted the option at any time to change their Health Homes if desired. A participant assigned to a Health Home will be notified by MHD of all available Health Home sites throughout the state. The notice will—

1. Describe the participant's choice in selecting a Health Home;

2. Provide a brief description of Health Home services, including the role of care managers and coordinators; and

3. Describe the process for the participant to opt out of receiving services from the assigned Health Home provider.

(D) Participants eligible for Health Home services who receive inpatient hospital or hospital emergency department services will be notified of eligible Health Homes and will be referred to Health Homes based on their choice of providers. Participants who are admitted to a hospital or who receive hospital emergency department services will be identified as eligible for Health Home services through the MHD comprehensive Medicaid electronic health record.

(E) Health Home providers to which patients have been auto-assigned will be notified by MHD of patients' enrollment for Health Home services. The Health Homes will notify their patients' other treatment providers in order to explain Health Home goals and services, and to encourage their patients' other treatment providers to participate in care coordination efforts.

(5) Required Health Home Services.

(A) All Health Homes shall provide clinical care management services for enrolled patients, including those who are at high risk for future hospital inpatient admissions or hospital emergency department use.

1. Essential clinical care management services include:

A. Identification of high-risk patients and use of patient information to determine the level of participation in clinical care management services;

B. Assessment of preliminary service needs;

C. Individual treatment plan development for each patient, including patient goals, preferences, and optimal clinical outcomes;

D. Intensive monitoring, follow-up, and clinical management of high-risk patients;

E. Assignment of health team roles and responsibilities by the clinical care manager;

F. Monitoring of individual and population health status and service use to determine adherence to, or variance from, treatment guidelines;

G. Development of treatment guidelines for health teams to follow across risk levels or health conditions; and

H. Development and dissemination of reports that indicate progress toward meeting desired outcomes for client satisfaction, health status, service delivery, and costs.

2. Clinical care management activities generally include frequent patient contact, clinical assessment, medication review and reconciliation, communication with treating clinicians, and medication adjustment by protocol.

3. A Health Home shall employ or contract with at least one (1) licensed nurse as the Health Home clinical care manager responsible for providing clinical care management services. The clinical care manager shall function as a member of the Home Health practice team whenever patients of the practice team are receiving clinical care management services.

4. Health Homes shall ensure and document that funding for clinical care management services is used exclusively to provide clinical care management services.

5. Recognized Health Homes may collaborate in the provision of clinical care management services.

(B) Health Homes shall provide health promotion services for their patients. Health promotion services include:

1. Providing health education specific to a patient's chronic conditions;

2. Emphasizing patient self-direction, planning, and skill development so patients can help manage and monitor their chronic health conditions;

3. Providing support for improving social networks; and

4. Providing health-promoting lifestyle interventions, including but not limited to:

A. Substance abuse prevention;

B. Smoking prevention and cessation;

C. Nutritional counseling;

D. Obesity prevention and reduction; and

E. Physical exercise activities.

(C) All Health Homes shall provide comprehensive care coordination services necessary to implement individual treatment plans, reduce hospital inpatient admissions, and interrupt patterns of frequent hospital emergency department use.

1. Care coordination requires that a member of the Health Home team assist patients in the development, revision, and implementation of their individual treatment plans.

2. Care coordination also includes appropriate linkages, referrals, and follow-ups to needed services and supports.

3. Health Homes that specialize in primary physical health care shall obtain the services of a licensed behavioral health professional to assist with care coordination services.

4. Other essential care coordination activities include:

A. Appointment scheduling;

B. Arranging transportation for medically-necessary services;

C. Monitoring referrals and follow-ups;

D. Providing comprehensive transitional care by collaborating with physicians, nurses, social workers, discharge planners, pharmacists, and other health care professionals to continue implementation of patients' treatment plans;

E. For patients with developmental disabilities (DD), coordinating with DD case managers for services more directly related to habilitation and other DD-related services;

F. Referring Health Home patients to social and community resources for assistance in areas such as legal services, housing, and disability benefits; and

G. Providing individual and family support services by working with patients and their families to increase their abilities to manage the patients' care and live safely in the community.

