

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

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 If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission.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

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

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

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

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

Proposed Amendment Text Reminder:

Boldface text indicates new matter.

[Bracketed text indicates matter being deleted.]

Title 2—DEPARTMENT OF AGRICULTURE Division 70—Plant Industries Chapter 10—Missouri Plant Law Rules

PROPOSED RULE

2 CSR 70-10.025 Nonprofit Nursery Dealer Defined

PURPOSE: This rule defines a nonprofit nursery dealer.

(1) A nursery dealer registered with the state as a nonprofit organization overseeing membership entities which may offer nursery stock for sale. The sale of such nursery stock is limited to not more than two (2) sales events conducted in a certificate year (October 1 to September 30) for each membership entity, with each sales event lasting a maximum of two (2) days. Nonprofit nursery dealers and their membership entities shall be subject to the provisions of 263.010 to 263.180. Nonprofit nursery dealers shall submit notification to the department for each membership entity sale at least thirty

(30) days prior to the sale. Notification shall include, but not be limited to, the name, contact name, address, phone number, sale location(s), and sale date(s) for the membership entity.

AUTHORITY: section 263.040, RSMo 2016. Original rule filed Oct. 22, 2019.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Department of Agriculture, ATTN: John Brunnert, PO Box 630, 1616 Missouri Boulevard, Jefferson City, MO 65102, or online at Agriculture.Mo.Gov/proposed-rules/. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE Division 70—Plant Industries Chapter 10—Missouri Plant Law Rules

PROPOSED AMENDMENT

2 CSR 70-10.050 Out-of-State Nurseryman to Verify Inspection-Certification. The director is amending section (1).

PURPOSE: This amendment clarifies how nurserymen shipping nursery stock into Missouri verify that their nurseries have been inspected and certified by their state plant regulatory agency.

(1) Any nurseryman of any other state, territory, or district of the United States desiring to ship nursery stock into Missouri shall be listed in their state certified nursery directory and this directory must be filed with the office of the Missouri state entomologist **or posted online by their state plant regulatory agency**. Nurseries in states that fail to file this directory individually must file a copy of their certificate of inspection **with the office of the Missouri state entomologist**.

AUTHORITY: section 263.040, RSMo 2016. Original rule filed Aug. 4, 1958, effective Aug. 14, 1958. Amended: Filed April 22, 1965, effective May 2, 1965. Amended: Filed March 25, 1966, effective April 4, 1966. Amended: Filed May 27, 1975, effective June 6, 1975. Refiled March 11, 1976. Rescinded: Filed Aug. 14, 1984, effective Jan. 1, 1985. Readopted: Filed Sept. 12, 1984, effective Jan. 1, 1985. Amended: Filed Oct. 22, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, ATTN: John Brunnert, PO Box 630, 1616 Missouri Boulevard, Jefferson City, MO 65102, or online at Agriculture.Mo.Gov/proposed-rules/. To be considered, comments

must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 10—Missouri Plant Law Rules

PROPOSED AMENDMENT

2 CSR 70-10.075 Fee Schedule. The director is amending sections (1) through (10), adding a new section (11), and renumbering the previous section (11).

PURPOSE: This amendment revises the fee schedule for inspections performed.

(1) Nursery inspection fees for all plants, except grass sod, shall be as follows: for less than one-half (1/2) acre of salable stock, [twenty] fifty dollars [(\$20)] (\$50); one-half to one (1/2-1) acre of salable stock, [thirty-five] seventy-five dollars [(\$35)] (\$75); each additional acre or fraction of an acre, [three] five dollars [(\$3)] (\$5). [Where semi-annual inspections are required, that is, strawberries, brambles, and the like, an annual fee shall be paid at the time of the spring inspection and shall include both inspections performed during the year.] Grass sod inspection fees shall be as follows: for less than one-half (1/2) acre of salable stock, [twenty] fifty dollars [(\$20)] (\$50); one-half to one (1/2-1) acre of salable stock, [thirty-five] seventy dollars [(\$35)] (\$70); each additional acre or fraction of an acre, [one dollar (\$1)] two dollars (\$2). Fees will be paid at the time of initial application and upon annual renewal.

(2) Fees for the field inspection of grain and forage crops or any other plants or plant products other than nursery stock and sod shall be as follows: for less than one-half (1/2) acre of salable stock, [twenty] fifty dollars [(\$20)] (\$50); one-half to one (1/2-1) acre of salable stock, [thirty-five] seventy dollars [(\$35)] (\$70); each additional acre or fraction of an acre, [two] four dollars [(\$2)] (\$4).

(3) Fees for supervising the fumigation of any plants, plant products, machinery, equipment or any other articles of any nature shall be [fifty-dollars] one hundred dollars [(\$50)] (\$100) for the first hour worked while on the premises with a [fifty-dollar] one hundred dollar [(\$50)] (\$100) minimum fee and [twenty] forty dollars [(\$20)] (\$40) for each additional hour or fraction of an hour worked while on the premises.

(4) Fees for the inspection of grain elevators, warehouses, and other facilities shall be [fifty] one hundred dollars [(\$50)] (\$100) for the first hour worked while on the premises with a [fifty-dollar] one hundred dollar [(\$50)] (\$100) minimum fee and [twenty] forty dollars [(\$20)] (\$40) for each additional hour or fraction of an hour while on the premises. These inspections shall be made as often as required by the destination state or country or the United States Department of Agriculture for the issuance of their certificates.

(5) Fees for specialty-type inspections including, but not limited to, phytosanitary, European corn borer, (that is not a grain elevator), vegetable transplant, house plant inspections, and any other plant regulatory work shall be [twenty-five] fifty dollars [(\$25)] (\$50) for the first hour worked while on the premises with a [twenty-five] fifty dollar [(\$25)] (\$50) minimum fee and [twenty] forty dollars [(\$20)] (\$40) for each additional hour or fraction of an hour worked while on the premises. There shall be a [ten-dollar] fifty dollar [(\$10)] (\$50) certification fee for each certificate issued.

(6) Fees for the reissuance of a phytosanitary certificate, or any other

type of certificate, based upon a prior inspection or some other documentation shall be [ten] fifty dollars [(\$10)] (\$50). [Firms operating under compliance agreements and utilizing state certificates shall pay a certificate fee of five dollars (\$5) per certificate.]

(7) Anyone desiring a phytosanitary inspection and certification or any other type inspection/certification for plants or plant products may bring those plants or plant products to the inspector at a designated time and place at the inspector's choosing and have that inspection performed and a certificate issued, providing the plant material meets the requirements of the destination state or country, for a fee of [five] twenty-five dollars [(\$5)] (\$25) for the inspection and [ten] fifty dollars [(\$10)] (\$50) for each certificate issued.

(8) [Certificates of inspection shall be issued after the inspection is completed and payment of the fee has been received unless otherwise required under sections 263.010-263.080, RSMo or the commodity or plant product being inspected is infested or infected with harmful plant pests or does not meet the requirements of the destination state or country, or both.] Payment of inspection and certification fees may be made at the time of inspection, or upon receipt of an invoice from the department. Certificates will not be issued until application has been made, certification requirements have been verified, and previous inspection and certification fees have been paid. Failure to qualify for certification does not remove the obligation of the owner to pay the designated inspection fees.

(9) Fees for greenhouse inspection shall be as follows: for twenty-five thousand (25,000) square feet or less, [twenty-five] fifty dollars [(\$25)] (\$50); for twenty-five thousand one to fifty thousand (25,001-50,000) square feet, [thirty-five] seventy dollars [(\$35)] (\$70); for each additional twenty-five thousand (25,000) square feet or portion, [ten] twenty dollars [(\$10)] (\$20). Fees shall be paid at the time of the fall inspection [and shall include] or upon receipt of an invoice from the department for both inspections performed during the year.

(10) Nursery dealer registration-inspection certificates shall be [fifty] one hundred twenty-five dollars [(\$50)] (\$125) annually per outlet and this fee is payable at the time of making application. Restricted nursery dealer registration-inspection certificates shall be [twenty-five] fifty dollars [(\$25)] (\$50) annually per outlet and this fee is payable at the time of making application. Nonprofit nursery dealer registration-inspection certificates shall be one hundred twenty-five dollars (\$125) annually per nonprofit organization overseeing membership entities and this fee is payable at the time of making application. If the nursery dealer registration-inspection certificate is not renewed prior to offering nursery stock for sale, there shall be a penalty of fifty percent (50%) assessed and added to the original fee and paid by the applicant before the registration-inspection certificate shall be issued. This penalty is to recover the costs associated with reinspections.

(11) Annual fees for fruit tree and grapevine virus-free certification shall be as follows: three dollars (\$3) per registered fruit tree and one dollar (\$1) per registered grapevine. Fees are payable by June 30 for the following year's certification.

[(11)](12) Fees are not prorated and certificates are effective from the time of issuance until the expiration date as mandated by section 263.070, RSMo or the destination state or country.

AUTHORITY: section 263.040, RSMo 2016. Original rule filed Sept. 12, 1984, effective Jan. 1, 1985. Amended: Filed Dec. 2, 1991, effective April 9, 1992. Amended: Filed Oct. 22, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies

or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities two hundred sixty-four thousand four hundred fourteen dollars (\$264,414) annually in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, ATTN: John Brunnert, PO Box 630, 1616 Missouri Boulevard, Jefferson City, MO 65102, or online at Agriculture.Mo.Gov/proposed-rules/. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE
PRIVATE COST**

- I. Department Title: 2 - Agriculture**
Division Title: 70 – Plant Industries
Chapter Title: 10 – Missouri Plant Law Rules

Rule Number and Title:	2 CSR 70-10.075 Fee Schedule
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
2100	Nursery Dealers	128,330
550	Nursery Growers	21,012
75	Greenhouse/Exporter/Other	93,072
2	Virus-free Certifications	22,000

III. WORKSHEET

IV. ASSUMPTIONS

**Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 35—Seed Regulation**

PROPOSED AMENDMENT

2 CSR 70-35.050 Submitting Service Samples. The director is amending section (2).

PURPOSE: This amendment updates costs on seed samples.

(2) Charges for analysis and analytical reports on seed samples not qualifying for free analysis as described in section (1) of this rule will be assessed at the following rates:

(A) A cost of ~~[ten]~~ **twenty** dollars (~~\$/10/20~~) per hour will be assessed for purity analysis on any seed having less than ninety percent (90%) pure seed;

(B) Purity analysis on seed having greater than ninety percent (90%) of the crop seed to be planted (purity analysis includes percentage measurements on pure seed, other crop, total weed seed, and inert matter) shall be—

1. For one (1) cultivar \$/12/24;
and

2. For more than one (1) cultivar
in the same sample \$/18/36;

(C) Germination (per cultivar) \$/12/24;

(D) Tetrazolium \$/25/50;

(E) Highly chaffy seed purity
(per hour) \$/10/20;

(F) Highly chaffy seed germination \$/14/28;

(G) Endophyte from growth \$/30/60;

(H) Endophyte from seed staining \$/20/40;

and

(I) Noxious and prohibitive
weed seed \$/12/24.

