



Rules of
Department of Insurance,
Financial Institutions and
Professional Registration
Division 400—Life, Annuities and Health
Chapter 7—Health Maintenance Organizations

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**Title 20—DEPARTMENT OF
INSURANCE, FINANCIAL
INSTITUTIONS AND
PROFESSIONAL REGISTRATION
Division 400—Life, Annuities and Health
Chapter 7—Health Maintenance
Organizations**

**20 CSR 400-7.010 Forms Which Must be
Approved Prior to Use**

PURPOSE: This rule describes the forms which must be filed by a health maintenance organization with the Department of Insurance for approval prior to use. This rule is promulgated pursuant to sections 354.405 and 354.485, RSMo.

(1) The following forms shall not be delivered or issued for delivery in this state until they have been submitted to the Missouri Department of Insurance and approved by the director:

- (A) Group and individual contracts;
- (B) Evidence of coverage to be issued to the enrollees;
- (C) Application forms;
- (D) Enrollment forms;
- (E) Riders;
- (F) Amendments;
- (G) Endorsements; and
- (H) Any other forms which are intended to become part of a contract which is provided to an enrollee or group subscriber.

(2) Each filing shall be made in accordance with the procedures outlined in 20 CSR 400-8.200.

*AUTHORITY: sections 354.405 and 354.485, RSMo 1986. * This rule was previously filed as 4 CSR 190-15.075. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.405, RSMo 1983 and 354.485, RSMo 1983.*

**20 CSR 400-7.020 Changes to Documents
Submitted to Obtain Original Certificate
of Authority**

(Rescinded May 30, 2019)

AUTHORITY: sections 354.405, 354.410, 354.425 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.080. Original rule filed Nov. 2, 1987, effective April 11, 1988. Rescinded: Filed Nov. 19, 2018, effective May 30, 2019.

**20 CSR 400-7.030 Mandatory Provisions—
All Contracts**

PURPOSE: This rule sets forth the provisions which must be present in an evidence of coverage. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) All group and individual contracts and all evidences of coverage must contain in substance the following provisions, or provisions which in the opinion of the director of insurance are more favorable to the enrollee or at least as favorable to the enrollee and more favorable to the contract holder: name, address and telephone number of the administrative offices of the health maintenance organization (HMO) must appear on the face page; the face page is the first page that contains any written material; and if in booklet form, the first page inside the cover is the face page.

(2) Benefits. A description of all health care services available to an enrollee under the health care plan, including any copayments or other charges for which the member may be responsible.

(3) Cancellation. A statement that the HMO must give the group contract holder, in the case of group coverage, or the enrollee, in the case of individual coverage, at least thirty-one (31) days' prior notice of any cancellation or termination except termination for nonpayment of premium. In the case of group coverage, the HMO may not terminate the contract prior to the first anniversary date except for nonpayment of the required premium or the failure to meet continued underwriting standards.

(4) Claim Filing Procedure. A provision setting forth the procedure for filing claims, including:

(A) How, when and where to obtain claim forms, if required; and

(B) The requirements for providing proper notice of claim and proof of loss. Failure to furnish the notice or proof within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to give notice or proof within this time.

(5) Definitions. A provision defining any words in the evidence of coverage which have other than the usual meaning.

(6) Effective Date. A statement of the effective date requirements for various classes of enrollees.

(7) Eligibility. A statement of the eligibility requirements for coverage including:

(A) The condition under which dependent enrollees may be added to those originally covered;

(B) Any limiting age for enrollees and dependents, including effects of Medicare eligibility; and

(C) A clear statement regarding the coverage of newborn children. All evidences of coverage which provide coverage for a family member of the enrollee, as to this family member's coverage, also shall provide that the benefits applicable for children also shall be applicable with respect to a newly born child of the enrollee from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The HMO may require that the enrollee notify the HMO during the initial thirty-one (31) days after the birth of the child and pay any additional premium required to provide coverage for the newborn child from the date of birth.

(8) Emergency Services. A description of how to obtain services in an emergency situation, including:

(A) Any requirements that the HMO be contacted before the enrollee obtains care; and

(B) What to do in case of a life-threatening emergency.

(9) Out-of-Area Benefits and Services. The contract and evidence of coverage shall contain a specific description of benefits and services available out of the service area. Medically necessary emergency benefits must be available when the enrollee is temporarily outside the service area and—

(A) Medically necessary health services are immediately required;

(B) The condition for which the services are required could not have been foreseen;

(C) The enrollee's medical condition does not permit his/her return to the service area for treatment;

(D) The reason for being outside the service area must be for some purpose other than the receipt of treatment for a medically-related condition;

(E) The HMO may require notification from or on behalf of the enrollee as soon as possible; and

(F) Services received by the enrollee outside the service area will be covered until the enrollee's medical condition permits travel or transport to the HMO's service area.



(10) Entire Contract, Amendments. A provision stating that the contract and any attachments constitute the entire contract between the parties and that, to be valid, any change in the contract must be approved by an officer of the HMO and attached to the affected contract and that no insurance producer or representative has the authority to change the contract or waive any of the provisions.

(11) Exclusions and Limitations. A provision setting forth any exclusions and limitations on health care services.

(12) Time Limit on Certain Defenses. A provision that, in the absence of fraud, all statements made by an enrollee are considered representations and not warranties and that no statement voids the coverage or reduces the benefits after the coverage has been in force for two (2) years from its effective date, unless the statement was material to the risk assumed and contained in a written application. A copy of the written application or enrollment form must have been furnished to the enrollee if the terms of the application or enrollment form are to be applied.

(13) Schedule of Rates. A provision that discloses the HMO's right to change the rates charged and indicates the amount of prior notice which must be given.

(14) Service Area. A map or clear description of the service area indicating major primary and emergency care delivery sites.

(15) Termination Due to Attaining Limiting Age.

(A) Medicare. A provision describing the effect of becoming eligible for Medicare on the part of an enrollee or dependent.

(B) Handicapped Child. A provision that a child's attainment of a limiting age does not operate to terminate coverage of the child while that child is incapable of self-sustaining employment due to mental or physical handicap and chiefly dependent upon the enrollee for support and maintenance. The enrollee may be required to furnish proof of incapacity and dependency within thirty-one (31) days before the child's attainment of the limiting age and subsequently, as required, but not more frequently than annually following the child's attainment of the limiting age.

(16) Where to Obtain Services. A statement explaining where and in what manner information is available as to how services may be obtained.

(17) Every HMO that has a plan which will affect the choice of physician, hospital or

other health care provider, such as by refusing to cover services rendered by a provider not affiliated with the HMO, shall set forth conspicuously the following statement, or other wording which has been approved by the director to the same effect, on the following materials when given to current and prospective enrollees: certificates and evidences of coverage, member handbooks, provider directories and any materials which make a direct offer to an individual prospective enrollee to become a member of the HMO.

NOTICE

THIS HMO MAY HAVE RESTRICTIONS REGARDING WHICH PHYSICIANS OR OTHER HEALTH CARE PROVIDERS AN HMO MEMBER MAY USE. PLEASE CONSULT YOUR MEMBER HANDBOOK OR PROVIDER DIRECTORY FOR MORE DETAILS. IF YOU HAVE ANY ADDITIONAL QUESTIONS, PLEASE WRITE OR CALL US AT:

(HMO's Name)

(HMO's Address)

(HMO's Telephone Number)

(A) The HMO shall not be required to place such a statement in materials that constitute or represent supplemental benefit riders, copayment schedules or marketing or promotional material including, but not limited to, posters or print or media advertisements, which are not directed to specific individual enrollees but which may be directed toward a group(s) of enrollees.

(B) Every HMO shall include such a statement at the time promotional and descriptive materials, disclosure forms and certificates and evidences of coverage are issued or revised for distribution, but in no case later than the effective date of section (17) of this rule (January 1, 1994).

AUTHORITY: sections 354.430, 354.485, and 374.045, RSMo 2000. This rule was previously filed as 4 CSR 190-15.090. Original rule filed Nov. 2, 1987, effective April 11, 1988. Amended: Filed Nov. 3, 1992, effective Jan. 1, 1994. Amended: Filed July 12, 2002, effective Jan. 30, 2003.*

**Original authority: 354.430, RSMo 1983, amended 1997; 354.485, RSMo 1983; and 374.045, RSMo 1967, amended 1993, 1995.*

20 CSR 400-7.040 Additional Mandatory Provisions—Group Contracts and Evidences of Coverage

PURPOSE: This rule sets forth provisions which must be included in group contracts and evidences of coverage in addition to the provisions set forth in 20 CSR 400-7.030. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) Group contracts and evidences of coverage must contain in substance the following provision(s) which, in the opinion of the director of insurance, are more favorable to the enrollee or at least as favorable to the enrollee and more favorable to the contract holder in addition to those set out in 20 CSR 400-7.030.