(6) Hospitals and participating Health Home sites shall communicate transitional care planning for Health Home participants, including inpatient discharge planning, such that effective patient-centered, quality-driven provider coordination is ensured.

(7) Health Home Payment Components.

(A) General.

1. All Health Home payments to a practice site are contingent on the site meeting the Health Home requirements set forth in this rule. Failure to meet these requirements is grounds for revocation of a site's Health Home status and termination of payments specified within this rule.

2. MO HealthNet Health Home reimbursement will be in addition to a provider's existing MHD reimbursement for services and procedures and will not change existing reimbursement for a provider's non-Health Home services and procedures.

3. No Health Home payments will be made to an MHD Health Home until the calendar month immediately following the Health Home's first learning collaborative session.

4. Should experience reveal to MHD that elements of the Health Home payment methodology will not function, or are not functioning, as MHD intended, MHD reserves the right to make changes to the payment methodology after consultation with recognized Health Homes and receipt of required federal approvals.

(B) MHD Health Homes shall receive per-member-per-month (PMPM) payments to reimburse Health Home sites for costs incurred for patient clinical care management services, comprehensive care coordination services, health promotion services, and Health Home administrative and reporting costs.

1. A Health Home's PMPM reimbursement will be determined from the number of patients that choose, or are assigned to, the Health Home site.

2. A current month's PMPM payments to a Health Home site will be based on—

A. The number of Health Home-eligible patients receiving Health Home services at the Health Home in the month considered for payment;

B. The number of Health Home-eligible patients in subparagraph (7)(B)2.A. who are assigned to the Health Home at the beginning of the month considered for payment; and

C. The number of Health Home-eligible patients in subparagraphs (7)(B)2.A. and (7)(B)2.B. who are Medicaid-eligible at the end of the month considered for payment.

3. During the first year of participation in the Health Home program, a Health Home will receive PMPM payments only for MHD or MHD managed care participants—

A. With two (2) or more of the following chronic conditions:

(I) Asthma;

(II) Diabetes;

(III) Cardiovascular disease, including hypertension;

(IV) Overweight (BMI > 25); or

(V) Developmental disabilities; or

B. With one (1) of the conditions in subparagraph (7)(C)3.A. and be at risk for a second chronic condition because of diabetes or tobacco use.

4. In order to generate a PMPM payment to a Health Home, a patient assigned to the Health Home must have received at least one (1) non-Health Home service based on paid Medicaid fee for service or managed care claims.

5. In order to receive PMPM payments, a Health Home must demonstrate to MHD that the Health Home has hired, or has contracted with, a clinical care manager to provide services at the Health Home site.

(8) Health Home Corrective Action Plans.

(A) Health Homes shall undergo an assessment process to be applied by MHD or its designee at six (6) months and at twelve (12) months of entering the Primary Care Health Home program. If the assessment shows that a Health Home practice site fails to meet the Health Home requirements as set forth in section (3) of this rule, or fails to provide the required Health Home services as set forth in section (5) of this rule, the Health Home practice site shall participate in a corrective action plan to address any such failures disclosed as a result of the assessment process. The corrective action plan will last for six (6) months, and may be extended or renewed at MHD's discretion. At the end of the corrective action plan period, the Health Home practice site will be reassessed to determine its compliance with the requirements of this rule.

(B) The Health Home practice site will be reassessed at the end of the corrective action plan period, including any extensions and renewals granted by MHD. If the reassessment shows that the Health Home still fails to meet Health Home requirements or provide required Health Home services, MHD shall terminate the Health Home practice site from the Primary Care Health Home program.

AUTHORITY: section 208.201, RSMo Supp. 2011. Original rule filed Dec. 15, 2011.

PUBLIC COST: This proposed rule is expected to cost state agencies or political subdivisions $5,974,599 in SFY 2012 and $17,923,796 in SFY 2013.