AUTHORITY: section 266.091, RSMo 2016. Original rule filed June 6, 1952, effective June 16, 1952. Amended: Filed Dec. 23, 1975, effective Jan. 2, 1976. Amended: Filed June 14, 1977, effective Sept. 11, 1977. Rescinded and readopted: Filed Sept. 28, 1979, effective March 13, 1980. Amended: Filed June 28, 1991, effective Jan. 1, 1992. Amended: Filed Oct. 22, 2019.

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

PRIVATE COST: This proposed amendment will cost private entities one thousand forty-two dollars (\$1,042) per year in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, ATTN: John Brunnert, PO Box 630, 1616 Missouri Boulevard, Jefferson City, MO 65102, or online at Agriculture.Mo.Gov/proposed-rules/. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE
PRIVATE COST**

- I. Department Title: 2 - Agriculture**
- Division Title: 70 – Plant Industries**
- Chapter Title: 35 – Seed Regulations**

Rule Number and Title:	2 CSR 70-35.050 Submitting Service Samples
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
18	Seed buyers, sellers, producers	\$1,042 annually

III. WORKSHEET

IV. ASSUMPTIONS

FY18 and FY19 averaged 18 entities submitting seed service sample fees at an annual average aggregate cost of \$1,042. Since the seed service sample fees are doubling under this proposed amendment, the estimated aggregate cost of compliance with the rulemaking is \$1,042.

**Title 5—DEPARTMENT OF ELEMENTARY AND
SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 400—Office of Educator Quality**

PROPOSED RESCISSION

5 CSR 20-400.150 Application for Certificate of License to Teach. This rule outlined the procedures for application for a certificate of license to teach where the applicant had a recommendation from a state-approved teacher preparation program or had earned a doctoral degree.

PURPOSE: This rule is being rescinded because these requirements are contained within 5 CSR 20-400.500.

AUTHORITY: sections 168.011, 168.405, and 168.409, RSMo 2000, and sections 161.092, 168.021, 168.071, 168.081, and 168.400, RSMo Supp. 2011. This rule previously filed as 5 CSR 80-800.200. Original rule filed April 26, 2000, effective Nov. 30, 2000. For intervening history, please consult the *Code of State Regulations*. Rescinded: Filed Oct. 25, 2019.

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

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

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

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 2—Boiler and Pressure Vessel Safety Rules**

PROPOSED AMENDMENT

11 CSR 40-2.015 Code/Standards Adopted by Board. The board is amending sections (1)–(11) and adding section (12).

PURPOSE: The division is amending the rule to update the codes and standards adopted by the board to the most current published standards in order to allow those companies installing equipment to avoid unnecessary costs associated with meeting an older code or applying for a variance.

(1) *ASME Boiler and Pressure Vessel Code of the American Society of Mechanical Engineers*[,] is hereby incorporated by reference in this rule. *ASME Boiler and Pressure Vessel Code* is published by the American Society of Mechanical Engineers. A copy of this code can be obtained from The American Society of Mechanical Engineers, Three Park Ave, New York, NY 10015-5990 or Internet: www.asme.org, Phone: 1 (800) 843-2763. This regulation does not include any later amendments or additions to the *ASME Boiler and Pressure Vessel Code*:

- (A) [2007] 2019 ASME Boiler and Pressure Vessel Code; and
- [(B) 2008 Addendum;]
- [(C)](B) Sections III and XI are exempt from state regulation.

(2) *National Board Inspection Code (ANSI/nb23)*[,] is hereby incorporated by reference in this rule. The *National Board Inspection Code* is published by The National Board. A copy of this code may be obtained from The National Board, 1055 Crupper Ave, Columbus, OH 43229-1183 or Internet: www.nationalboard.org, Phone: (614) 888-8320. This regulation does not include any later amendments or additions to the *National Board Inspection Code*. NB-23—*Manual for Boiler and Pressure Vessel Inspectors*:

- (A) [2007] 2019 Edition; Parts 1, 2, and 3, with Part 2 being permissive[]; and].
- [(B) 2008 Addendum.]

(3) *ASME Code for Power Piping*, B31.1 of the American Society of Mechanical Engineers. *ASME Boiler and Pressure Vessel Code* is hereby incorporated by reference in this rule. It is published by the American Society of Mechanical Engineers. A copy of this code can be obtained from The American Society of Mechanical Engineers, Three Park Ave, New York, NY 10015-5990 or Internet: www.asme.org, Phone: 1 (800) 843-2763. This regulation does not include any later amendments or additions to the *ASME Boiler and Pressure Vessel Code*.

- (A) [2007] 2018 Edition.
- [(B) 2008 Addendum.]

[(C)](B) Adopted for Boiler Proper and Boiler External Piping only; requirements for Non-Boiler External Piping and Joint (NBEP) as defined in B31.1, [2007] 2018 Edition are permissive.

(4) *Code for Controls and Safety Devices for Automatically Fired Boilers CSD-1*-[2009] 2018 Edition of the American Society of Mechanical Engineers. The *Code for Controls and Safety Devices for Automatically Fired Boilers CSD-1*-[2009] 2018 edition is hereby incorporated by reference in this rule. It is published by the American Society of Mechanical Engineers. A copy of this code may be obtained from The American Society of Mechanical Engineers, Three Park Ave, New York, NY 10015-5990 or Internet: www.asme.org, Phone: 1 (800) 843-2763. This regulation does not include any later amendments or additions to the *Code for Controls and Safety Devices for Automatically Fired Boilers CSD-1*-[2009] 2018.

- (A) With part CM being permissive.

(5) NFPA 85, *Boiler and Combustion Systems Hazards Code*, [2007] 2019 Edition. The *Boiler and Combustion Systems Hazards Code NFPA 85*, [2007] 2019 Edition is hereby incorporated by reference in this rule. It is published by the National Fire Protection Agency. A copy of this code may be obtained from National Fire Protection Agency, 1 Battery Park, Quincy, MA 02169-7471, Internet: www.nfpa.org, Phone: 1 (617) 770-3000. This regulation does not include any later amendments or additions to the *Boiler and Combustion Systems Hazards Code NFPA 85*, [2007] 2019 Edition.

(6) NFPA 54, *National Fuel Gas Code (ANSI Z221.1-2006)*, [2009] 2018 Edition. The *National Fuel Gas Code NFPA 54*, [2009] 2015 Edition is hereby incorporated by reference in this rule. It is published by the National Fire Protection Agency. A copy of this code may be obtained from National Fire Protection Agency, 1 Battery Park, Quincy, MA 02169-7471, Internet: www.nfpa.org, Phone: 1 (617) 770-3000. This regulation does not include any later amendments or additions to the *National Fuel Gas Code NFPA 54*, [2009] 2018 Edition.

(7) *Pressure Vessel Inspection Code, API-510 of the American Petroleum Institute*, [1997] 2014 Edition is hereby incorporated by reference in this rule. The *American Petroleum Institute 510* is published by the American Petroleum Institute. A copy of this code may be obtained from The American Petroleum Institute, 1220 L Street NW, Washington, DC 20005-4070, Internet: <http://api-ec.api.org/frontpage.cfm>, Phone: (202) 682-8000. This regulation

does not include any later amendments or additions to the *American Petroleum Institute 510*.

(8) *American National Standard/CSA Standard For Gas-Fired Pool Heaters* (ANSI Z21.56-2006/CSA 4.7-[2006] 2013) is hereby incorporated by reference in this rule. A copy of this standard may be obtained from CSA America, 8501 East Pleasant Valley Road, Cleveland, OH 44131-5575, Internet: www.csa-america.org, Phone: (216) 524-4990. This regulation does not include any later amendments or additions to the *Standard for Gas-Fired Pool Heaters, [2006] 2013* Edition.

(9) *American National Standard/CSA Standard for Gas Water Heaters* (ANSI Z21.10.3-2004/2015/CSA 4.3-[2004] 2015) is hereby incorporated by reference in this rule. A copy of this standard may be obtained from CSA America, 8501 East Pleasant Valley Road, Cleveland, OH 44131-5575, Internet: www.csa-america.org, Phone: (216) 524-4990. This regulation does not include any later amendments or additions to the *Standard for Gas Water Heaters, [2004] 2015* Edition.

(10) *NFPA 31-Standard for Installation of Oil-Burning Equipment, [2006] 2016* Edition is hereby incorporated by reference in this rule. The Standard for Installation of Oil-Burning Equipment is published by the National Fire Protection Agency. A copy of this code may be obtained from National Fire Protection Agency, 1 Battery Park, Quincy, MA 02169-7471, Internet: www.nfpa.org, Phone: (617) 770-3000. This regulation does not include any later amendments or additions to [T]the *Standard for Installation of Oil-Burning Equipment, [2006] 2016* Edition.

(11) *ASME PVHO-1-[2007] 2016, Safety Standard for Pressure Vessels for Human Occupancy* is hereby incorporated by reference in this rule. A copy of this code can be obtained from The American Society of Mechanical Engineers, Three Park Ave, New York, NY 10015-5990 or Internet: www.asme.org, Phone: 1 (800) 843-2763. This regulation does not include any later amendments or additions to the *ASME Safety Standard for Pressure Vessels for Human Occupancy, [2007] 2012* Edition.

(12) *NFPA 57—Liquefied Natural Gas (LNG) Vehicular Fuel Systems Code, 2002* Edition is hereby incorporated by reference in this rule. The *Liquefied Natural Gas Vehicular Fuel Systems Code* is published by the National Fire Protection Agency. A copy of this standard may be obtained from NFPA, 1 Batterymarch Park, Quincy, Massachusetts 02169. This regulation does not include any later amendments or additions to The *Liquefied Natural Gas (LNG) Vehicular Fuel Systems Code, 2002* Edition.

AUTHORITY: section 650.215, RSMo [2000] 2016. Original rule filed Sept. 25, 2002, effective May 30, 2003. Amended: Filed Jan. 12, 2006, effective June 30, 2006. Amended: Filed June 30, 2009, effective Feb. 28, 2010. Amended Filed Sept. 2013. Amended: Filed Oct. 16, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in *Missouri Register*. No public hearing is scheduled.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators**

PROPOSED AMENDMENT

11 CSR 40-5.050 New Installations. The division is amending the rule to update the codes and standards adopted by the board to more current published standards in order to allow those companies installing, inspecting and servicing equipment to avoid unnecessary costs associated with meeting an older code or applying for a variance. The Elevator Safety Board is amending sections (1)-(3).