(2) Evidence of Coverage. Provisions that the group contract holder must be provided with evidence of coverage to be delivered to each enrollee, that the evidence of coverage is a part of the group contract as if fully incorporated in the contract; and that any direct conflict between the group contract and the evidence of coverage will be resolved according to the terms which are most favorable to the enrollee. Note: This section does not apply if the same form is used for both the group contract and the evidence of coverage.

(3) New Employees. A provision specifying the conditions under which new enrollees may be added to those originally covered, including the terms under which coverage will be effective.

(4) Grace Period. A provision for a grace period of at least thirty-one (31) days for the payment of any premium falling due after the first premium, during which time the coverage remains in effect. Coverage may be terminated at the end of the grace period and, if services are rendered during the grace period, the group will be responsible for either the premium due or the value of services received.

AUTHORITY: sections 354.430 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.110. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.430, RSMo 1983, and 354.485, RSMo 1983.*

20 CSR 400-7.050 Additional Mandatory Provisions—Individual Contracts and Evidences of Coverage

PURPOSE: This rule sets forth provisions which must be included in individual contracts and evidences of coverage in addition



to the provisions set forth in 20 CSR 400-7.030. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) Individual contracts and evidences of coverage must contain in substance the following provision(s) which, in the opinion of the director of insurance, are at least as or more favorable to the enrollee, in addition to those set out in 20 CSR 400-7.030.

(2) Reinstatement. A provision that clearly sets forth the requirements for reinstatement and discloses how reinstatement changes or affects the rights and coverages originally provided. New evidence on insurability may be required.

(3) Ten (10) Days to Examine Agreement. A provision stating that the enrollee to whom the evidence of coverage is issued shall be permitted to return the evidence of coverage within ten (10) days of receiving it and have the premium paid refunded to them if, after examination of the agreement, the enrollee is not satisfied with it for any reason. If the enrollee, pursuant to provision, returns the evidence of coverage to the issuing health maintenance organization (HMO) or to the insurance producer or representative through whom it was purchased, it is considered void from the beginning and the parties are in the same position as if no evidence of coverage had been issued. If services are rendered or claims paid by the HMO during the ten (10) days, the person shall not be permitted to return the contract and receive a refund of the premium paid.

(4) Original Premium. The original premium for coverage must be stated in the evidence of coverage or in the application.

(5) Grace Period. A provision for a grace period of at least ten (10) days, for payment of any premium falling due after the first premium, during which time the coverage remains in effect. If payment is not received within ten (10) days, coverage may be cancelled after the tenth day. The terminated enrollee will be responsible for the cost of services received during the grace period if this requirement is disclosed in the evidence of coverage.

AUTHORITY: sections 354.430, 354.485 and 374.045, RSMo 2000. This rule was previously filed as 4 CSR 190-15.100. Original rule filed Nov. 2, 1987, effective April 11, 1988. Amended: Filed July 12, 2002, effective Jan. 30, 2003.*

**Original authority: 354.430, RSMo 1983, amended 1997; 354.485, RSMo 1983; and 374.045, RSMo 1967, amended 1993, 1995.*

20 CSR 400-7.060 Integration With Other Benefits

PURPOSE: This rule provides that a health maintenance organization integration provision must be consistent with the Coordination of Benefit Provisions in Group Health Plans set forth in 20 CSR 400-2.030. This rule is promulgated pursuant to section 354.485, RSMo.

Those provisions of a health maintenance organization (HMO) contract which are designed to coordinate with the benefits of other health plans must be consistent with the corresponding provisions of 20 CSR 400-2.030, Coordination of Benefit Provisions in Group Health Plans.

AUTHORITY: section 374.045, RSMo 2000. This rule was previously filed as 4 CSR 190-15.130 Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 374.045, RSMo 1983.*

20 CSR 400-7.070 Bonding Requirements

PURPOSE: This rule sets forth the health maintenance organization bond requirements and when those requirements will be deemed satisfied. This rule is promulgated pursuant to sections 354.425 and 354.485, RSMo.

(1) The requirement of section 354.425, RSMo that every health maintenance organization (HMO) shall maintain in force a surety bond on any director, officer or partner who receives, collects, disburses or invests funds in connection with the activities of the HMO will be deemed to be satisfied by a fidelity bond or contract of equal purpose. This bond or contract shall—

(A) Be in an amount of not less than one hundred thousand dollars (\$100,000) or other sum as may be prescribed by the director;

(B) Be written with at least a one (1)-year discovery period. If written with less than a three (3)-year discovery period, the bond or contract shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of ninety (90) days after written notice of the cancellation or termination has been filed with the director of the Department of Insurance, unless an earlier date is approved by the director; and

(C) Specify on the declaration page of the bond or contract the length of the discovery period and, if less than three (3) years, that the bond or contract complies with the ninety (90)-day notification of cancellation or ter-

mination provision of section 354.425, RSMo.

AUTHORITY: sections 354.425 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.140. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.425, RSMo 1983 and 354.485, RSMo 1983.*

20 CSR 400-7.080 Enrollee Protection Provisions

PURPOSE: This rule sets forth enrollee protection provisions. This rule is promulgated pursuant to section 354.485, RSMo.

(1) Providers who provide health care services to health maintenance organization (HMO)-covered enrollees pursuant to a provider contract between themselves and the HMO, under no circumstances (including, but not limited to, nonpayment by an HMO for medical services rendered to an enrollee by a provider, insolvency of an HMO or an HMO's breach of any term or condition of its agreement with a provider), shall bill, charge, collect a deposit, seek compensation, remuneration or reimbursement from or have any recourse against an enrollee or person acting on behalf of an enrollee for fees, charges or expenses relating to medical services which the HMO is obligated to provide and pay for under the terms of the enrollee's subscriber agreement with the HMO.

(2) In order to ensure compliance with this provision, no contract between an HMO and provider will be valid or enforceable by the provider unless the contract specifically establishes an independent contractor relationship between the HMO and the provider and further provides that under no circumstances (including, but not limited to, those sets of circumstances previously described) shall the provider bill, charge or in any way seek to hold an enrollee legally liable for the payment of any fees which are the legal obligation of the HMO as provided in this rule.

(3) The contract must further provide that the provision referred to in this rule will survive the termination of the provider's agreement with the HMO regardless of the cause of the termination and that the terms are applicable to, and binding upon, all individuals with whom a provider may subcontract to provide services to HMO enrollees. Nothing in this provision, however, shall in any way affect or limit a provider's right or obligation to collect from enrollees copayments, deductibles or fees assessed for noncovered services in



accordance with the agreement governing the enrollee's enrollment with the HMO.

AUTHORITY: section 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.160. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.485, RSMo 1983.*

20 CSR 400-7.090 Service Area Expansion

PURPOSE: This rule sets forth the information to be provided to the director by a health maintenance organization seeking to expand its service area. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) For a contiguous service area expansion request to be approved, the health maintenance organization (HMO) must provide the director with the following information in support of the request:

(A) If prior action of the HMO's board is required, minutes of the board meeting at which expansion was authorized and any related amendments to the basic organization document or bylaws;

(B) A map of the new service area showing locations of primary care physicians, hospitals and emergency care facilities;

(C) Any *pro forma* contracts or agreements with physicians and other providers in the new area; and

(D) A list of all physicians and other providers who have agreed to provide services in the new area.

(2) If the new area is not contiguous with the previously approved area, the following additional information must be provided:

(A) A brief narrative description of the administrative arrangements and other pertinent information;

(B) Biographical data sheets for the management staff assigned to the new area;

(C) Enrollee participation plan for the new area;

(D) Marketing information about the new area, including demographic material, enrollment projections for the period from the beginning of operations until operations in the new service area have produced a net income for twelve (12) consecutive months and proposed advertising and sales materials;

(E) Evidence of coverage to be used in the new area;

(F) Rates to be charged and appropriate actuarial certifications;

(G) Copies of leases, loans and contracts to be used in the proposed new area; and

(H) Sources of financing and financial projections for the period from the beginning of operations until operations in the new area will have produced a net income for twelve (12) consecutive months.

(3) The HMO shall provide other information as the director may consider necessary to adequately describe the proposal.

AUTHORITY: section 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.170. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.485, RSMo 1983.*

20 CSR 400-7.095 HMO Access Plans

PURPOSE: This rule clarifies the information required to be submitted as part of an access plan for a health maintenance organization's managed care plans pursuant to section 354.603, RSMo Supp. 2001, and the process for approval or disapproval of the access plans filed.

(1) Definitions.

(A) Access plan—The plan required to be filed with the department pursuant to section 354.603, RSMo, and in accordance with the requirements of this regulation.

(B) Categories of counties—

1. Urban access counties—Counties with a population of two hundred thousand (200,000) or more persons.

2. Basic access counties—Counties with a population between fifty thousand (50,000) persons and one hundred ninety-nine thousand, nine hundred ninety-nine (199,999) persons.

3. Rural access counties—Counties with a population of fewer than fifty thousand (50,000) persons.

4. Population figures shall be based on census data as reported in the latest edition of the *Official Manual of the State of Missouri*.