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

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

FISCAL NOTE
PUBLIC COST

I. **Department Title:** Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 3 – Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

Rule Number and Name:	13 CSR 70-3.240 MO HealthNet Primary Care Health Home
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Social Services, MO HealthNet Division	SFY 2012: Total PMPM cost = $5,974,599; federal share = $5,377,139 state share = $597,460 SFY 2013: Total PMPM cost = $17,923,796; federal share = $16,131,416 state share = $1,792,380

III. WORKSHEET

	SFY 2012	SFY 2013
Number of Primary Care Health Home Patients	25,372	25,372
Primary Care Health Home Per-Member Per-Month (PMPM) Payment	$58.87	$58.87
Estimated Monthly PMPM Cost	$1,493,650	$1,493,650
Number of Months PMPM Payments Are Made	4	12
Estimated Health Home PMPM Cost per SFY	$5,974,599	$17,923,796
State Share of PMPM Cost	10%	10%
Estimated State PMPM Cost per SFY	$597,460	$1,792,380
Federal Share of PMPM Cost	90%	90%
Estimated Federal PMPM Cost per SFY	$5,377,139	16,131,416

IV. ASSUMPTIONS

See above Worksheet.

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

PROPOSED AMENDMENT

13 CSR 70-4.110 Placement of Liens on Property of Certain Institutionalized *[Medicaid] MO HealthNet* Eligible Persons. The division is amending the purpose statement and sections (1)–(5), adding new sections (3) and (8), and renumbering as needed.

PURPOSE: This amendment changes the purpose statement and sections (1)–(5) and adds new sections (3) and (8) to clarify the guidelines for placement of liens on the property of certain institutionalized MO HealthNet eligible persons in accordance with the authority given to states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended.

*PURPOSE: This rule implements the guidelines for placement of liens on the property of certain institutionalized [Medicaid] **MO HealthNet** eligible persons, in accordance with the authority given to states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended.*

(1) When an applicant for *[Medicaid]* **MO HealthNet** or a *[Medicaid recipient]* **MO HealthNet participant** is a patient, or will become a patient, in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, the Department of Social Services will determine if the placement of a lien against the property of the applicant or *[recipient]* **participant** is applicable. A lien is imposed on the property of an individual, in accordance with the authority given states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), when*[:]*—

(A) The *[Medicaid recipient]* **MO HealthNet participant** is or has made application to become a patient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution, to spend for costs of medical care all but a minimal amount of his/**her** income required for personal needs;

(B) The institutionalized *[Medicaid recipient]* **MO HealthNet participant** owns property. Property includes the homestead and all other real property in which the person has a sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than fair market value within thirty-six (36) months prior to the person entering the nursing facility;

(C) The department has determined after notice and opportunity for hearing that there is no reasonable expectation that the person can be discharged from the facility within one hundred twenty (120) days and return home. The hearing, if requested, will proceed under the provision of Chapter 536, RSMo, before a hearing officer designated by the director of the Department of Social Services. The fact that there is no reasonable expectation that the person can be discharged from the facility within one hundred twenty (120) days and return home may be substantiated by one (1) of the following:

1. Applicant/*[recipient]***participant** states in writing that he/she does not intend to return home within one hundred twenty (120) days;

2. Applicant/*[recipient]***participant** has been in the institution for longer than one hundred twenty (120) days; and

3. A physician states in writing that the applicant/*[recipient]* **participant** cannot be expected to be discharged within one hundred twenty (120) days of admission; and

(D) A lien is imposed on the property unless one (1) of the following persons lawfully resides in the property:

1. The institutionalized person's spouse;

2. The institutionalized person's child who is under twenty-one (21) years of age or is blind or permanently and totally disabled; **or**

3. The institutionalized person's sibling who has an equity interest in the property and who was residing in such individual's home for a period of at least one (1) year immediately before the date of the individual's admission to the institution.

(2) After determining the applicability of the lien, the *[Medicaid recipient]* **MO HealthNet participant** is given an Explanation of TEFRA Lien. A person who objects to the imposition of a lien is ineligible for medical assistance. Ineligibility is based on the person's objection without good cause to the imposition of the lien, which impedes the department's ability to implement its lien requirements.

(3) A lien may be imposed upon the property but the department will not seek adjustment or recovery of the costs of medical assistance correctly paid on behalf of the participant when the participant's child over the age of twenty-one (21) resides in the home and facts are established, to the satisfaction of the department, by sworn affidavit of the participant's child or authorized representative with personal knowledge of the facts, conclusively showing that—

(A) The participant's child has lived with and cared for the participant in the participant's home continuously for the two (2) years immediately prior to the participant entering a nursing facility, intermediate care facility for the mentally retarded, or other medical institution; and

(B) By providing that care the participant's child has allowed the participant to live at home rather than in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution; and

(C) The participant's child continues to reside in the home since the participant entered into a nursing facility, intermediate care facility for the mentally retarded, or other medical institution.