PURPOSE: This amendment adopts standards for new installations.

(1) Minimum Standards. All new elevator equipment shall be constructed and installed in conformity with the standards prescribed in the American Society of Mechanical Engineers, ASME A17.1, [2004 edition ASME A17.1a Addenda and ASME A17.1s 2005 supplement with amendments] 2016 edition adopted by the board, *Safety Code for Elevators and Escalators*, A18.1, [2005] 2016 edition, *Safety Standards for Platform Lifts and Stairway Chair Lifts*, ASME A17.2 [2004] 2014 edition Guide for Inspection of Elevators, Escalators, and Moving Walks, *American National Standard Institute Safety Code for Manlifts* ANSI A90.1, [2003] 2015 edition, *American National Standard Institute Safety Code for Personnel Hoist* ANSI A10.4, [2004] 2016 edition, **ANSI/SIA A92.10 Transport Platforms, 2009, edition** unless [as] exempted by section 701.359, RSMo.

(2) Installation Permit.

(B) Elevator Installation Permit Obtained from the Department.

1. Application for an elevator equipment permit shall be made on a form furnished by the department and shall be submitted by the installing contractor[, or in the absence of an installing contractor, the owner, operator, lessee or agent of either]. The application shall require the submission of detailed plans and specifications.

2. Upon receipt of an application for installation of elevator equipment, the required plans and specifications, and the required fee for an elevator equipment permit, the department shall review the application for compliance with the provisions of these rules and regulations. The department shall issue an elevator equipment permit or shall notify the applicant, in writing, of the reasons the elevator equipment permit is denied.

3. Any applicant who has been denied an elevator equipment permit by the department may appeal that denial to the Elevator Safety Board, as provided in 11 CSR 40-50.140 as listed herein.

(C) Elevator installation permit obtained from authorized representative. Procedures for new installation permits shall be defined by the authorized representative.

(3) Inspection and Testing.

(A) Prior to the operation of any new elevator equipment or the issuance of the operating certificate, such elevator equipment shall be inspected by a licensed inspector. Testing must be performed by a **Licensed Mechanic** in accordance with these rules and regulations. The testing must be witnessed by a licensed inspector.

(B) An inspection report shall be filed with the department or its authorized representative, installing contractor and the owner, operator, lessee, or agent of either, by the licensed inspector making the inspection within ten (10) days after completion of the inspection. The inspection report shall be on a form furnished and approved by the department or its authorized representative. It shall indicate whether the elevator equipment was installed in accordance with the plans and specifications approved by the department or its authorized representative and meets the requirements of these rules and regulations.

AUTHORITY: section 701.355, RSMo [2000] 2016. Original rule filed Aug. 26, 1998, effective July 1, 1999. Amended: Filed Aug. 17, 2000, effective Feb. 28, 2001. Amended: Filed Dec. 16, 2002, effective June 30, 2003. Amended: Filed Dec. 4, 2006, effective May 30, 2007. Amended: Filed Oct. 16, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in Missouri Register. No public hearing is scheduled.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators**

PROPOSED AMENDMENT

11 CSR 40-5.055 Code Additions, Amendments and Interpretations. The Elevator Safety Board is deleting section (2) and adding a new section (2).

PURPOSE: This amendment eliminates the twelve (12) month effective date mandate originally contained in the rule. This mandate is no longer necessary or applicable due to the fact new elevator equipment is manufactured to the newest code version. The amendment also specifies board approved code deletions and additions within the code referenced.

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) The definitions, rules, and regulations for new construction shall be based upon and, at all times, follow the generally accepted nationwide engineering standards, formulae, and practices established and pertaining to elevator equipment construction and safety, known as the [“]Elevator and Escalator Safety Code of the American Society of Mechanical Engineers.[“] with all amendments and interpretations thereto made and approved by the council of the society/ 2016 Edition, which is incorporated by reference in this rule as published by ASME, Two Park Avenue, New York, NY 10016-5990. [Any amendments and interpretations subsequently made and published by the same authority when so adopted shall be deemed incorporated into, and constitute a part of the whole of the definitions, rules and regulations of the board.] **This rule does not include any later amendments or additions.** Amendments and interpretations to the code shall be effective immediately upon being promulgated, to the end that the definitions, rules, and regulations shall at all times follow the generally accepted nationwide engineering standards.

[(2) The rules and regulations and any subsequent amendments thereto, pertaining to the construction of new elevator equipment shall not be mandatory until twelve (12) months after the effective date of the rules and regulations.]

(2) Amendments to American Society of Mechanical Engineers, ASME A17.1, 2016 edition.

(A) Code deletions.

1. Section 1.2.1 Purpose.
2. Section 2.20.1 Suspension Means.
3. Section 2.20.4.2 Aramid Fiber Ropes.

(B) Code additions.

1. Purpose of this code is to provide for safety and to promote the public welfare. The provisions of this code are not intended to prevent the use of systems, methods, or devices of equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety to those prescribed by this code, provided there is technical documentation to demonstrate the equivalency of the system, method, or device. The specific stipulations of this code may be modified by the authority having jurisdiction based upon technical documentation or physical performance verification to allow alternative arrangements that will assure safety equivalent to that which would be provided by conformance to the corresponding requirements of this code or functions that do not conform with certain requirements in ASME A17.1/CSA B44, but do conform with the applicable requirements in ASME A17.1/CSA B44.7 may be considered by the board for meeting the requirements of this code. Exceptions may be based on the stipulations of the above section.

2. Suspension means.

A. Elevator cars and counterweights shall be suspended by steel wire ropes or noncircular elastomeric-coated steel suspension members attached to the car frame or passing around sheaves attached to the car frame specified in 2.15.1.

B. Suspension means which have previously been installed and/or used on another installation are not to be reused. All suspension members in a set of suspension means need to be the same material, grade, construction, and dimensions. A suitable means is to be provided to protect the suspension means during the installation process. Only the following may be permitted:

(I) Steel wire ropes constructed in accordance with ASME A17.6 2010 Edition, Part 1; or

(II) Noncircular elastomeric-coated steel suspension members constructed in accordance with ASME A17.6 2010 Edition, Part 3.

AUTHORITY: section 701.355, RSMo [1994] 2016. Original rule filed Aug. 26, 1998, effective July 1, 1999. Amended: Filed Oct. 16, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

PROPOSED AMENDMENT

11 CSR 40-5.065 Missouri Minimum Safety Codes for Existing Elevator Equipment. The Elevator Safety Board is amending section (1).

PURPOSE: This amendment provides clarity and consistency to sections of the existing rules referencing the proposed updated code adoption in 11 CSR 40-5.050.

(1) In a political subdivision or municipality that had adopted an edition of ASME A17.1 code, [annual safety inspection and tests] elevator equipment shall [be performed] conform to the code requirements adopted and enforced at the time the elevator equipment was installed. The following standards apply to all existing elevator equipment installed prior to July 1, 1999 as provided in 11 CSR 40-5.060. Any installation which is in compliance with the latest ASME A17.1 version adopted and amended by the Elevator Safety Board, unless as exempted by 701.359, RSMo shall be considered to be in compliance with 11 CSR 40-5.065.

(A) Hoistways.

1. Each passenger elevator hoistway landing shall be protected with a door or gate. The door or gate shall be of solid construction and shall guard the entire entrance.

2. All automatic passenger elevators with power doors shall have non-vision panels on hoistway doors.

3. Each hoistway landing in any elevator hoistway shall be continuously provided with a properly working door or gate.

4. Where freight elevator hoistway doors or gates are of open or lattice construction they shall be at least six feet (6') high and shall come within two inches (2") of the floor when closed. Gates shall be constructed as to reject a ball two inches (2") in diameter. They shall withstand a force of two hundred fifty (250) pounds pressure applied in the center of the gate without breaking or forcing it out of its guides.

5. Manually operated bi-parting entrances of elevators which can be operated from the landings shall be provided with pull straps on the inside and outside of the upper panel where the lower edge of the upper panel is more than six feet six inches (6'6") above the landing when the panel is in the fully opened position.

6. Each hoistway door or gate shall be provided with interlocks designed to prevent the car from moving unless the doors or gates are closed. Where doors or gates do not lock when closed they shall lock when the elevator is not more than twelve inches (12") away from the floor. Passenger elevator hoistway doors shall be closed and locked before the car leaves the floor.

7. All hoistway-door interlocks shall be of the hoistway unit type.

8. Automatic fire doors shall not lock any landing opening in the hoistway enclosure from the hoistway side nor lock any exit leading from any hoistway landing to the outside of the building.

9. Emergency keys for hoistway doors and service keys shall be kept readily accessible to authorized persons.

10. Access means shall be provided at one (1) upper landing to permit access to the top of the car, and at the lowest landing if this landing is the normal point of access to the pit.

11. Each hoistway door or gate, which is counterweighted, shall have its weights enclosed in a box-type guide or run in metal guides. The bottom of the guides or boxes shall be so constructed as to retain the counterweight if the counterweight suspension means breaks.

12. Hoistways containing freight elevators shall be fully

enclosed. Enclosures shall be unperforated to a height of six feet (6') above each floor or landing and above the treads of adjacent stairways. Unperforated enclosures shall be so supported and braced as to deflect not over one inch (1") when subjected to a force of one hundred (100) pounds applied horizontally to any point. Open work enclosure may be used above the six-foot (6') level and shall reject a ball two inches (2") in diameter.

13. Hoistways containing passenger elevators shall be fully enclosed and the enclosure shall be of solid construction to its full height.

14. Except where vertical opening bi-parting doors are provided, all elevators provided with automatic leveling, inching, or teasing devices and where the landing sills project within the hoistway, shall be equipped with a bevel on the underside of the landing sill. Bevels shall be constructed of smooth concrete or not less than sixteen (16) gauge metal securely fastened to the hoistway entrance. Bevels shall extend the full depth of the leveling zone plus three inches (3").

15. Every hoistway window opening seven (7) stories or less on an outside wall above a thoroughfare and every such window three (3) stories or less above a roof of the building or of an adjacent building shall be guarded to prevent entrance by fire or emergency rescue persons. Each such window shall be marked "hoistway" in a readily visible manner.

16. All electrical wiring in the hoistway shall be enclosed in metal conduit, flexible conduit or metal raceway or be in compliance with NFPA 70, *National Electric Code*.

17. No pipes conveying liquids, gases, or vapors shall be located in a hoistway. Exception: branch lines for sprinkler system and low pressure steam lines for heating.