(C) Closed practice provider—A health care provider who does not accept new or additional patients from the health maintenance organization (HMO) that is reporting the provider as part of the managed care plan's network.

(D) Department—The Missouri Department of Insurance, Financial Institutions and Professional Registration.

(E) Distance standard—The travel distance standards set forth in Exhibit A, which is included herein. Each distance standard represents the maximum number of miles an enrollee may be required to travel in order to access participating providers of the managed

care plan. The standards set forth in Exhibit A shall be used to evaluate enrollee access in each county of an HMO's current service area.

(F) Employer specific network—A network created for a specific employer group that differs from the networks of all other managed care plans customarily offered by the HMO in either the identity or number of providers included within the network. An employer specific network constitutes a different or reduced network for the purposes of section 354.603.1(4), RSMo, and is a distinct managed care plan for access plan filing purposes.

(G) Enrollee access rate—The percentage of a managed care plan's enrollees living or working within a county who are able to access a participating provider within the travel distance standards set forth in Exhibit A.

(H) Health benefit plan—A policy, contract, certificate or agreement entered into, offered or issued by an HMO to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, and identified by the form number or numbers used by the HMO when the health benefit plan was filed for approval pursuant to 20 CSR 400-7.010 and 20 CSR 400-8.200.

(I) Hospitals—

1. Basic—Hospitals that meet any of the following criteria:

A. Licensed or state owned hospitals that designate themselves as general medical surgical hospitals in the Department of Health and Senior Services licensure survey and which offer general medical surgical care to all ages of the general population;

B. Hospitals located in an adjacent state, appropriately licensed or owned by that state, and offering general medical surgical care to all ages of the general population; or

C. Children's hospitals, except that children's hospitals shall not be included in the calculation of the basic hospital enrollee access rate.

2. Secondary—Basic hospitals reporting on the most recent available Department of Health and Senior Services licensure survey or other available sources of information that are appropriate and verifiable that the following services are available at the reporting hospital:

A. At least one (1) functioning operating room;

B. Obstetrics services except that hospitals delivering babies only on an emergency basis shall not be included in the calculation of the secondary hospital enrollee access rate; and

C. Intensive care services.



(J) Managed Care Plan—A health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use an identified set of health care providers managed, owned, under contract with or employed by the HMO. A managed care plan is a type of health benefit plan. For purposes of this rule, a managed care plan consists of a health benefit plan and a network. If an HMO offers managed care plans where the health benefit plan, the network or both differ, the HMO is offering more than one (1) managed care plan. For example:

1. If the HMO offers the same health benefit plan with two (2) different networks, the HMO is offering two (2) managed care plans.

2. If the HMO offers two (2) different health benefit plans with the same network, the HMO is offering two (2) managed care plans.

3. If the HMO offers two (2) different health benefit plans each with a different network, the HMO is offering two (2) managed care plans.

(K) Mental health facilities—

1. Inpatient mental health treatment facility—

A. A hospital offering staffed psychiatric or alcohol/chemical dependency beds and having psychiatrists on staff based on the most recent available Department of Health and Senior Services licensure survey; or

B. A facility recognized by the federal Substance Abuse and Mental Health Service Administration as a psychiatric hospital, a general hospital with a psychiatric unit; or

C. An inpatient substance abuse hospital, or an inpatient facility identified through other available sources of information that are appropriate and verifiable.

2. Ambulatory mental health treatment provider—

A. A hospital outpatient psychiatric or alcohol/chemical dependency service identified in the most recent available Department of Health and Senior Services licensure survey; or

B. A provider recognized by the Missouri Department of Mental Health as a community psychiatric rehabilitation center, a community psychiatric rehabilitation program, a community psychiatric rehabilitation day program, an outpatient program, an access crisis intervention program, an off-site day habilitation program, an on-site day habilitation program, a day program, a supported employment program, an alcohol or drug treatment and rehabilitation program, an alcohol or drug abuse prevention program; or

C. A provider recognized by the fed-

eral Substance Abuse and Mental Health Service Administration as a multi-setting mental health organization, a partial hospitalization/day treatment provider or an outpatient clinic; or

D. A nonresidential, non-inpatient provider of mental health related services identified through other available sources of information that are appropriate and verifiable.

3. Residential mental health treatment provider—

A. A provider recognized by the Missouri Department of Mental Health as a group home, a residential care facility, a semi-independent living arrangement, an intermediate care facility, a residential center, a residential habilitation provider, a supported living arrangement, a family living arrangement; or

B. A provider recognized by the federal Substance Abuse and Mental Health Service Administration as a residential substance abuse provider, a community residential organization, a residential treatment center for children; or

C. A provider of mental health services in residential settings identified through other available sources of information that are appropriate and verifiable.

(L) Network—The group of participating providers providing services to a managed care plan or pursuant to a health benefit plan established by an HMO. The meaning of the term network is further clarified for purposes of this rule as such: A network is one (1) component of a managed care plan. A network is the identified set of health care providers managed, owned, under contract with or employed by the HMO, either directly or indirectly, for purposes of rendering medical services to all enrollees of a managed care plan.

(M) Offer—An HMO is offering a managed care plan when it is presenting that managed care plan for sale in Missouri.

(N) Participating provider—A provider who, under a contract with the HMO or with the HMO's contractors or subcontractors, has agreed to provide health care services to all enrollees of a managed care plan with an expectation of receiving payment directly or indirectly from the HMO. The following types of providers are not participating providers:

1. Providers to which an enrollee may not go for covered services, with or without a referral from a primary care provider;

2. Providers that are only available in the event that an enrollee has a point-of-service benefit level, or other option attached to the HMO level of benefits; and

3. A provider that has agreed to render services to an enrolled person in an isolated instance for purposes of treating a medical need that cannot otherwise be met within the network.

(O) Pharmacy—Any pharmacy, drug store, chemical store or apothecary shop possessing a valid and current permit issued by the State of Missouri Board of Pharmacy and doing business for the purposes of compounding, dispensing and retailing any drug, medicine, chemical or poison to be used for filling a physician's prescription.

(P) Primary care provider (PCP)—A participating health care professional designated by the HMO to supervise, coordinate, or provide initial care or continuing care to an enrollee, and who may be required by the HMO to initiate a referral for specialty care and maintain supervision of health care services rendered to the enrollee. A PCP may be a professional who practices general medicine, family medicine, general internal medicine or general pediatrics. A PCP may be a professional who practices obstetrics and/or gynecology, in accordance with the provider contracts and health benefit plans of the HMO.

(Q) Specialist—A licensed health care professional whose area of specialization is in an area other than general medicine, family medicine or general internal medicine. A professional whose area of specialization is pediatrics, obstetrics and/or gynecology may be either a PCP or a specialist within the meaning of this rule.

(R) Tertiary services—Hospitals that offer the following types of services are required in every HMO network and will be identified through hospital responses to the most recent available annual Department of Health and Senior Services licensing survey or other available sources of information that are appropriate and verifiable:

1. Level I or Level II trauma hospital—a hospital as designated by the Department Health and Senior Services. A trauma unit that is designated as pediatric only does not satisfy the requirements of this rule.

2. Neonatal intensive care services—a hospital or children's hospital or secondary hospital offering neonatal intensive care services and at least one (1) functioning operating room.

3. Perinatology services—a secondary hospital with active board certified perinatologists on staff and a level II or III obstetrical unit.

4. Comprehensive cancer services—any hospital with active board certified oncologists on staff and providing all cancer treatment services listed in the annual licensing



survey, and at least one (1) functioning operating room.

5. Comprehensive cardiac services—any hospital with active board certified cardiovascular disease physicians on staff, at least one (1) functioning operating room and providing all interventional cardiac services and open heart surgery.

6. Pediatric subspecialty care—a hospital or children’s hospital or secondary hospital with active board certified pediatricians and pediatric specialists on staff, at least one (1) functioning operating room and providing intensive care services, neonatal intensive care services or pediatric intensive care services.

(2) Requirements for Filing Access Plans.