(D) Facts to be included in the affidavit shall include but not be limited to:

1. The number of days and hours each week the child was providing care to the participant; and

2. Types of care provided; such as, bathing and grooming, administering medication, providing therapeutic/health related activities; and

3. Types of assistance provided; such as, household chores/cleaning, maintenance, repair, improvements; and

4. Types of errands outside the home provided; such as, shopping for groceries and household items, transportation to medical visits, pharmacy, recreational and social activities, and religious activities.

(E) The department may, at its discretion, require the participant to provide documentation to support the statements in the affidavit.

(F) The affidavit must be provided to the MO HealthNet Division, TEFRA Lien Recoveries at P.O. Box 6500, Jefferson City, MO 65102-6500 in a timely manner before the lien has been satisfied against the participant's home.

(G) Upon a determination by the department that the facts established in the affidavit satisfy the department that the exception has been met, then the TEFRA Lien shall be maintained but not enforced so long as the child resides in the property and it is not sold, transferred, or leased, other than the child may take title to the property subject to the lien.

(H) Upon a determination by the department that the facts established in the affidavit do not satisfy the department that the exception has been met, then the lien may be enforced as otherwise provided in section (6).

(I) Participants who object to a TEFRA Lien in a timely manner under this subsection are entitled to a fair hearing, under the provision of Chapter 536, RSMo, before a hearing officer designated by the director of the Department of Social Services. A

timely objection must be made in writing to the department within ninety (90) days of the objected adverse decision.

*[(3)]***(4)** The director of the department or the director's designee will file for record, with the recorder of deeds of the county in which any real property is situated, a written Certificate of TEFRA Lien. The lien will contain the name of the *[Medicaid recipient]* **MO HealthNet participant** and a description of the property. The recorder will note the time of receiving such notice and will record and index the certificate of lien in the same manner as deeds of real estate are required to be recorded and indexed. The county recorder shall be reimbursed by presenting a statement showing the number of certificates and releases filed each calendar quarter to the Department of Social Services.

*[(4)]***(5)** The TEFRA lien will be for the debt due the state for medical assistance paid or to be paid on behalf of the *[Medicaid recipient]* **MO HealthNet participant**. The amount of the lien will be for the full amount due the state at the time the lien is enforced. Fees paid to county *[records]* **recorder** of deeds for filing of the lien will be included in the amount of the lien.

*[(5)]***(6)** The TEFRA lien does not affect ownership interest in a property until it is sold, transferred, or leased, or upon the death of the individual, at which time the lien must be satisfied*[.]***, subject to the following.**

(A) Any costs of sale of the property that are to be paid before the lien must be approved in advance by the department, and if a HUD-1 statement is prepared for that sale transaction, then a copy must be provided to the department prior to the closing for review and approval.

(B) Subject to the provisions of subsection (6)(A), in any case of a pending probate matter in a court of the state of Missouri for the administration of the assets and interests of the participant, including the property subject to the lien, then the following probate costs and expenses may be paid from the sale of the real estate at closing ahead of the lien:

1. Filing fees, publication fees, appraisal fees, personal representative fees, executor fees, attorney's fees; and

2. Costs to maintain and repair the property for sale; such as, insurance premiums, lawn care, necessary repairs to prepare for sale, customary real estate sales commissions, publication of sale notice; and the participant or authorized representative shall produce documentation to support costs and incurred expenses; and

3. Burial costs of the participant.

(C) The lien shall not be released against the real estate, except as required in section (7), until all net equity in the property remaining after closing costs after sale, transfer, or lease has been paid in satisfaction of the lien to the department, after payment of customary and approved costs from the sale proceeds as set forth in subsections (6)(A) and (6)(B). Closing costs are shared equally by all beneficiaries of the net proceeds of the real estate sale. In no case shall the state directly pay any costs of the sale or probate.