(B) Car Enclosure: Passenger.

1. Each passenger car shall be fully enclosed except on the sides used for entrance and exit. The enclosure shall be of solid construction. Grill work at the top of the sides shall not be more than eight inches (8") high. If the car is provided with a solid door and there is no grill work in the enclosure, adequate means of ventilation shall be provided.

2. Each passenger car enclosure shall have a top constructed of solid material. The top shall be capable of sustaining a load of three hundred (300) pounds on any area of two feet (2') on a side and one hundred (100) pounds applied at any point. Simultaneous application of these loads is not required.

3. Passenger car enclosure tops shall have an emergency exit with cover. Opening size shall be as set forth in ASME A17.1, rule 204.1E, 1955 edition. Exception: Hydraulic elevators provided with a manual lowering valve.

4. Each passenger car shall have a door or gate at each entrance. Doors or gates shall be of the horizontally sliding type. Doors shall be of solid construction. Gates shall be of the collapsible type. Gates and doors shall conform to ASME A17.1, rule 204.4, 1955 edition.

5. Each passenger car door or gate shall have an electric contact to prevent the car from running with doors or gates open. Exceptions:

A. By a car-leveling or truck-zoning device;

B. By a combination hoistway access switch and operating device; or

C. When a hoistway access switch is operated.

6. All automatic passenger elevators with power doors shall have reopening devices on the doors, designed to reopen doors in the event the doors should become obstructed.

7. Where a car door or gate of an automatic or continuous-pressure operation passenger elevator is closed by power, or is of the automatically released self-closing type, and faces a manually operated or self-closing hoistway door, the closing of the car door or gate shall not be initiated unless the hoistway door is in the closed position; and the closing mechanism shall be so designed necessary to prevent closing of a horizontally sliding car door or gate from rest

shall be not more than thirty (30) pounds. Exception: Where a car door or gate is closed by power through continuous pressure of a door-closing switch, or of the car operating device, and where the release of the closing switch or operating device will cause the car door or gate to stop or to stop and reopen.

8. Each passenger car shall have lighting inside the enclosure of not less than five (5) foot-candles. Bulbs and tubes shall be guarded to prevent breakage.

9. Each passenger elevator shall have a capacity plate prominently displayed in its enclosure. The capacity plate shall list its capacity in pounds.

10. All passenger elevator car floors shall be maintained so that persons are not exposed to the hazards of tripping or falling.

11. All automatic passenger elevators shall be provided with an alarm bell capable of being activated from inside the car and audible outside the hoistway. If the elevator is not equipped with a bell, a two- (2-)/-/ way conversation device to the elevator and a ready accessible point outside the hoistway may be acceptable.

12. All automatic passenger elevators shall have their door open zones adjusted to where the door shall not open unless the car has stopped within six inches (6") of floor level.

(C) Car Enclosure: Freight.

1. Each freight elevator car shall have a solid enclosure of at least six feet (6') in height. The space between the solid section and the car top shall be covered solid or with perforated or lattice-type work. The perforated or lattice work shall reject a ball one and one-half inches (1 1/2") in diameter. The portion of open-type enclosure, which passes the counterweights, shall be of solid construction the entire width of the counterweights plus six inches (6") on either side. The enclosure top shall be provided with an emergency exit. Exception: Hydraulic elevators provided with a manual-lowering valve.

2. Each freight car enclosure shall have doors or gates at each entrance and shall be not less than six feet (6') high. Each door or gate shall be constructed in accordance with ASME A17.1, rule 204.4, 1955 edition.

3. Each car door or gate on a freight elevator shall have electric contacts to prevent the car from running with doors or gates open. Exceptions:

- A. By a car-leveling or truck-zoning device;
- B. By a combination hoistway access switch and operating device; or
- C. When a hoistway access switch is operated.

4. Each freight elevator car enclosure shall be provided with a top. The top may be solid or open-work construction and shall be of metal. The open work shall reject a ball two inches (2") in diameter. Car tops shall be constructed to sustain a load of two hundred (200) pounds applied at any point on the car top. The top shall not have hinged or folding panels other than the emergency exit cover.

5. Each freight car enclosure shall have lighting not less than two and one-half (2 1/2) foot-candles. Bulbs or tubes shall be guarded to prevent breakage.

6. Each freight car enclosure shall have capacity plate, loading class plates, and a "No Passengers" sign conspicuously posted. Letters shall not be less than one-half inch (1/2") high.

7. Freight elevators shall not be loaded to exceed the rated load as stated on their capacity plates.

8. Each freight elevator car floor shall be maintained so that personnel will not readily slip or trip. The floor shall be maintained so that it will hold its rated load without breaking through at any place in the car.

9. Freight elevators shall not be permitted to carry passengers other than persons to load and unload material and the operator. Permission may be granted to allow the carrying of employees on freight elevators. Application shall be submitted and may be approved by the authorized representative after which the installation

shall be tested as determined by the Department of Public Safety.

(G) Maintenance, Repair and Alterations.

1. All maintenance, repair and replacement shall comply with **the applicable standard established by 11 CSR 40-5.050(1) ASME A17.1, section 8.6 [2004 edition with 2005 Addenda and 2005 supplement] Safety Code for Elevators and Escalators.**

2. All alterations shall comply with **the applicable standards established by 11 CSR 40-5.050(1) ASME A17.1, section 8.7 [2004 edition with ASME A17.1a 2005 Addenda and ASME A17.1S 2005 supplement] Safety Code for Elevators and Escalators.**

3. All maintenance, repair and alterations to platform lifts and stairway chair lifts shall comply with **the applicable standards established by 11 CSR 40-5.050(1) ASME A18.1, [2005 edition,] Safety Standard for Platform Lifts and Stairway Chair Lifts.**

(H) Machine Rooms.

1. All means of access to elevator machine rooms shall be of a permanent nature and shall be constructed and maintained in a clear and unobstructed manner.

2. The elevator machine and control equipment shall be located in a separate room or separated space designed as an elevator machine room or space and shall be accessible only to authorized personnel. Existing machines and equipment essential to the operation and purpose of the building are permitted but must not interfere with the safety and work area for maintaining elevator equipment. Pipes conveying liquid, gas, or vapor that cross overhead of elevator equipment or come in close proximity of the equipment shall be guarded or guttered. Where other existing machines and equipment essential to the operation and purpose of the building are located in the machine room or space, the elevator related equipment and machines shall be separated by a substantial grill constructed of non-combustible material not less than six feet (6') high and the grill shall be of a design that will reject a ball two inches (2") in diameter. All rooms or enclosures shall have a self-closing and self-locking door and shall be operable from the interior space without use of a key. After the effective date of this rule, no equipment shall be added to the machine room or space that is not used in connection with the operation of the elevator.

3. All elevator machine rooms shall be provided with a floor. The floor shall cover the entire area of the machine room and hoistway.

4. Machine room floors shall be kept clean and free of grease and oil. Articles or materials not necessary for the maintenance or operation of the elevator shall not be stored therein. Flammable liquids having a flash point of less than one hundred ten degrees Fahrenheit (110°F) shall not be stored in the machine room.

5. Lighting in the machine room shall be not less than ten (10) foot-candles at floor level.

6. Where there is more than one machine in a room, each machine shall have a different number conspicuously marked on it. The controller, disconnect switch and relay panels for each machine shall be conspicuously numbered to correspond to the machine it controls.

7. All electrical equipment in the machine room shall be grounded which shall conform to ASME A17.1, 1996 edition and NFPA, 70, *National Electric Code*.

8. All electrical wiring in the machine room shall be enclosed in metal conduit, flexible conduit or metal raceways or be in compliance with NFPA 70, *National Electric Code*.

9. Each elevator having polyphase alternating current power supply shall be provided with means to prevent the starting of the elevator motor if:

A. The phase rotation is in the wrong direction; or

B. There is a failure of any phase. This protection shall be considered provided in the case generator-field control having alternating current motor-generator driving motors, provided a reversal of phase will not cause the elevator driving-machine motor to operate

in the wrong direction. Controllers whose switches are operated by polyphase torque motors provide inherent protection against phase reversal or failure.

(I) Pits.

1. All pits shall be kept dry, clean, and free of equipment or material not relating to the operation of the elevator. Exception: Sump pumps.

2. Buffers (spring or oil type) under cars and counterweights shall be permanently fastened to the floor or their supporting beams.

3. All elevators shall have counterweight guards. Guards shall be of unperforated metal of at least the strength of or braced to the equivalent strength of number fourteen (14) gauge sheet steel. Guards shall extend from a point not more than twelve inches (12") above the pit floor to a point not less than seven feet (7') above the pit floor. Where guards are not feasible, warning chains shall be installed on the bottom of the counterweights and shall extend no less than five feet (5') below counterweight. Chains shall be of a number ten (10) U.S. gauge wire or of equal size. Exception: When compensating chains or ropes are used, a counterweight guard is not required.

4. Buffers shall be installed where elevator pits are not provided with buffers and where the pit depth will permit, buffers shall comply with ASME A17.1, 1955 edition, section 201.

5. Where the depth of any pit is four feet (4') or more it shall have a ladder permanently installed. The ladder shall extend not less than thirty inches (30") above the sill of the access door, or hand grips shall be provided to the same height. Ladder shall be of non-combustible material.

6. A permanent lighting fixture shall be provided in all pits to provide an illumination of not less than five (5) foot-candles at the pit floor. The fixture switch shall be provided and accessible from the pit access door.

7. An enclosed stop switch meeting the requirements of ASME A17.1, 1995 edition, rule 210.2(e) shall be installed in the pit of all power elevators and be accessible from the pit access door.

8. Pit sump holes, with or without pumps, and well holes that are accessible, shall be covered flush with the pit floor. The covering shall consist of a noncombustible material.

(J) Counterweights.

1. Broken or cracked sections of counterweights shall be replaced.

2. Counterweight hanger rods, tie rods or both shall firmly support and secure the counterweight sections in place.

3. Wire ropes extending through counterweights from one (1) stack to another shall be guarded by metal sleeves attached to the wire ropes. Guards shall be of a suitable design to prevent accidental crushing or deforming for the ropes and rope sockets. Stacks shall not be spaced less than eight inches (8") apart.

(K) Car Platforms and Car Slings.

1. All platforms shall be soundly constructed without cracks or breaks in stringers or frames. All floors shall be free of holes.

2. All car slings shall be soundly constructed and free of cracks or breaks.

3. Where cable sheaves are used on the crosshead, they shall be firmly attached and free of cracks or breaks.

4. All elevators shall have data plates attached to the crosshead.

5. All elevators with automatic leveling, inching or teasing devices shall have a platform guard or an apron. All other elevators shall have warning chains hung within two inches (2") of the edge of the platform on the entrance sides. Chains shall be of number ten (10) U.S. gauge wire or of equal size. Chains shall extend not less than five feet (5') below the platform and shall not be spaced more than four inches (4") apart.