(A) Annual filing—By March 1 of each year, an HMO must file an access plan for each managed care plan it was offering in this state on January 1 of that same year. An HMO may file separate access plans for each managed care plan it offers, or it may file a consolidated access plan incorporating information for multiple managed care plans that it offers, so long as the information submitted with the consolidated access plan clearly identifies the managed care plan or plans to which it applies. The access plan must contain the following information for each managed care plan to which it applies:

1. Pursuant to section 354.603.2(1), RSMo, either:

A. Information regarding the participating providers in each managed care plan’s network and the enrollees covered by each managed care plan in a format to be determined by the department including, but not limited to, the following:

(I) The name, address where medical care is provided, zip code, professional license number or other unique identifier as assigned by the appropriate licensing or oversight agency, and specialty, degree or type of each provider;

(II) Whether or not the provider is a closed practice provider, as defined in subsection (1)(C) of this regulation, above; and

(III) The number of enrollees by either work or residence zip code in each managed care plan to which the access plan applies;

B. Proof of accreditation identifying the accredited entity and an affidavit in the form contained in Exhibit B, which is included herein, certifying that the managed care plan to which the affidavit applies has met one (1) or more of the following standards:

(I) The managed care plan is a Medicare+Choice (M+C) or successor coordinated care plan operated by the HMO

pursuant to a contract with the federal Centers for Medicare and Medicaid Services;

(II) The managed care plan is accredited by the National Committee for Quality Assurance (NCQA), or successor organization, at a level of “accredited” or better, and such accreditation is in effect at the time the access plan is filed;

(III) The managed care plan’s network is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), or successor organization, at a level of “accredited” or better, and such accreditation is in effect at the time the access plan is filed. The presence of any Type I recommendations for standards related to access to care shall prevent JCAHO accreditation from fulfilling the requirements of this part. The department shall annually review current JCAHO requirements and identify the specific JCAHO standards that address access to care. The department will annually notify all HMOs of those JCAHO standards that address access to care;

(IV) The managed care plan is accredited by the utilization review accreditation commission (URAC), or successor organization, at a level of full URAC Health Plan accreditation, and such accreditation is in effect at the time the access plan is filed; or

(V) The managed care plan or its network is accredited by any other nationally recognized managed care accrediting organization, similar to those above, that is approved by the department prior to the filing of the access plan, and such accreditation is in effect at the time the access plan is filed. Requests for approval of another nationally recognized managed care accrediting organization must be submitted to the department no later than October 15 of the year prior to the year the access plan is filed;

C. If the managed care plan’s service area has expanded beyond that which was in effect at the time the current accreditation was awarded, then the department may request additional data on that service area expansion pursuant to the provisions of (2)(A)1.A., above.

2. Pursuant to section 354.603.2(2) through (8), RSMo, a written description with any relevant supporting documentation addressing each of the requirements set forth in that statute.

3. Pursuant to section 354.603.2(9), RSMo, the following information:

A. For all managed care plans, information demonstrating that:

(I) Emergency medical services—A written triage, treatment and transfer protocol for all ambulance services and hospitals is in place. The protocol shall address post-emer-

gency situations when members have received emergency care from a non-participating provider;

(II) Home health providers—Home health providers are contracted to serve enrollees in each county where enrollment is reported. A home health provider need not be physically located or headquartered in each county. However, there must be at least one (1) home health provider under contract to serve enrollees in each county if the need arises; and

(III) Administrative measures are in place which ensure enrollees timely access to appointments with the medical providers listed in Exhibit A, based on the following guidelines:

(a) Routine care, without symptoms—within thirty (30) days from the time the enrollee contacts the provider;

(b) Routine care, with symptoms—within five (5) business days from the time the enrollee contacts the provider;

(c) Urgent care for illnesses/injuries which require care immediately, but which do not constitute emergencies as defined by section 354.600, RSMo—within twenty-four (24) hours from the time the enrollee contacts the provider;

(d) Emergency care—a provider or emergency care facility shall be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency care as defined by section 354.600, RSMo;

(e) Obstetrical care—within one (1) week for enrollees in the first or second trimester of pregnancy; within three (3) days for enrollees in the third trimester. Emergency obstetrical care is subject to the same standards as emergency care, except that an obstetrician must be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency obstetrical care; and

(f) Mental health care—Telephone access to a licensed therapist shall be available twenty-four (24) hours per day, seven (7) days per week.

B. For all managed care plans, a section demonstrating that the entire network is available to all enrollees of a managed care plan, including reference to contracts or evidences of coverage that clearly state the entire network is available and describing any network management practices that affect enrollees’ access to all participating providers;

C. For employer specific networks, a section demonstrating that the group contract holder agreed in writing to the different or reduced network. An employer specific



network is subject to the standards in this rule;

D. For all managed care plans, a listing of the product names used to market those plans;

E. For all managed care plans, written policies and procedures to assure that, with regard to providers not addressed in Exhibit A of this regulation, access to providers is reasonable. For otherwise covered services, the policies and procedures must show that the HMO will provide out-of-network access at no greater cost to the enrollee than for access to in-network providers if access to in-network providers cannot be assured without unreasonable delay; and

F. Any other information the department may require.

(B) Updates to annual filing—An HMO must file an updated access plan for a managed care plan if, at any time between the time annual access plan filings are due, one (1) of the following occurs:

1. If an affidavit was submitted for a managed care plan pursuant to the provisions of (2)(A)1.B., above, and the accreditation specified in the affidavit is no longer in effect, the HMO must file, within thirty (30) days of the date such accreditation is no longer in effect, or such longer period of time as the department determines is reasonable, either:

A. Network and enrollee information for the managed care plan as required by the provisions of (2)(A)1.A., above; or

B. If the accreditation has been replaced by alternative acceptable accreditation, an affidavit as required by the provisions of (2)(A)1.B., above.

2. If changes in the network or in the number or location of enrollees cause an accredited managed care plan not to meet any of the distance standards set forth in Exhibit A, the HMO must file, within thirty (30) days of such changes, updated network and enrollee information as required.

3. If network and enrollee information was submitted for a managed care plan pursuant to the provisions of (2)(A)1.A., above, and changes in the network or number of enrollees may cause the managed care plan not to meet any of the distance standards set forth in Exhibit A, the HMO must file, within thirty (30) days of such changes, updated network and enrollee information as required by the provisions of (2)(A)1.A., above.

(C) Prior to offering a new managed care plan—If at any time between the time annual access plan filings are due an HMO proposes to begin offering a new managed care plan in this state, the HMO must file an access plan

for the new managed care plan prior to offering the new managed care plan, including a managed care plan with an employer specific network.

(D) Waiver for the filing of the annual access plan—

1. An HMO may request a waiver of the filing of the annual access plan for a managed care plan if it certifies to the department that:

A. The HMO has notified enrollees of the managed care plan and producers with whom the HMO does business that the managed care plan is no longer being marketed, and the HMO has ceased writing any new contracts for the managed care plan; and

B. The HMO has informed enrollees of the managed care plan that they may access any provider at no greater cost than if that provider was a participating provider in the event the managed care plan cannot provide access to providers as required under this rule.

2. A request to waive the filing of the annual access plan for a managed care plan must be received by the department no later than January 15 of the year in which an access plan would otherwise be required.

(3) Evaluation of Access Plans.

(A) For the information submitted pursuant to section 354.603.2(1), RSMo, the information will be evaluated as follows:

1. If information regarding a managed care plan's network and enrollees is submitted, the department will calculate the enrollee access rate for each type of provider in each county in the HMO's approved service area to determine if the average enrollee access rate for each county and the average enrollee access rate for all counties is greater than or equal to ninety percent (90%). In calculating the enrollee access rate for a managed care plan, the department will give consideration to the following:

A. Tertiary services may be contracted at one (1) hospital, or among multiple hospitals; and

B. With the department's approval, a managed care plan's network may receive an exception for one (1) or more of the distance standards set forth in Exhibit A under the following circumstances:

(I) Quality of care exception—An exception may be granted if the managed care plan's access plan is designed to significantly enhance the quality of care to enrollees, demonstrates that it does in fact enhance the quality of care, and imposes no greater cost on enrollees than would be incurred if they had access to contracted, participating providers as otherwise required under this rule;

(II) Noncompetitive market exception for PCPs and pharmacies—In the event an HMO can demonstrate to the department that there is not a competitive market among PCPs and/or pharmacies who meet the HMO's credentialing standards, and who are qualified within the scope of their professional license to provide appropriate care and services to enrollees, the department may grant an exception for the managed care plan's network that doubles the distance standard indicated in Exhibit A for PCPs or pharmacies;

(III) Noncompetitive market exception for other provider types—If no provider (exclusive of PCPs and pharmacies) of the appropriate type provides services to enrollees of a managed care plan in a county within the distance standards indicated in Exhibit A, an exception may be granted if the HMO can demonstrate that no fewer than ninety percent (90%) of the population of that county (or, at the HMO's discretion, ninety percent (90%) of the enrollees residing or working in the county) have access to a participating provider of the appropriate type, which provider is located no more than twenty-five (25) miles further than the provider closest to that county;

(IV) Staff or Independent Practice Association (IPA) Model exception—An exception may be granted for those health care services provided to enrollees of the managed care plan if substantially all of those services are provided by the HMO to its enrollees through qualified full-time employees of the HMO or qualified full-time employees of a medical group that does not provide substantial health care services other than on behalf of such HMO. In order to qualify for the exception provided for in this part, an HMO must demonstrate that all or substantially all of the type of health care services in question are provided by full-time employees, that enrollees have adequate access to such health care services as described in the provisions of (2)(A)3.A., above, and that the contract holder was made aware of the circumstances under which such services were to be provided prior to the decision to contract with the HMO for that managed care plan; or

(V) Use of physician extenders—If there is insufficient availability of physicians of the appropriate type providing services to enrollees of a managed care plan in a county within the distance standards indicated in Exhibit A, an exception may be granted for the use of physician extenders. The HMO must demonstrate that enrollees residing or working in the county may access a participating provider who may be either a physician or an advanced practice nurse rendering



care under a collaborative agreement pursuant to 4 CSR 200-4.200, and in accordance with the provider contracts and health benefit plans of the HMO. An exception may be granted for other types of physician extenders in addition to advanced practice nurses if information is submitted justifying, to the satisfaction of the department, that the other types of physician extenders are able to provide the appropriate services within the scope of their license, and in accordance with the provider contracts and health benefit plans of the HMO.