*[(6)]***(7)** The lien will be dissolved in the event the individual is discharged from the institution and returns home. A Notice of TEFRA Lien Release will be filed within thirty (30) days with the recorder of deeds of the county in which the original Certificate of TEFRA Lien was filed.

(8) The department shall apply a cost effectiveness review for each TEFRA lien when a reduction of recovery on the lien is requested. It shall be cost effective to accept a reduced recovery on a lien when the reduction is less than five hundred dollars ($500) and it appears that rejection of the reduced recovery would result in an even greater reduction in recovery, no recovery at all, or result in additional costs that net a recovery which is less than the requested reduction in recovery.

AUTHORITY: section[s] 208.201, RSMo 2000, and ***section*** *208.215 [as enacted by the 93rd General Assembly],* ***RSMo Supp. 2011****. Emergency rule filed Aug. 15 2005, effective Sept. 1, 2005, expired Feb. 27, 2006. Original rule filed May 16, 2005, effective Nov. 30, 2005. Amended: Filed Dec. 15, 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 amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person, or by courier within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

20 CSR 2010-2.022 Privilege to Practice. The board is proposing to amend section (2).

PURPOSE: This amendment removes the requirement that individuals from other states with a restricted license must fill out a provisional licensure form for privilege to practice.

(2) Any individual who has a valid but restricted license that otherwise meets the provisions of section (1), shall apply to the board in writing, on a *[provisional licensure]* form provided by the board, for practice privilege.

AUTHORITY: sections 326.256.1(9), 326.283.1(1), and 326.286.3, RSMo Supp. [2009] ***2011****. This rule originally filed as 4 CSR 10-2.022. Emergency rule filed Nov. 15, 2001, effective Nov. 25, 2001, expired May 23, 2002. Original rule filed Nov. 15, 2001, effective June 30, 2002. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Dec. 2, 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 Board of Accountancy, PO Box 613, Jefferson City, MO 65102, by facsimile at (573) 751-0012, or via email at mosba@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2165—Board of Examiners for Hearing Instrument Specialists
Chapter 2—Licensure Requirements

PROPOSED AMENDMENT

20 CSR 2165-2.050 Continuing Education Requirements. The board is proposing to amend paragraph (1)(A)1. and subsection (1)(C), add a new section (2), and renumber the remaining section accordingly.

PURPOSE: This amendment allows the board to approve an alternative continuing education program for any licensee who submits a request stating good cause.

(1) The following guidelines govern the attendance and approval of educational programs for license renewal:

(A) The board may approve individual educational programs whose curriculum provides training which enhances the licensee's ability to dispense hearing instruments and which benefits the hearing impaired. Documentation supporting the educational program's relevance is required. The board will automatically approve continuing education programs that are approved by the following organizations without requiring documentation supporting the educational program's relevance:

1. *[International Hearing Society (IHS)]* **International Institute for Hearing Instrument Studies (IIHIS)**;
2. American Speech and Hearing Association (ASHA);
3. American Academy of Audiology (AAA);

(C) The licensee may submit the information outlined in 20 CSR 2165-2.050(1)(B) to the board for review and approval **of a particular class**.

(2) The board, for good cause shown, may approve continuing education hours or waive continuing education hours required for an individual licensee in lieu of satisfying the requirements of 20 CSR 2165-2.050(1) and 20 CSR 2165-2.060. The board may make such approval or waiver conditional. A request for approval or waiver of continuing education hours shall be submitted in writing to the board no less than thirty (30) days prior to the continuing education requirement deadline for which the approval or waiver is sought.

*[(2)]***(3)** Each licensee shall be provided with evidence of attendance from the sponsoring organization. This evidence shall be in the form of documentation received from the sponsoring organization, showing the name of the course, date, place**,** and hours of attendance. All licensees shall maintain full and complete records of all approved continuing education hours earned for the two (2) previous reporting periods in addition to the current reporting period.

*AUTHORITY: sections **346.095 and** 346.115[.170)], RSMo [2000] **Supp. 2011**. This rule originally filed as 4 CSR 165-2.050. Original rule filed Oct. 16, 1996, effective May 30, 1997. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Dec. 2, 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 Board of Examiners for Hearing Instrument Specialists, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 526-3856, or via email at behis@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*