6. All car slings shall have guide shoes at the top and bottom of the sling. Shoes that are worn to a degree which affect the safe operation of the car shall be repaired or replaced.

(L) Wire Ropes—Hoisting, Governor, and Tiller.

1. All hoisting and governor ropes, when replaced, shall have

rope tags. The tags shall provide the following information:

- A. The diameter in inches;
- B. The manufacturer's rated breaking strength;
- C. The grade of material used;
- D. The month and year ropes were installed;
- E. Whether preformed or non-preformed;
- F. Construction classification;
- G. Name of person or firm who installed ropes; and
- H. Name of manufacturer of ropes.

2. Wire ropes on drum-type machines shall be resocketed in compliance with ASME A17.1, 1996 edition, rule 1206.3.

3. Suspension ropes on drum-type machines shall have not less than one (1) turn of the rope on the drum when the car is resting on the fully compressed buffers.

4. Winding drum machines shall not be used unless they are provided with not less than two (2) hoisting ropes. Each counterweight stack shall be provided with not less than two (2) ropes.

5. Tiller cables on cable-operated elevators shall be kept free of breaks.

6. On tiller-cable operations, the cable shall pass through a guiding or stopping device mounted on the car. The cable shall be provided with adjustable stop balls and be provided with means to lock and hold the car at a floor. Stop balls at top and bottom shall be adjusted to automatically stop the car. The tiller cable shall be completely enclosed in the hoistway.

7. All hoisting or counterweight ropes located outside of the hoistway that are exposed shall be covered with a box-type guard. The guard shall be not less than six feet (6') high from floor level.

8. Hoisting, governor and tiller ropes shall not be lengthened or repaired by splicing.

9. Suspension means of chains other than a roller chain type shall not be allowed. Any elevator suspended by a roller chain type shall not be used for the carrying of passengers. Exception: Elevators for the disabled.

10. Hoisting ropes for power elevators shall not be less than three-eighths inch (3/8") in diameter.

11. Hoisting rope fastening means shall be of the socket, babbitting or wedge type. Clamps shall not be used.

12. Rope (cable) replacement. Hoisting, governor and tiller ropes shall be replaced when the Inspection of Elevators, Escalators and Moving Walks, ASME A17.2, 1996 edition Inspectors' Manual, Division 103, Item 103.4 dictates they shall be changed.

(M) Car Safeties and Speed Governors.

1. Each elevator suspended by ropes shall be provided with mechanically applied car safeties which shall be capable of stopping and sustaining its rated load.

2. Broken rope or slack rope safeties may be allowed if the car speed is not in excess of fifty feet per minute (50 fpm).

3. Elevators which are provided solely with broken rope or slack rope safeties shall not be used for passenger service. Exception: Elevators for the disabled.

4. All safeties shall be adjusted so that clearances from the rail shall be in accordance with ASME A17.1, 1955 edition rule 1001.2.

5. All slack cable safeties shall be provided with an electrical switch which disconnects power to the elevator machine and brake when setting of the safeties occurs.

6. All safeties operated by a speed governor shall be provided with a speed switch operated by the governor when used with type B or C car safeties on elevators having a rated speed exceeding one hundred fifty (150) fpm. A switch shall be provided on the speed governor when used with a counterweight safety for any car speed.

7. Speed governors shall have their means of speed adjustment sealed.

8. For hoistways not extending to the lowest floor and where space below the hoistway is used for a passageway or is occupied by persons, or if unoccupied but not secured against unauthorized access, the counterweights of the elevator shall be provided with safeties. Safeties shall be tripped by a speed governor if the car speed

is in excess of one hundred fifty (150) fpm. Speed governors shall be set to trip above the car governor tripping speed but not more than ten percent (10%) greater.

(N) Guide Rails.

1. All guide rails and brackets whether of wood or steel shall be firmly and securely anchored or bolted in place. Where T rail is used all fish-plate bolts shall be tight. This shall comply with ASME A17.1, 1955 edition, section 200.

2. Where guide rails which are worn to such a point that proper clearance of safety jaws cannot be maintained, the worn sections shall be replaced to achieve clearances as specified in ASME A17.1, 1996 edition, rule 1001.2.

(O) Existing Hydraulic Elevators.

1. Cylinders of hydraulic-elevator machines shall be provided with a means for releasing air or other gas.

2. Each pump or group of pumps shall be equipped with a relief valve conforming to the following requirements:

A. Type and location. The relief valve shall be located between the pump and the check valve and shall be of such a type and so installed in the bypass connection that the valve cannot be shut off from the hydraulic system;

B. Setting. The relief valve shall be preset to open at a pressure not greater than that necessary to maintain one hundred twenty-five percent (125%) of working pressure;

C. Size. The size of the relief valve and bypass shall be sufficient to pass the maximum rated capacity of the pump without raising the pressure more than twenty percent (20%) above that at which the valve opens. Two (2) or more relief valves may be used to obtain the required capacity; and

D. Sealing. Relief valves having exposed pressure adjustments if used, shall have their means of adjustment sealed after being set to the correct pressure. Exception: No relief valve is required for centrifugal pumps driven by induction motors, provided the shut-off, or maximum pressure which the pump can develop, is not greater than one hundred and thirty-five percent (135%) of the working pressure at the pump.

3. Storage and discharge tanks shall be covered and suitably vented to the atmosphere.

4. All repair and alterations of hydraulic elevators shall comply with ASME A17.1, 1996 edition, section 1201 with supplements thereto.

(P) Existing Sidewalk Elevators.

1. Hoistways shall be permanently enclosed. The enclosures shall conform to ASME A17.1, 1955 edition rule 401.1.

2. All interior landings shall have a door or gate which shall be provided with an interlock.

3. Doors opening in sidewalks or other areas exterior to the building shall be of the hinged type. Doors or covers shall be designed to hold a static load of three hundred pounds per square foot (300 ppsf). Doors shall always be closed unless elevator is at the landing.

4. Stops shall be provided to prevent the cover in the opening of the sidewalk from opening more than ninety degrees (90°) from its closed position.

5. Covers in sidewalk shall be designed to close when the car descends from the top landing.

6. Recesses or guides which will securely hold the cover in place on the car stanchions shall be provided on the underside of the cover.

7. All electrical wiring shall be enclosed in metal conduit, flexible conduit, or metal raceways. If hoistway opens in the sidewalk, the wiring shall be weatherproof.

8. Operating devices and control equipment shall comply with ASME A17.1, 1955 edition, rule 402.4.

9. All electric sidewalk elevators shall have upper and lower final limit switches. Open-type switches shall not be allowed.

10. Cars shall have enclosures which shall be not less than six feet (6') in height provided the stanchions and bow iron are of suffi-

cient height. The enclosure shall be provided with electric contacts to prevent the car from running with doors or gates open.

11. Cars shall have safeties. Where the speed of the elevator does not exceed fifty (50) fpm, car safeties which operate as a result of breaking or slackening of the hoisting ropes may be used. Such safeties may be of the inertia type or approved type without governors. Governors shall not be required when car speed does not exceed fifty (50) fpm.

12. Car enclosures and car gates shall not be required for hand-powered sidewalk elevators.

13. All repair and alterations shall comply with ASME A17.1, 1955 edition, section 1200.

(Q) Existing Hand Elevators.

1. Hand-powered elevators shall have hoistway doors. Doors shall be of the self-closing and self-locking type.

2. Hoistway doors shall have signs attached to them indicating elevator hoistway. Sign shall be as follows in not less than two-inch (2") letters: DANGER ELEVATOR—KEEP CLOSED.

3. All hand-powered elevators shall be provided with safeties or slack cable devices. Safeties do not have to be operated by a speed governor unless the speed is in the excess of fifty (50) fpm.

4. Hand-powered elevators shall have a car enclosure which shall be constructed of metal or sound seasoned wood. The enclosure shall cover all sides which are not used for entrance or exit. The enclosure shall be secured to the car platform or frame in such a manner that it cannot work loose or become displaced in ordinary service.

5. Each hand-powered elevator shall be provided with a brake which shall be capable of stopping and sustaining the car whether loaded or unloaded.

6. Hand-powered elevators shall not be converted or changed to electric powered unless the complete facility is brought into conformity with ASME A17.1, 1996 edition.

7. Repair or replacement of worn or broken parts shall be in compliance with ASME A17.1, 1996 edition, rule 1202.2.

(R) Power Operated Special Purpose Elevators.

1. Elevators complying with the following requirements may be installed in any structure where the elevator is not accessible to the general public, is used exclusively for designated operating and maintenance employees only, and where transportation of one (1) or two (2) persons is required to attend machinery or equipment frequently.

2. The inside platform area of the car shall not exceed nine (9) square feet. The rated speed shall not exceed one hundred (100) fpm. The rated load shall not exceed six hundred fifty (650) pounds.

3. Hoistways shall be enclosed to their full width, to a height of not less than seven feet (7') with solid or perforated noncombustible material braced to deflect not more than one inch (1") when subjected to a force of one hundred (100) pounds applied horizontally at any point. Open work enclosures shall be at least number thirteen (13) steel wire gauge or expanded metal at least number thirteen (13) U.S. gauge and shall reject a ball two inches (2") in diameter. Where counterweights pass, landing and stairway side shall be of solid construction.

4. Wiring shall comply with the requirements of ASME A17.1, 1978 edition and NFPA 70.

5. Counterweights shall comply with the requirements of ASME A17.1, 1978 edition, Part XV.

6. Hoistway doors shall comply with rules ASME A17.1, 1978 edition, Part XV.

7. Cars shall be solidly constructed in accordance with ASME A17.1, 1978 edition, Part XV.

8. Car enclosure.

A. Except at the entrance, the car shall be enclosed on all sides and the top. The enclosure at the sides shall be solid or open work. All open work shall reject a ball one inch (1") in diameter. The enclosure shall be constructed of sufficient strength that it will not deflect more than one inch (1") at any one (1) point.

B. There shall be an electric light to illuminate the car or

hoistway with the switch placed on or near the operating panel.

C. There shall be no glass used in the elevator car except for the car light.

9. A car door shall be provided at each car entrance. Door or gate shall guard the complete entrance. The door or gate shall be at least seven feet (7') high, of metal construction with solid or open construction to reject a ball one inch (1") in diameter. A contact switch shall be provided to prevent the operation of the elevator with doors or gates open. The door or gate shall be provided with interlocks.