2. If an affidavit is submitted, the department will review it to make sure that it meets all the requirements of Exhibit B. If the access plan is a consolidated access plan including information for more than one (1) managed care plan, the department will also review the affidavit for the following:

A. An affidavit that relies upon a managed care plan being an M+C or successor coordinated care plan will only apply to the specific managed care plan that is such a plan. All other managed care plans included in the access plan must be accompanied by either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating they are otherwise accredited pursuant to the provisions of (2)(B)1.B., above;

B. An affidavit that relies upon a managed care plan being accredited by the NCQA, or successor organization, will only apply to the specific managed care plan included with the accreditation. All other managed care plans included in the access plan must be accompanied by either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating they are otherwise accredited pursuant to the provisions of (2)(B)1.B., above;

C. An affidavit that relies upon a managed care plan's network being accredited by the JCAHO, or successor organization, will only apply to that portion of the managed care plan's network that is included within the accreditation. For the remainder of the network, either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating the remaining network is otherwise accredited pursuant to the provisions of (2)(B)1.B., above, must be submitted. All other managed care plans included in the access plan must be accompanied by either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating they are otherwise accredited pursuant to the provisions of (2)(B)1.B., above;

D. An affidavit that relies upon a managed care plan being accredited by

URAC, or successor organization, will only apply to the specific managed care plan included with the accreditation. All other managed care plans included in the access plan must be accompanied by either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating they are otherwise accredited pursuant to the provisions of (2)(B)1.B., above;

E. An affidavit that relies upon a managed care plan being accredited by any other nationally recognized managed care accrediting organization, similar to those above, will only apply to the specific managed care plan included with the accreditation. All other managed care plans included in the access plan must be accompanied by either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating they are otherwise accredited pursuant to the provisions of (2)(B)1.B., above.

(B) For information submitted pursuant to sections 354.603.2(2) through (9), RSMo, the department will evaluate the information to determine whether it is sufficient to meet the requirements of sections 354.600 to 354.636, RSMo, for each managed care plan to which the access plan applies.

(4) Approval or Disapproval of Access Plans.

(A) For a managed care plan for which network and enrollee information is submitted pursuant to the provisions of (2)(A)1.A. above, the department will:

1. Approve the access plan or portion of a consolidated access plan that applies to that managed care plan when the enrollee access rate across the entire network (all counties, all provider types) for that managed care plan is ninety percent (90%) or better, and the average enrollee access rate in each county in an HMO's approved service area for that managed care plan is ninety percent (90%) or better, and the information submitted pursuant to the provisions of (2)(A)2. and 3., above, is satisfactory;

2. Conditionally approve the access plan or portion of a consolidated access plan that applies to that managed care plan when the enrollee access rate across the entire network (all counties, all provider types) for that managed care plan is ninety percent (90%) or better, but the average enrollee access rate in any county for that managed care plan is less than ninety percent (90%), and the information submitted pursuant to the provisions of (2)(A)2. and 3., above, is satisfactory. If an access plan or portion of an access plan is conditionally approved, the department may require the HMO to present an action plan for increasing the enrollee access rate for that

managed care plan's network to ninety percent (90%) or better in those counties where this standard is not met; or

3. Disapprove the access plan or portion of a consolidated access plan that applies to that managed care plan when the enrollee access rate across the entire network (all counties, all provider types) for that managed care plan is less than ninety percent (90%) and/or the information submitted pursuant to the provisions of (2)(A)2. and 3., above, is unsatisfactory. Disapproval of the access plan or portion of the access plan will subject the HMO and its managed care plan to the enforcement mechanisms described in section (5), below, of this regulation.

(B) For a managed care plan for which an affidavit is submitted pursuant to (2)(A)1.B. above, the department will:

1. Approve the access plan or portion of a consolidated access plan that applies to that managed care plan when both the managed care plan's affidavit and the information submitted pursuant to (2)(A)2. and 3., above, are satisfactory; or

2. Disapprove the access plan or portion of a consolidated access plan that applies to that managed care plan when the managed care plan's affidavit and/or the information submitted pursuant to (2)(A)2. and 3., above, are unsatisfactory. Disapproval of the access plan or portion of the access plan will subject the HMO and its managed care plan to the enforcement mechanisms described in section (5), below, of this regulation.

(C) Approval of an access plan or portion of an access plan is subject to the following:

1. Approval of an access plan shall not remove any HMO's obligations to provide adequate access to care as expressed in this regulation or in section 354.603, RSMo. In any case where a managed care plan's network has an insufficient number or type of participating providers to provide a covered benefit, the HMO shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director. This may include, but is not limited to, the following:

A. With regard to the types of providers listed in Exhibit A and only those types of providers, allowing an enrollee access to a nonparticipating provider at no additional cost when no participating provider of that same type is within the distance standard prescribed by Exhibit A;

B. With regard to the types of providers listed in Exhibit A, and only those types of providers, allowing an enrollee access to a nonparticipating provider at no



additional cost when no participating provider is available to provide the service within the time prescribed in (2)(A)3.A.(III), above, for timely access to appointments; and

C. With regard to medical providers not expressly stated in Exhibit A, allowing an enrollee access to a nonparticipating provider at no additional cost when no participating provider is available without unreasonable delay, pursuant to the written policies and procedures of the HMO;

2. If there is no participating provider in a managed care plan's network with the appropriate training and experience to meet the particular health care needs of an enrollee, the HMO shall make arrangements with an appropriate nonparticipating provider, pursuant to a treatment plan developed in consultation with the primary care provider, the nonparticipating provider and the enrollee or enrollee's designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

(5) Enforcement Process for Disapproved Access Plans. If a managed care plan's access plan has been disapproved pursuant to section (4), above, it is subject to the following:

(A) The managed care plan may be placed on probationary status by the department for a period not to exceed ninety (90) days. If information sufficient to allow the department to "approve" or "conditionally approve" the managed care plan's access plan is submitted prior to the expiration of the probationary period, the managed care plan will be removed from probationary status;

(B) If the HMO fails to submit information sufficient to allow the department to "approve" or "conditionally approve" the managed care plan's access plan by the end of the probationary period, the department may, after notice and hearing pursuant to sections 354.470 and 354.490, RSMo, order the HMO to refrain from offering that managed care plan in part or all of the HMO's service area until such time as the HMO can demonstrate to the department's satisfaction that the managed care plan fully meets the requirements of this rule;

(C) If all of an HMO's managed care plans are disapproved at the time of renewal of the HMO's certificate of authority, the department may, after notice and hearing pursuant to section 354.490, RSMo, deny renewal of the HMO's certificate of authority until such time as the HMO demonstrates to the satisfaction of the department that one or more of its managed care plans meet the requirements of this regulation.



Exhibit A

Provider/Service Type	Distance Standards		
	Urban County	Basic County	Rural County
Physicians			
PCPs	10	20	30
Obstetrics/Gynecology	15	30	60
Neurology	25	50	100
Dermatology	25	50	100
Physical Medicine/Rehab	25	50	100
Podiatry	25	50	100
Vision Care/Primary Eye Care	15	30	60
Allergy	25	50	100
Cardiology	25	50	100
Endocrinology	25	50	100
Gastroenterology	25	50	100
Hematology/Oncology	25	50	100
Infectious Disease	25	50	100
Nephrology	25	50	100
Ophthalmology	25	50	100
Orthopedics	25	50	100
Otolaryngology	25	50	100
Pediatric	25	50	100
Pulmonary Disease	25	50	100
Rheumatology	25	50	100
Urology	25	50	100
General surgery	15	30	60
Psychiatrist-Adult/General	15	40	80
Psychiatrist-Child/Adolescent	22	45	90
Psychologists/Other Therapists	10	20	40
Chiropractor	15	30	60
Hospitals			
Basic Hospital	30	30	30
Secondary Hospital	50	50	50
Tertiary Services			
Level I or Level II trauma unit	100	100	100
Neonatal intensive care unit	100	100	100
Perinatology services	100	100	100
Comprehensive cancer services	100	100	100
Comprehensive cardiac services	100	100	100
Pediatric subspecialty care	100	100	100
Mental Health Facilities			
Inpatient mental health treatment facility	25	40	75
Ambulatory mental health treatment providers	15	25	45
Residential mental health treatment providers	20	30	50
Auxiliary Services			
Physical Therapy	30	30	30
Occupational Therapy	30	30	30
Speech Therapy	50	50	50
Audiology	50	50	50
Pharmacy			
Pharmacy	10	20	30



Exhibit B

AFFIDAVIT PURSUANT TO 20 CSR 400-7.095(2)(A)1.B.