10. Guide rails shall comply with ASME A17.1, 1978 edition, Part XV.

11. The means and methods of suspension shall comply with ASME A17.1, 1978 edition, Part XV.

12. Electrical switches shall comply with ASME A17.1, 1978 edition, Part XV.

13. Brakes shall comply with ASME A17.1, 1978 edition Part XV.

14. Emergency signal or communication shall comply with ASME A17.1, 1978 edition, Part XV.

(S) Fire Service.

1. Elevators with fire service features shall comply with the edition of ASME A17.1 that the elevator was constructed to meet.

(T) Existing Dumbwaiters, Escalators, and Moving Walks.

1. Dumbwaiters. All dumbwaiters whether electric or hand powered shall conform to ASME A17.1, 1971 edition, section 700. Exceptions: Required rules for hoistway construction as set forth in ASME A17.1, 1971 edition shall not apply to existing installations.

2. Escalators.

A. Each escalator shall be provided with an electrically released mechanically applied brake capable of stopping the up and down traveling escalator with any load up to and including the rated load. The brake shall be located either on the driving machine or on the main drive shaft.

B. Starting switches shall be of the key-operated type. Starting switches shall be located on or near the escalator.

C. Emergency stop buttons or other type manually operated switches having red buttons or handles shall be accessibly located at or near the bottom and top landings. The buttons or levers shall be protected to prevent accidental operation.

D. A broken step-chain device shall be provided on each escalator that will cause interruption of power to the driving machine if a step chain breaks or if excessive sag occurs in either step chain.

E. Each escalator shall have comb plates at top and bottom landings of the escalator. Comb plate teeth shall be meshed with and set into slots in the tread surface of the steps so that the points of the teeth are always below the upper surface of the treads.

F. Each escalator balustrade or molding on the balustrade shall have a smooth surface. Screw heads shall set flush with the surface or be of the oval head type without any burrs or rough places on their surface.

G. The clearance on either side of the steps between the step tread and the adjacent skirt panel shall be not more than three-sixteenths inch (3/16").

H. Step treads shall be illuminated throughout their run. The light intensity shall be not less than two (2) foot-candles.

I. An enclosed fused disconnect switch or circuit breaker arranged to disconnect the power supply to the escalator shall be in each machine room or wherever the controller is located.

J. A stop switch shall be provided in each machinery space where means of access to the space is provided. The switch when opened shall cause electric power to be removed from the escalator driving-machine motor and brake. The switch shall be of the manually opened and closed type and shall be marked "STOP."

K. Hand or finger guards shall be provided at the point where the handrail enters the balustrade.

L. Where the clearance of the upper outside edge of the balustrade and a ceiling or scaffold is less than twelve inches (12")

or where the intersection of the outside balustrade and a ceiling or soffit is less than twenty-four inches (24") from the centerline of the handrail, a solid guard shall be provided in the intersection of the angle of the outside balustrade and the ceiling or soffit. The vertical front edge of the guard shall project a minimum of fourteen inches (14") horizontally from the apex of the angle. The escalator side of the vertical face of the guard shall be flush with the face of the well-way. The exposed edge of the guard shall be rounded.

3. Moving walks.

A. Each moving walk shall be provided with an electrically released, mechanically applied brake capable of stopping and holding treadway with a load up to and including the rated load.

B. Starting switches shall be of the key-operated type and shall be located within sight of the exposed treadway.

C. Each moving walk shall be provided with an emergency stop button or manually operated switch at each entrance and exit. The switches shall be protected to prevent the accidental operation of them. The operation of any of these switches shall interrupt the power to the driving-machine motor and brake.

D. A device shall be provided which will cause interruption of power to the driving-machine motor and brake if the connecting means between pallets break.

E. The entrance to and exit from a moving treadway shall be provided with a threshold plate which shall have teeth and be adjusted so that the teeth are below the treadway.

F. An enclosed fused disconnect switch or a circuit breaker arranged to disconnect the power supply to the moving walk shall be provided in the space where the controller is located.

G. If the balustrade covers the edge of the treadway the clearance between the top surface of the treadway and the underside of the balustrade shall not exceed one-fourth inch (1/4"). Where skirt panels are used the horizontal clearance on either side of the treadway and the adjacent skirt panel shall be not more than one-fourth inch (1/4").

H. A stop switch shall be provided in each machinery space where means of access to the space is provided. The switch when opened shall cause electrical power to be removed from the driving-machine motor and brake. The switch shall be of the manually operated type, and shall be marked "STOP."

I. Hand or finger guards shall be provided at the point handrails enter the balustrade.

J. All balustrades shall be smooth and free of rough surfaces. All screws shall be flush or oval head. Screw heads shall be smooth and free of burrs.

K. On pallet type treadways adjacent ends of the pallets shall not vary in elevation more than one-sixteenth inch (1/16"). The distance between pallets shall not exceed five thirty-seconds inch (5/32").

L. All repairs and alterations shall comply with ASME A17.1, 1996 edition.

(U) Existing Vertical and Inclined Platform Lifts.

1. Existing vertical and inclined platform lifts shall meet the requirements of ASME A17.1, 1984 edition, Part 20.

(V) Existing Manlifts.

1. Existing manlifts shall be inspected per the requirements of ASME A90.1, 1997 edition.

AUTHORITY: section 701.355, RSMo [2000] 2016. Original rule filed Aug. 26, 1998, effective July 1, 1999. For intervening history, please consult the Code of State Regulations. Amended: Filed Oct. 16, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators**

PROPOSED AMENDMENT

11 CSR 40-5.070 Accessibility to the Disabled. The Elevator Safety Board is amending section (1).

PURPOSE: This amendment changes the rule to adopt the most current version of the standard used to ensure accessibility to elevator equipment meets ADA requirements.

(1) New Installations of Accessible Passenger Elevators and Wheelchair Lifts. In addition to the standards imposed, the board hereby adopts and incorporates herein the *American National Standards Institute Standard for Buildings and Facilities Providing Accessibility and Usability for Physically Disabled People*, ANSI A117.1 [2003] 2009 edition, Sections 407, 408, and 410, American Society of Mechanical Engineers (ASME), Three Park Avenue, New York, NY 10016 adopted by the Elevator Safety Board. This rule does not include any later amendments or additions.

AUTHORITY: section 701.355, RSMo [2000] 2016. Original rule filed Aug. 26, 1998, effective July 1, 1999. Amended: Filed Dec. 16, 2002, effective June 30, 2003. Amended: Filed Dec. 4, 2006, effective May 30, 2007. Amended: Filed Oct. 16, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in Missouri Register. No public hearing is scheduled.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators**

PROPOSED AMENDMENT

11 CSR 40-5.080 Alterations. The Elevator Safety Board is amending sections (1) and (3).

PURPOSE: This amendment ensures consistency in the references to code versions in the elevator safety rules; replaces obsolete terminology and code references with current terminology and code references; and requires testing be performed by a licensed mechanic.

(1) Minimum Standards. When any alterations are made, all elevator equipment, as a minimum, shall conform to the applicable requirements of section 8.7 of the ASME A17.1 [2004 edition with 17.1

2005 addendum and 2005 supplement] as amended by the Elevator Safety Board.

(A) Major Alterations listed below require an alteration permit to be obtained and submission of plans or scope of work for review by the division. The plan review fee is one hundred fifty dollars (\$150) plus twenty-five dollars (\$25) per each floor opening including the bottom floor plus twenty-five dollars (\$25) for the alteration permit fee. An acceptance inspection shall be conducted after completion of the alteration.

Item	Electric	Hydraulic	MW & Esc.
<i>[**Alternating current, change to direct current]</i>			
**Change in Power Supply	8.7.2.27.3	8.7.3.31.4	
*Car, increase/decrease in dead weight of Car	8.7.2.15.2	8.7.3.21	
**Controller	8.7.2.27.4	8.7.3.31.5	
<i>[**Direct current, change to alternating current</i>			
<i>[**Driving machine]</i>			
**Alterations to Driving Machines and Sheaves	8.7.2.25.1		
**Hydraulic Jack		8.7.3.23.1	
*Driving machine, change in location	8.7.2.25.2	8.7.3.23.6	
**Electrically operated control valve in place of Mechanical valve		8.7.3.24	
<i>[**Freight elevator change to passenger service]</i>			
Carrying of Passengers of Freight Elevators	8.7.2.16.3	8.7.3.[17]/19	
*Increase in rated load	8.7.2.16.4	8.7.3.20	
<i>[**Increase in rated speed</i>			
*Increase in travel	8.7.2.17.1	8.7.3.22.2&3	
	8.7.2.17.1	8.7.3.22.1]	
*Change in Rise or Rated Speed	8.7.2.17		
*Change in Travel or Rated Speed		8.7.3.22	
<i>[*Operation, change in type of] *Change in Type of Service</i>			
*Change in Type of Operation Control	8.7.2.16.1	8.7.3.17	
	8.7.2.27.6	8.7.3.31.7	
<i>[**Pressure, working change in]</i>			
** Increase in working pressure		8.7.3.23.4	
*Addition of elevator to existing hoistway	8.7.2.1.2	[8.7.2.1.2]	
*Hoistway Enclosures		8.7.3.1	
<i>[**Car decrease or increase in dead weight of]</i>			
**Increase or Decrease in Deadweight of Car.	8.7.2.15.2	8.7.3.21	
<i>[*Decrease in travel</i>			
*Freight elevator permitted to carry passengers	8.7.2.17.1	8.7.3.22.1	
	8.7.2.16.3	8.7.3.19]	
<i>[*Location of driving machine, change in]</i>			
*Change in Location of Driving Machine	8.7.2.25.2	8.7.3.23.[4]/6	
*Location of hydraulic jack, change in		8.7.3.23.5	
<i>[*Location of hydraulic machine, change in</i>			
*Relocation of moving walk		8.7.3.23.6]	8.7.6.2.2
*Relocation of escalator			8.7.6.2.1
*Trusses and Girders (New onto Existing Truss) Escalator			8.7.6.1.9
*Trusses and Girders (New onto Existing Truss) Moving Walk			8.7.6.2.9
*Top of car operating device	8.7.2.27.1	8.7.3.31.1	
**Change in Suspension Means	8.7.2.21.1	8.7.3.25.1	

* Plans submitted with permit

** Scope of work submitted with permit

(B) Alterations and major repairs listed below only require an alteration permit to be obtained and an acceptance inspection conducted. Alteration permit fee is twenty-five dollars (\$25).