State of _____)
County of _____)

ss.

_____, first being duly sworn, on his/her oath states:
(Insert Name)

He/she is the _____ of _____,
a(n) _____ corporation, and as such officer is duly authorized to make this affidavit
on behalf of said corporation;

The managed care plan to which this affidavit applies is known by the product name(s):
(Insert Product Name(s) used by the HMO for this Managed Care Plan; if none, so state)

The form number(s) of the health benefit plan for this managed care plan are:
(Insert Form Numbers as Filed for Approval with the Department of Insurance, Financial Institutions and Professional Registration)

The effective dates for each accreditation for Medicare+Choice (M+C) or successor coordinated care plan contract are:

This managed care plan meets the following criteria:
(insert an "X" in one or more of the following, as applicable.)

- The managed care plan is an M+C or successor coordinated care plan offered pursuant to a contract with the federal Centers for Medicare and Medicaid Services, and the contract is currently in effect;
The managed care plan is accredited by the National Committee for Quality Assurance (NCQA), or successor organization, at a level of "accredited" or better, and the accreditation is currently in effect;
All/some (circle one) of the managed care plan's network is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO), or successor organization, at a level of "accredited" or better, and the accreditation is currently in effect. There are no Type I recommendations for standards related to access to care. (If "some" is circled, additional information for that portion of the Network not covered by the JCAHO accreditation must be submitted pursuant to 20 CSR 400-7.095(2)(A)1.A. or B.)
The managed care plan is accredited by the utilization review accreditation commission (URAC), or successor organization, for full URAC Health Plan accreditation, and the accreditation is currently in effect;
The managed care plan or its network is accredited by _____, this accreditation was approved by the department prior to the date of this affidavit, and this accreditation is currently in effect.

(Signature of Affiant Corporate Officer)

Subscribed and sworn to before me this _____ day of _____, 20_____.

My commission expires _____, 20_____.

Notary Public



AUTHORITY: sections 354.615 and 374.045, RSMo 2000 and 354.405 and 354.603, RSMo Supp. 2006. Original rule filed Nov. 3, 1997, effective May 30, 1998. Rescinded and readopted: Filed Oct. 1, 2002, effective April 30, 2003. Amended: Filed May 11, 2004, effective Dec. 30, 2004. Amended: Filed July 29, 2005, effective Feb. 28, 2006. Amended: Filed Dec. 14, 2006, effective June 30, 2007.*

**Original authority: 354.405, RSMo 1983, amended 1997, 2003; 354.603, RSMo 1997, amended 2001, 2003; 354.615, RSMo 1997; and 374.045, RSMo 1967, amended 1993, 1995.*

20 CSR 400-7.100 Copayments

PURPOSE: This rule states that an health maintenance organization may require copayments of its enrollees as a condition for the receipt of health care services. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

A health maintenance organization (HMO) may require copayments of its enrollees as a condition of the receipt of specific health care services. An HMO may not impose copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty percent (20%) of the total cost of providing all basic health services. An HMO may not impose copayment charges for basic health care services on any enrollee in any calendar year after the copayments made by the enrollee in that calendar year for basic health care services total two hundred percent (200%) of the total annual premium which is required to be paid by, or on behalf of, that enrollee and shall be stated as a dollar amount in the group contracts. Copayments shall be the only allowable charge, other than premiums, assessed to enrollees for basic and supplemental health care services. Single service copayment amounts shall be disclosed either as a percentage or as a stated dollar amount in the evidence of coverage. For group contracts the copayment amount may be changed only on the anniversary date of the group contract except by mutual agreement of the parties to the contract.

AUTHORITY: sections 354.430 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.190. Original rule filed Nov. 2, 1987, effective April 11, 1988. Amended: Filed Aug. 16, 1989, effective Dec. 15, 1989.*

**Original authority: 354.430, RSMo 1983 and 354.485, RSMo, 1983.*

20 CSR 400-7.110 Health Maintenance Organizations—Resolution of Enrollee Grievances

PURPOSE: This rule sets forth the guidelines and procedures to be used by a health maintenance organization to resolve enrollee grievances. This rule is promulgated pursuant to section 354.485, RSMo and implements sections 354.430.3(2)(e) and 354.445, RSMo.

(1) Definitions.

(A) Grievance means a complaint submitted in writing in accordance with the health maintenance organization's (HMO) formal grievance procedure by or on behalf of the enrollee regarding the interpretation of the certificate of coverage or dissatisfaction with the quality of health care provided by an HMO employee or a contracted provider.

(B) Grievance advisory panel means a panel established by the HMO which may review the HMO's decision regarding grievances which have not been resolved to the satisfaction of the enrollee and which an enrollee has requested the panel to review. This panel must be comprised, at least in part, of enrollees and also may include representatives from the HMO, but shall not include anyone involved in the circumstances giving rise to the grievance, or in any subsequent investigation or determination of the grievance placed before it.

(2) An HMO shall set forth in its certificate of coverage the procedures for resolving enrollee grievances. At a minimum, the certificate of coverage shall include the following provisions:

(A) The definition of a grievance;

(B) How, where and to whom the enrollee should file his/her grievance; and

(C) That upon receiving notification of a grievance related to payment of a bill for medical services, the HMO will—

1. Acknowledge receipt of the grievance in writing within ten (10) working days unless it is resolved within that period of time;

2. Conduct a complete investigation of the grievance within twenty (20) working days after receipt of a grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty (20) working days after receipt of a grievance, the enrollee shall be notified in writing within thirty (30) working days time, and every thirty (30) working days after that, until the investigation is completed. The notice shall set forth the reasons for which additional time is needed for the investigation;

3. Have within five (5) working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the HMO's decision regarding the grievance and of any right to appeal. The notice shall explain the resolution of the grievance and any right to appeal. The notice shall explain the resolution of the grievance in terms which are clear and specific; and

4. Notify, if the HMO has established a grievance advisory panel, the enrollee of his/her right to request the grievance advisory panel to review the HMO's decision. This notice shall indicate that the grievance advisory panel is not obligated to conduct the review. This provision shall also state how, where and when the enrollee should make his/her request for this review.

(3) An HMO shall keep a record or report of the total number, type, nature and result of all grievances. Upon request by the director of the Department of Insurance or his/her appointee, the HMO shall provide, promptly, all those records or reports.

(4) An HMO, upon receipt of any inquiry from the Department of Insurance regarding a grievance, within fifteen (15) working days of receipt of the inquiry, shall furnish the department with a written response to the information requested.

(5) All written grievances shall be date stamped when received by the HMO. The date shall be legible and easily identified.

(6) The director of the Department of Insurance may institute disciplinary action for a violation of this rule in accordance with the provisions of section 354.550, RSMo and any other applicable law.

AUTHORITY: sections 354.430, 354.445 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority: 354.430, RSMo 1983; 354.445, RSMo 1983; and 354.485, RSMo 1983.*

20 CSR 400-7.120 Health Maintenance Organization—Enrollee Participation

PURPOSE: This rule sets forth the health maintenance organization's method for enrollees to participate in matters of policy and operation. This rule is promulgated pursuant to section 354.485, RSMo and implements section 354.420, RSMo.



(1) Definitions.

(A) Enrollee means an individual who is covered by a health maintenance organization (HMO).

(B) Evidence of coverage means any certificate, agreement or contract issued to an enrollee which sets out the coverage to which the enrollee is entitled under the HMO contract which covers the enrollee.

(2) Enrollee Participation. Every HMO shall establish a mechanism which affords enrollees an opportunity to participate in matters of the HMO's policy and operation. The HMO in its evidence of coverage shall clearly advise the member that a mechanism which affords enrollees an opportunity to participate in matters of the HMO's policy and operation, and which has been approved by the Missouri Department of Insurance, will be made available to this member upon request. At a minimum, the mechanism used must both afford enrollees an opportunity to offer appropriate suggestions to the policy-making body of the HMO and ensure that the policymaking body gives these suggestions due consideration, and either approves or disapproves them. For purposes of this section, suggestions deemed appropriate for presentation to the policymaking body shall be those selected by either an enrollee advisory committee, the composition of which is set forth in the HMO's organizational documents or such other means as have been approved by the director.

(3) Discipline. The director of the Department of Insurance may institute disciplinary action for a violation of this rule in accordance with the provisions of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.420 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority: 354.420, RSMo 1983 and 354.485, RSMo 1983.*

20 CSR 400-7.130 Authorization for Emergency Medical Services

PURPOSE: This rule sets forth the requirements of a health maintenance organization when prior authorization for emergency medical services is required. This rule is promulgated pursuant to section 354.485, RSMo and implements sections 354.410.1(2) and 354.470.1(3), RSMo.

(1) A health maintenance organization (HMO) that requires prior authorization

before making payment for the treatment of medical emergency conditions, as defined by the HMO, shall provide enrollees with a toll-free telephone number answered twenty-four (24) hours per day, seven (7) days a week. At least one (1) person with medical training who is authorized to determine whether an emergency condition exists shall be available twenty-four (24) hours per day, seven (7) days a week to make these determinations.