Item	Electric	Hydraulic
*Buffer	8.7.2.23	8.7.3.27
*Car safeties	8.7.2.18	8.7.3.15
<i>[**Check valve</i>		
<i>[**Control valve] **Valves, Pressure Piping, and Fittings</i>		
*Counterweight safeties	8.7.2.18	8.7.3.24]
*Hydraulic Jack		8.7.3.15
		8.7.3.23
<i>[**Door, power operation of]</i>		
**Power Operation of Hoistway Doors	8.7.2.12	8.7.3.[10]/12
**Emergency operation [(not signaling devices)]	8.7.2.28	8.7.3.31.8
**Final terminal stopping device	8.7.2.26	(none)
**Firefighters service	8.7.2.28	8.7.3.31.8
<i>[*Governor</i>		
	8.7.2.19	8.7.3.16]
<i>[**Governor rope (not if same type, size and material)]</i>		
**Speed Governor and Governor Ropes.	8.7.2.19	8.7.[2].3.16

Item	Electric	Hydraulic
**Guide rail	8.7.2.24	8.7.3.28
[* *Hoist-way door, power operation of	8.7.2.12	8.7.3.12]
**Normal terminal stopping device	8.7.2.26	8.7.3.30
**Piping supply		8.7.3.24
*Piston		8.7.3.23.2
[* *Rope, suspension (not if same type, size & material)	8.7.2.21.1	8.7.3.25.1]
**Plunger Gripper		8.7.3.23.7
*Operating device	8.7.2.27	8.7.3.31
[* Overlay	8.7.2.27.6	8.7.3.31.5]
[* *Sleeving] **Cylinders replaced, altered or sleeved		8.7.3.23.3
[* Spring Buffer	8.7.2.27	8.7.3.27]
[* *Wire rope] **Suspension Means and Their Connections	8.7.2.21	8.7.3.25
[* *Valve		8.7.3.24]
**Brake	8.7.2.25.1(a)	
**Capacity, Loading and Classification	8.7.2.16	8.7.3.18

- * Plans submitted with permit
- ** Scope submitted with permit

(C) All other alterations are required to conform to **11 CSR 40-5.050 ASME A17.1[-]2004 with 2005 Addendum and 2005 Supplement** section 8.7. as amended by the Elevator Safety Board.

(2) Alteration Permit.

(B) Alteration Permit Obtained from the Department.

1. Application for an alteration permit shall be made on a form furnished by the department and shall be submitted by the installing contractor, or in the absence of an installing contractor, the owner, operator, lessee or agent of either. The application shall require the submission of detailed plans and specifications.

2. Upon receipt of an application and the required fee for an alteration permit, the required plans and specifications, shall be reviewed by the department for compliance with the provisions of these rules and regulations. The department shall issue an alteration permit or shall notify the applicant in writing of the reasons the alteration permit is denied.

3. Any applicant who has been denied an alteration permit by the department may appeal that denial to the Elevator Safety Board, as provided in 11 CSR 40-5.140 as listed herein.

(3) Inspection and Testing.

(A) Prior to the operation of any elevator equipment, which has undergone an alteration or major repair and prior to the issuance of a new operating certificate, the elevator equipment shall be inspected by a licensed inspector. Testing must be performed by a **licensed mechanic** in accordance with these rules and regulations. The testing must be witnessed by a licensed inspector.

(B) An inspection report shall be filed with the department or its authorized representative, installing contractor and the owner, operator, lessee, or agent of either, by the licensed inspector within ten (10) days after completion of the inspection. The inspection report shall be on a form furnished and approved by the department or its authorized representative. It shall indicate whether the elevator equipment was installed in accordance with the plans and specifications approved by the department or its authorized representative and meets the requirements of these rules and regulations.

AUTHORITY: section 701.355, RSMo [2000] 2016. Original rule filed Aug. 26, 1998, effective July 1, 1999. Amended: Filed Dec. 16, 2002, effective June 30, 2003. Amended: Filed Dec. 4, 2006, effective May 30, 2007. Amended: Filed Oct. 16, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators**

PROPOSED AMENDMENT

11 CSR 40-5.090 Inspection and Testing. The Elevator Safety Board is amending sections (1)–(3).

PURPOSE: This amendment clarifies terminology within this rule and removes obsolete references to codes.

(1) Minimum Standard. All inspections and testing required by Missouri Statute 701.350–701.380 and these rules and regulations shall be made in accordance with the **applicable** standards established by *[these rules and regulations and the American Society of Mechanical Engineers Manuals for Elevators and Escalators, ASME A17.1 April 30, 2004, with A17-1a April 29, 2005 Addenda and 17.1s March 23, 2005 supplement, 17.2 March 20, 2005, and A18.1 November 29, 2005, American Society of Mechanical Engineers (ASME), Three Park Avenue, New York, NY 10016,]* **11 CSR 40-5.050**, adopted by the Elevator Safety Board excluding periodic inspection requirements of Table N-1, six- (6-)[-] month interval in ASME A17.1 The requirements of the six- (6-)[-] month periodic inspection is to be performed with the twelve- (12-)[-] month periodic inspection. The foregoing standards are incorporated by reference in this rule. This does not include any later amendments or additions.

(2) Periodic Inspections.

(A) The owner, operator, lessee, or agent of either of any elevator equipment as described herein shall have it inspected, every twelve (12) months, as defined by sections 701.350–701.380, RSMo and these rules and regulations. The inspection may be made within thirty (30) days prior to or thirty (30) days following the anniversary date of the initial inspection. Other variations to the twelve- (12-)[-] month inspection period may be authorized by the chief elevator inspector as deemed necessary to schedule inspections in remote locations or for multiple elevator equipment situations.

(3) Testing Procedures.

(C) Tests required by these rules and regulations shall be made by a *[person qualified]* **licensed elevator mechanic** to perform such service employed by the owner, operator, lessee, or agent of either, in the presence of a licensed inspector. The department has within its discretion, the authority to allow the testing to be performed without a licensed inspector present. In such cases, the elevator equipment shall be properly tagged by the qualified person performing the testing. The inspector shall verify the proper tagging of the elevator equipment within a ten- (10-)[-] day period. It will be required, without exception, that the testing be witnessed in the presence of a licensed inspector, at least every five (5) years.

AUTHORITY: section 701.355, RSMo [2000] 2016. Original rule filed Aug. 26, 1998, effective July 1, 1999. Amended: Filed Aug. 17, 2000, effective Feb. 28, 2001. Amended: Filed June 14, 2004, effective Dec. 30, 2004. Amended: Filed Dec. 4, 2006, effective May 30, 2007. Amended: Filed Oct. 16, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators**

PROPOSED AMENDMENT

11 CSR 40-5.120 Inspectors. The Elevator Safety Board is amending sections (1), (2), (4), (5), and (11).

PURPOSE: This amendment is needed due to the fact that the American Society of Mechanical Engineers has discontinued their qualified elevator inspector certification process. The change allows for the acceptance of a national or internationally recognized organization that provides an elevator inspector certification program. The amendment also adds additional causes for action on a license by the Board.

(1) Certification Required. The inspection of all elevator equipment required by sections 701.350–701.380, RSMo and these rules and regulations shall be made only by a licensed inspector certified by the board.

(A) Inspectors certified by the board and directly employed by the state, municipality, political subdivision, or authorized representative in a full-time position are exempt from the insurance requirements listed herein, until such time as they perform inspections outside the jurisdiction of the governing authority.

(2) Qualification of Special Inspector. To be eligible for a license to inspect elevator equipment, the applicant or licensee shall—

(A) Have a high school diploma or general educational development (GED) equivalent;

(B) Have had at least four (4) years experience in some mechanical or electrical endeavor, at least one (1) year of which shall have been in the design, construction, installation, repair, or inspection of elevators. The non-elevator, mechanical, or electrical experience shall be at the journeyman mechanical level or technical work and the work must have been comparable to work in the elevator industry. Engineering education on a college level may be substituted on a year-for-year basis for the non-elevator qualifying experience. The one (1) year of required elevator experience may be on the basis of continuous employment for one (1) year in which at least half (1/2) of the applicant's time is devoted to elevator work;

(C) Have successfully passed the written examination for elevator inspectors administered by an association accredited by *[the American Society of Mechanical Engineers]* a **nationally or internationally recognized organization** and evidenced by a certification of the applicant or licensee as a qualified elevator inspector (QEI). This is commonly referred to as being QEI certified;

(D) Have submitted proof of insurance coverage insuring the applicant against professional liability, insurance covering the errors and omissions of the applicant and commercial general liability coverage, with an occurrence limit of not less than one (1) million dollars and a general aggregate limit of not less than three (3) million dollars. Additionally, insurance coverage of an employer for whom the special inspector is employed shall be considered to comply with the aforementioned, if the coverage provides equivalent coverage for each special inspector; and

(E) Have no direct financial interest in any business or operation which manufactures, installs, repairs, modifies, or services elevator equipment. This qualification does not prohibit employees of insurance companies insuring automatic elevator equipment from obtaining a license as an inspector.

(4) Qualifications of Municipal or Political Subdivision Inspector. To be eligible for a license to inspect elevator equipment for a municipality or political subdivision, the applicant or licensee shall meet the requirements listed in subsections 11 CSR 40-5.120(2)(A), (2)(B), (2)(C), and (2)(E). If applicant or licensee does not meet these requirements then (4)(A), (4)(B), (4)(C), and (4)(F) shall be met./;

(A) Have a high school diploma or general educational development (GED) equivalent;

(B) Have had at least one (1) year experience in some mechanical or electrical endeavor. The mechanical or electrical experience shall be at the journeyman mechanical level or technical work and the work must have been comparable to work in the elevator industry. Engineering education on a college level may be substituted on a

year-for-year basis for the qualifying experience; *[and]*

(C) Have successfully passed the written examination for elevator inspectors administered by an association accredited by the American Society of Mechanical Engineers and evidenced by a certification of the applicant or licensee as a qualified elevator inspector (QEI). This is commonly referred to as being QEI certified. If applicant or licensee does not meet subsections (4)(A), (4)(B), (4)(C) and (4)(F) then (4)(D), (4)(E), and (4)(F) shall be met./;

(D) Have successfully completed the Building Officials Code Administrators (BOCA) certification program for elevator inspector and evidenced by a certification of the applicant or licensee as a BOCA certified elevator inspector/;/, or a nationally recognized elevator certification program approved by the Elevator Safety Board;

(E) Attend one (1) continuing education and certification class per year as approved by the Missouri Elevator Safety Board; and

(F) Have no direct financial interest in any business or operation that manufactures, installs, repairs, modifies, or services elevator equipment. This qualification does not prohibit employees of insurance companies insuring automatic elevator equipment from obtaining a license as an inspector. If applicant or licensee does not meet subsections (4)(D), (4)(E), and (4)(F) then section (5) candidate's license requirements shall be met.