(2) An HMO shall not base its denial of payment for emergency medical services solely on the enrollee's failure to receive authorization prior to receiving the emergency medical service. The enrollee must notify the HMO of receipt of medical services for emergency conditions within twenty-four (24) hours or as soon after that as is reasonably possible. Nothing shall require the HMO to authorize payment for any services provided during that twenty-four (24)-hour period, regardless of medical necessity, if those services do not otherwise constitute benefits under the certificate of coverage approved by the department.

(3) If the participating provider is responsible for seeking prior authorization from the HMO before receiving payment for the treatment of emergency medical conditions and the enrollee is eligible at the time when covered services are provided, then the enrollee will not be held financially responsible for payment for covered services if the prior authorization for emergency medical services has not been sought and received, other than for what s/he would otherwise be responsible, such as copayments and deductibles.

(4) All disputes between an enrollee and an HMO arising under the provisions of this regulation shall be resolved by means of the HMO's grievance procedure.

(5) Discipline. The director of the Department of Insurance may institute disciplinary action for violation of this rule in accordance with the provisions of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.410, 354.470 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority: 354.410, RSMo 1983; 354.470, RSMo 1983; and 354.485, RSMo 1983.*

20 CSR 400-7.140 Health Maintenance Organizations—Reinsurance Agreements

PURPOSE: This rule sets forth the requirements that relate to the filing of reinsurance agreements with the Department of Insurance. This rule is promulgated pursuant to section 354.485, RSMo and implements sections 354.405.5. and 354.410.1(3)(c) and (6), RSMo.

(1) Definition. As used in this rule, a contract of reinsurance means the entire contract, including the signatures of the representatives of the health maintenance organization (HMO) and the reinsurer, and any binders, certificates, attachments, amendments or modifications to the contract.

(2) Filing. A contract of reinsurance shall be submitted to the Department of Insurance for filing and approval no later than ten (10) working days after receipt by the HMO. If it appears there will be a substantial delay between the issuance of a binder and all other documents connected with the contract of reinsurance, or difficulty in obtaining a contract of reinsurance as evidenced by the negotiation process, the HMO shall file a copy of the binder or a letter signed by an officer of the reinsurer explaining the circumstances pertaining to the delay. After filing this binder or letter, the HMO shall file its contract of reinsurance ten (10) working days after receipt of the contract. Proof of coverage shall be filed no later than ten (10) working days after its effective date.

(3) Provisions. A contract of reinsurance shall not contain a provision stating that the contract of reinsurance will not apply or will become ineffective in the event the HMO is unable to meet its financial obligations or is insolvent.

(4) Requests. Upon request by the director of the Department of Insurance or his/her appointee, the HMO shall provide promptly to the Department of Insurance all contracts of reinsurance required by this section and available to the HMO.

(5) Discipline. The director of the Department of Insurance may institute disciplinary action for violation of this rule in accordance with the provisions of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.405, 354.410 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*



*Original authority: 354.405, RSMo 1983; 354.410, RSMo 1983; and 354.458, RSMo 1983. 1983.

20 CSR 400-7.150 Health Maintenance Organizations—Disenrollments

PURPOSE: This rule specifies when a health maintenance organization may disenroll an enrollee for nonpayment of a copayment when his/her premium has been paid. This rule is promulgated pursuant to section 354.485, RSMo and implements section 354.462, RSMo.

(1) Definitions.

(A) Copayment means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

(B) Copayment maximum means the total amount of copayments an enrollee is obligated to pay during the calendar year as defined by the contract.

(C) Disenrollment means a health maintenance organization's (HMO) termination of an enrollee's eligibility for service.

(D) Enrollee means an individual who is properly enrolled in an HMO.

(2) Disenrollment. An enrollee for whom premium has been paid may not be disenrolled nor denied renewal for nonpayment of a copayment except when the HMO or provider to whom the copayment is due has initiated collection efforts within sixty (60) days after the HMO is notified that copayment is due. The enrollee also must receive written notice from the HMO stating the disenrollment will occur unless arrangements for payment of the copayment are made within ten (10) working days after receipt of the notice.

(3) Refunds. An HMO shall refund any premium payment, net of copayments due, made to cover the period after disenrollment.

(4) Copayment Notification. Upon request, an HMO shall inform an enrollee if s/he has reached his/her copayment maximum.

(5) Discipline. The director of the Department of Insurance may institute disciplinary action for a violation of this rule in accordance with the provision of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.462 and 354.485, RSMo 1986.* Original rule filed April 14, 1992, effective Feb. 26, 1993.

*Original authority: 354.462, RSMo 1983 and 354.485, RSMo 1983.

20 CSR 400-7.160 Multiple Names Prohibited

PURPOSE: This rule implements the provisions of sections 354.405, 354.460, 375.934 and 375.936(4), RSMo regarding the name of a health maintenance organization and misleading information and advertising. This rule prohibits an health maintenance organization from using any name other than its true name on its certificate of authority and sets forth specific requirements for the use of multiple names on its other documents and publications.

(1) A health maintenance organization (HMO) must use its true name for its certificate of authority to conduct business as an HMO in this state.

(2) An HMO will be permitted to use a fictitious name, an acronym or a portion of its true name, in its advertising, agreements, contracts, policies, evidences of coverage, filings with the director or any other publication of its name, provided that the HMO uses its true name at least once in each advertisement, agreement, contract, policy, evidence of coverage, filing with the director, or any other publication of its name.

(3) Any HMO which does business as an HMO in this state under a fictitious name shall file with the director a copy of all documents, including the authorization from the Missouri secretary of state, which shows the legal authority for the HMO to use such other name. Any acronym or portion of the true name must be registered with the director.

(4) Any HMO which prior to the effective date of this rule used or employed more than one (1) name shall cease using more than one (1) name, except as permitted by this rule, and take all steps necessary to comply with this rule within sixty (60) days after the effective date of this rule (June 6, 1994), including but not limited to, the filing of an application for an amended certificate of authority to reflect the true name of the HMO and the payment of fees in accordance with section 354.495, RSMo.

(5) The director may institute disciplinary action for violations of this rule in accordance with the provisions of sections 354.490, 354.500, 374.046 and 375.942, RSMo and any other applicable law.

AUTHORITY: section 374.045, RSMo Supp. 1993.* Original rule filed Oct. 1, 1993, effective June 6, 1994.

*Original authority: 374.045, RSMo 1967, amended 1993.

20 CSR 400-7.170 Distribution of Written Disclosure Information

PURPOSE: This rule sets forth with greater specificity the enrollees who are entitled to written disclosure information. This rule is promulgated pursuant to section 354.485, RSMo, and implements section 354.442.1, RSMo.

(1) Definition. As used in this rule, a household means those persons who dwell under the same roof and are covered by the same policy.

(2) If a household includes more than one (1) enrollee, a health maintenance organization is only required to provide one (1) written disclosure to that household.

AUTHORITY: sections 354.442.1, RSMo Supp. 1997 and 354.485, RSMo 1994. Original rule filed Nov. 3, 1997, effective June 30, 1998.

*Original authority: 354.442, RSMo 1997 and 354.485, RSMo 1983.

20 CSR 400-7.180 Standard Form To Establish Credentials

PURPOSE: This rule sets forth the standard form which shall be used by all health carriers when soliciting the credentials of a health care professional in a managed care plan. This rule is promulgated pursuant to section 354.485, RSMo, and implements section 354.442.1(15), RSMo.

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

(1) Definitions.

(A) Health care professional means a physician or other appropriately licensed health care practitioner.

(B) Health carrier means a health maintenance organization as organized pursuant to



sections 354.400 through 354.636, RSMo.

(C) Managed care plan means a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with or employed by the health carrier.

(2) The Universal Credentialing DataSource form (Form UCDS), incorporated by reference and published on October 31, 2006, by the Council for Affordable Quality Healthcare, 601 Pennsylvania Avenue NW, South Building, Suite 500, Washington, DC 20004, has been adopted and shall be used by all health carriers and their agents when credentialing or recredentialing health care professionals in a managed care plan. The director on request will supply in printed format the form specified in this rule. The form referenced herein is available at <http://www.insurance.mo.gov>. This rule does not incorporate any subsequent amendments or additions. Use of another standardized credentialing form is permissible so long as the director determines prior to its use that it is substantially similar to Form UCDS. Carriers shall accept any form approved by the director for credentialing purposes, and shall not require a Missouri health care professional to use any particular approved form to the exclusion of any other approved form, so long as the form submitted by the Missouri health care professional is Form UCDS or any other form approved pursuant to this rule. Requests for the director's approval of the use of another standardized credentialing form should be submitted to the following address: Missouri Department of Insurance, Managed Care Section, PO Box 690, Jefferson City, MO 65102-0690. A request must include a complete copy of the form to be approved and the name, address, and telephone number of the person requesting approval. The director will provide written notice to all Missouri licensed health maintenance organizations of the approval of the use of another standardized credentialing form. The director also will provide on the department's Internet home page a copy of Form UCDS with a list of other standardized credentialing forms that have been approved.

(3) Health carriers may request additional information to explain or provide details regarding responses obtained on the standard form. Health carriers and their agents are prohibited from routinely requiring additional information, or information that duplicates information on Form UCDS, from health care professionals. This prohibition shall not apply to gathering information on standard

claim forms for purposes of routine claims submission and payment processes.

(4) An on-site examination by the health carrier or their agent of the health care professional's place of business shall not, in itself, be considered a routine request for additional information.

(5) Accurate reproduction of the form may be utilized in lieu of the printed form. This includes, but is not limited to, accurate reproduction in paper, electronic, or Internet based formats. Health carriers and their agents shall accept an accurate reproduction, and shall not require a health care professional to use any particular accurate reproduction to the exclusion of any other accurate reproduction, except that a health carrier or agent may require a paper format if a health care professional submits an electronic or Internet based format that the health carrier or agent is not prepared to accept.

AUTHORITY: section 354.442.1(15), RSMo 2000 and section 354.485, RSMo Supp. 2007. Original rule filed Nov. 3, 1997, effective June 30, 1998. Amended: Filed June 6, 2000, effective Feb. 28, 2001. Amended: Filed May 14, 2008, effective Jan. 30, 2009.

**Original authority: 354.442, RSMo 1997 and 354.485, RSMo 1983, amended 2007.*

20 CSR 400-7.200 Provider Selection Standards

PURPOSE: This rule sets forth the reporting requirements of each health carrier found in section 354.606, RSMo, H.B. 335, 1997, to file its selection standards for all participating providers.

(1) Every health carrier, including its intermediaries and any provider networks with which it contracts, shall file with the director annually, on or before March 1, a complete copy of all selection standards and any modifications thereto, for the selection of participating primary care professionals and participating health care professional specialties.

(2) Every health carrier shall make the information required to be reported by this rule available directly to all licensed health care providers upon request.

AUTHORITY: sections 354.485 and 374.045, RSMo 2000 and 354.606, RSMo Supp. 2003. Original rule filed Nov. 3, 1997, effective May 30, 1998. Amended: Filed Feb. 27, 2004, effective Aug. 30, 2004.*

**Original authority: 354.485, RSMo 1983; 354.606, RSMo 1997, amended 2001; and 374.045, RSMo 1967, 1993, 1995.*

20 CSR 400-7.300 Evidence Required to Prove Criteria for Designation as Community-Based Health Maintenance Organization

PURPOSE: This rule describes the evidence the department will require of a health maintenance organization to prove the health maintenance organization meets the criteria set out in sections 354.400(2)(d), 354.400(2)(e) and 354.400(2)(f), RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997), to be designated as a community-based health maintenance organization and other information which the department may take into account in determining whether or not a health maintenance organization meets the aforementioned criteria.

(1) In order to evidence that a health maintenance organization has met the requirements of sections 354.400(2)(d), 354.400(2)(e) and 354.400(2)(f), RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997), to be designated as a community-based health maintenance organization, a health maintenance organization must file with the department a Community Benefits Mission Statement adopted by resolution of its board of directors (or trustees) containing a board-approved Community Benefits Plan (Plan) which shall be available to the public and which—

(A) Demonstrates the health maintenance organization's active and ongoing involvement in attempting to improve performance on indicators of health status in the communities it serves, including the health status of those not enrolled in the health maintenance organization; and

(B) Demonstrates its accountability to the public for the cost of, quality of, and access to health care treatment services and for the effect such services have on the health of the community or communities served by the health maintenance organization.

(2) The Plan shall, at a minimum—

(A) Identify health care indicators in the communities served by the health maintenance organization and rate each community served by the health maintenance organization as to each indicator;

(B) Describe the means by which the health maintenance organization will be actively involved in attempting to improve performance on the identified indicators of



health status in the community or communities in which the health maintenance organization is operating, including the health status of those not enrolled in the health maintenance organization;

(C) Describe the means by which the health maintenance organization will be accountable for the cost, quality, and access to health care treatment services and for the effect such services have on the health of the communities served by the health maintenance organization. Community-based health maintenance organizations shall at a minimum be required to hold an annual public hearing at which time they will seek public comment on their proposed budget for the coming year. The proposed budget should be made publicly available at least ten (10) days prior to the hearing. This budget should include, but not be limited to, a description of the community-based health maintenance organization's cost of providing health care services on a per-member, per-month basis for the past year and their projections for the coming year including their proposed premium structure. The information disclosed in the proposed budget should be of sufficient detail to help the public understand the components of health care costs in their proposed premium, which components are changing most rapidly, and what proportion of cost each component comprises. The public hearing should allow for ample time for public comment as well as a requirement on the part of the community-based health maintenance organization to publicly respond to the input that it received at the public hearing;

(D) Set out a timetable for the development and implementation of the Plan;

(E) Identify the members of the governing body and the senior management of the health maintenance organization responsible for the oversight, development, and implementation of the Plan;

(F) Identify the resources to be allocated to the Plan;

(G) Identify the administrative mechanisms for the Plan's regular evaluation; and

(H) Establish an advisory group comprised of enrollees and representatives of community interests to make recommendations to the health maintenance organization regarding the policies and procedures of the health maintenance organization.

(3) The department will utilize public resources and participation, including, but not limited to, plans or written comments from Community Health Resource Team programs established through the Department of Health in evaluating whether or not Plans submitted prove the submitting health mainte-

nance organization meets the criteria of sections 354.400(2)(d), 354.400(2)(e) and 354.400(2)(f), RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997), for designation as a community-based health maintenance organization. The department will also consider priorities set by the health maintenance organization to improve community performance on the indicators of health status it identified in the Plan, including, but not limited to, those which concern—

(A) Promoting and marketing products to attract segments of the population of the communities which have not historically been served by the health maintenance organization;

(B) Avoiding marketing and advertising practices designed to discourage older, poorer, and less healthy persons from applying for membership;

(C) Allowing direct enrollment for non-group coverage;

(D) Promoting translator and telecommunications device for the deaf (TDD) services at all key points of patient contact;

(E) Providing subsidized coverage to those who are uninsured and unable to pay for health care services; and

(F) Providing assistance to consumers in obtaining and maintaining health care coverage, at least for limited periods of time at reduced rates.

(4) Any information which a community-based health maintenance organization deems to be proprietary, shall be handled in accordance with 20 CSR 10-2.400.

(5) A community-based health maintenance organization which has a grievance procedure established which is in compliance with Health Care Financing Administration guidelines for grievance procedures for Medicare recipients, may use that procedure for non-Medicare enrollees, provided that such enrollees may appeal an adverse determination to the Missouri Department of Insurance grievance procedure as set out in 20 CSR 100-5.020 Grievance Review Procedures, and the enrollee is notified of that procedure in a manner consistent with 20 CSR 100-5.010 Notice Requirements of an Adverse Determination.

AUTHORITY: section 354.485, RSMo 1994. Original rule filed Nov. 3, 1997, effective June 30, 1998.*

**Original authority: 354.485, RSMo 1983.*

20 CSR 400-7.400 Pharmacies and Prescription Drugs

PURPOSE: This rule carries out the provisions of section 354.535, RSMo H.B. 335 (89th General Assembly, First Regular Session, 1997).

(1) Except as otherwise indicated in this rule, the terms used in this rule shall have the same meaning as those terms defined in section 354.400 and as used in section 354.535.

(2) A health maintenance organization (HMO) offering enrollees a particular package of coinsurance, copayment, and deductible factors must offer to allow any pharmacy to sell prescriptions with that package of factors, if and only if the pharmacy—

(A) Is in the HMO's network; and

(B) Is willing to meet the explicit product cost determination set by the HMO; and

(C) Has been granted a permit or license from the Missouri Board of Pharmacy to operate in this state.

(3) If a pharmacy provider rejects a contract offered by the HMO containing the HMO's explicit product cost determination and the participation of that provider in the network is necessary for the HMO to comply with network adequacy provisions of section 354.400 to 354.636 or a rule adopted to implement those sections, the HMO may offer such other contracts as may be necessary to secure the pharmacy provider's participation in the network, but no such other contract need be offered to other pharmacy providers.

(4) No HMO may establish a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription, unless such limit is uniformly applied to all pharmacy providers in the HMO's network. A "limit on the quantity of drugs" means any limitation of the length of a prescription or quantity of drugs. If an enrollee may have filled a prescription of a given length or quantity by any pharmacy provider in the HMO's network, the HMO must ensure that the enrollee may have such prescription filled by all pharmacy providers in the HMO's network.

(5) An explicit product cost determination means and must be stated as a percentage of average wholesale price (AWP), maximum allowable cost (MAC) or similar measure plus a dispensing fee.



AUTHORITY: section 354.485, RSMo 1994.
Original rule filed Nov. 3, 1997, effective
June 30, 1998.*

**Original authority: 354.485, RSMo 1983.*