(5) Apply for a Candidate's License to the Missouri Elevator Safety Board. To be eligible for and to maintain a candidate's license to inspect elevator equipment for a municipality or political subdivision the applicant shall—

(F) Within five (5) years of the date of application to the Missouri Elevator Safety Board for a candidate's license to inspect elevator equipment the applicant shall have successfully passed the written examination for elevator inspectors administered by an association accredited by the American Society of Mechanical Engineers and evidenced by a certification of the applicant or licensee as a qualified elevator inspector (QEI), commonly referred to as being QEI certified; or have successfully completed the Building Officials Code Administrators (BOCA) certification program for Elevator Inspector and evidenced by a certification of the applicant or licensee as a BOCA certified elevator inspector/;/, or a nationally recognized elevator certification program approved by the Elevator Safety Board; and

(G) Have no direct financial interest in any business or operation that manufactures, installs, repairs, modifies, or services elevator equipment. This qualification does not prohibit employees of insurance companies insuring automatic elevator equipment from obtaining a license as an inspector.

(11) Revocation of License.

(A) The board may revoke any license for cause. Such cause includes, but is not limited to the following:

1. Failure to comply with the provisions of sections 701.350–701.380, RSMo, or these rules and regulations;

2. Falsifying or making a material misstatement or omission on any application for license, financial disclosure statement, or inspection report; *[and]*

3. Failure to attend at least one (1) Missouri state elevator code update meeting per calendar year conducted by the department./;

4. Conducting or performing state required safety inspections without a state licensed mechanic, if required.

AUTHORITY: section 701.355, RSMo [2000] 2016. Original rule filed Aug. 26, 1998, effective July 1, 1999. Emergency amendment filed Aug. 24, 2000, effective Sept. 4, 2000, expired March 2, 2001. Amended: Filed Aug. 29, 2000, effective Feb. 28, 2001. Amended: Filed Dec. 16, 2002, effective June 30, 2003. Amended: Filed Oct. 16, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies

or political subdivisions more than five hundred dollars (\$500) in the aggregate.

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators**

PROPOSED AMENDMENT

11 CSR 40-5.170 Elevator Mechanic License. The division is amending sections (1) and (2) to remove expired paragraphs (1)(A)1., (1)(A)2., and (2)(A)1. and adding Limited Use/Limited Application elevators and dumbwaiters to the conveyances allowable for work by a Mechanic II licensee.

PURPOSE: This amendment changes the manner in which an elevator mechanic may be licensed and equipment available for installation by Mechanic II licensees.

(1) Elevator Mechanic I—This license authorizes the holder to construct, install, alter, maintain, examine, relocate, test, remove, service, and repair all types of elevators and other conveyances in any location as covered in sections 701.350 to 701.383, RSMo, 11 CSR 40-5.010 to 11 CSR 40-5.195, and American Society of Mechanical Engineers (ASME) A17.1 and ASME A18.1.

(A) Elevator Mechanic I license *[shall]* **may** be granted only to individuals who have demonstrated their qualifications and abilities. *Applicants shall meet* in meeting one (1) of the following paragraphs:

[1. Furnish the board with acceptable proof the applicant has previously worked as an elevator mechanic for an elevator contractor or as approved by the board, without direct and immediate on-site supervision on equipment covered by A17.1 and A18.1 for a period of no less than four (4) years prior to the effective date of this rule. The person shall make application within one (1) year of the effective date of this rule;

2. Possess a certificate of completion documenting the applicant has successfully passed the mechanic examination of a nationally recognized training program for the elevator industry. The person must make application within one (1) year of the effective date of this rule;

[3.]1. Possess a certificate of completion of an apprenticeship program registered with the United States Department of Labor's Bureau of Apprenticeship and Training for elevator mechanics;

[4.]2. Applicants with licenses issued by another state shall provide the board documentation that the out-of-state licensing requirements meet or exceed Missouri requirements, and that the license is valid and has not been revoked or suspended; or

[5.]3. *[For an applicant whose experience does not immediately precede their application, the]* **The** board may, at its discretion, issue a license to an applicant who provides documentation *[that]* the applicant has a minimum of four (4) years of prior experience and **acceptable** training, and has successfully passed a mechanic examination of a nationally recognized training program

acceptable to the board; and

[6.]4. Upon approval of an application by the board and receipt of the applicable fee, the board *[shall]* **may** issue an elevator mechanic I license *[which will be in effect]* **effective** for a two- (2-) year period from date of issuance or renewal, unless thereafter revoked or suspended.

(2) Elevator Mechanic II—This license authorizes the holder to construct, install, alter, maintain, examine, relocate, test, remove, service, and repair all types of *[elevators and other]* conveyances in any location, as covered in sections 701.350 to 701.383, RSMo, 11 CSR 40-5.010 to 11 CSR 40-5.150, and ASME A18.1, **as well as section 5.2 of ASME A17.1 as it specifically relates to Limited-Use/Limited Application elevators and Section 7 of ASME A17.1 as it specifically relates to dumbwaiters.**

(A) Elevator mechanic II license *[shall]* **may** be granted only to individuals who have demonstrated their qualifications and abilities. *Applicants shall meet* meeting (1) of the following paragraphs:

[1. Furnish the board with acceptable proof the applicant has previously worked as an elevator mechanic for an elevator contractor or as approved by the board, without direct and immediate on-site supervision on equipment covered by ASME A18.1 for a period of no less than two (2) years prior to the effective date of this rule. The person shall make application within one (1) year of the effective date of this rule;]

[2.]1. Possess a certificate of completion documenting the applicant has successfully passed the mechanic examination of a nationally recognized training program for the elevator industry access products (ASME A18.1) as accepted by the board;

[3.]2. Possess a certificate of completion of an apprenticeship program registered with the United States Department of Labor's Bureau of Apprenticeship and Training for elevator mechanics;

[4.]3. Applicants with licenses issued by another state shall provide the board documentation that the out-of-state licensing requirements meet or exceed Missouri requirements, and that the license is valid and has not been revoked or suspended; or

[5.]4. For an applicant whose experience does not immediately precede their application the board may, at its discretion, issue a license to an applicant who provides documentation acceptable to the board to establish the applicant has sufficient previous training and experience related to the elevator industry; and

[6.]5. Upon approval of an application by the board and receipt of the applicable fee, the board *[shall]* **may** issue an elevator mechanic license II, which will be in effect for a two- (2-) year period from date of issuance or renewal, unless thereafter revoked or suspended.

AUTHORITY: sections 701.355 and 701.377, RSMo *[Supp. 2013] 2016.* Original rule filed Nov. 12, 2014, effective June 30, 2015. Amended: Filed Oct. 16, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Division of Fire Safety, PO Box 844 Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 7—Blasting

PROPOSED AMENDMENT

11 CSR 40-7.010 Blasting—Licensing, Registration, Notification, Requirements, and Penalties. The State Blasting Safety Board, is amending sections (1), (2), (5), and (9).

PURPOSE: This amended rule incorporates changes to the explosives used annual fee structure based upon the passage of SCS HCS HB 1286 (2018) and clarifies location data to be collected for the blast sites and seismograph monitoring devices.

- (1) The following definitions shall be used in interpreting this rule:
- (A) “Blaster,” a person qualified to be in charge of and responsible for the loading and firing of an explosive or explosive material;
 - (B) “Blast,” detonation of explosives;
 - (C) “Blasting,” the use of explosives in mining or construction;
 - (D) “Blast site,” the area where explosives are handled during loading of a bore hole, including fifty feet (50') in all directions from the perimeter formed by loaded holes. A minimum of thirty feet (30') may replace the fifty- (50-)/- foot requirement if the perimeter of loaded holes is marked and separated from non-blast site areas by a barrier. The fifty- (50-)/- foot or thirty- (30-)/- foot distance requirements, as applicable, shall apply in all directions along the full depth of the bore hole;
 - (E) “Board,” the State Blasting Safety Board created in section 319.324, RSMo;
 - (F) “Bore hole,” a hole made with a drill, auger, or other tool in which explosives are placed in preparation for detonation;
 - (G) “Burden,” the distance from an explosive charge to the nearest free or open face at the time of detonation;
 - (H) “Business day,” any day of the week except Saturday, Sunday, or a federal or state holiday;
 - (I) “Deck,” charge of explosives separated from other charges by stemming;
 - (J) “Delay period,” the time delay provided by blasting caps which permits firing of bore holes in sequence;
 - (K) “Detonation,” the action of converting the chemicals in an explosive charge to gases at a high pressure by means of a self-propagating shock wave passing through the charge;
 - (L) “Detonator,” any device containing initiating or primary explosive that is used for initiating detonation of another explosive material. A detonator may not contain more than ten (10) grams of total explosives by weight, excluding ignition or delay charges. The term includes, but is not limited to, electric blasting caps of instantaneous and delay types, blasting caps for use with safety fuse, detonating cord delay connectors, and nonelectric instantaneous and delay blasting caps which use detonating cord, nonelectric shock tube, or any other replacement for electric leg wires;
 - (M) “Division,” the Missouri Division of Fire Safety;
 - (N) “Direct supervision,” to mean the supervisor (blaster) is physically present on the same job site as the person loading or firing the explosives;
 - (O) “Explosives,” any chemical compound, mixture, or device, the primary or common purpose of which is to function by explosion, including, but not limited to, dynamite, black powder, pellet powder, initiating explosives, detonators, millisecond connectors, safety fuses, squibs, detonating cord, igniter cord, and igniters; includes explosive materials such as any blasting agent, emulsion explosive, water gel, or detonator. Explosive materials determined to be within the coverage of sections 319.300 to 319.345, RSMo shall include all such materials listed in Chapter 40 of Title 18 of the *United States Code*, as amended, as issued at least annually by the

Department of Justice, Bureau of Alcohol, Tobacco, Firearms and Explosives;

(P) “Firing,” causing explosives to be detonated by the use of a fuse, electric detonator, or nonelectric shock tube;

(Q) “Fire protection official,” an authorized representative of a municipal fire department, fire protection district, or volunteer fire protection association for the area where blasting occurs;

(R) “Fugitive from justice,” any person who has fled from the jurisdiction of any court of record to avoid prosecution for any crime or to avoid giving testimony in any criminal proceeding. The term shall also include any person who has been convicted of any crime and has fled to avoid case disposition;

(S) “Initiation system,” components of an explosive charge that cause the charge to detonate, such as primers, electric detonators, and detonating charge;

(T) “Loading,” placing of explosives in a hole in preparation for detonation;

(U) “Local government,” a city, county, fire protection district, volunteer fire protection association, or other political subdivision of the state;

(V) “Person using explosives,” any individual, proprietorship, partnership, firm, corporation, company, or joint venture that is required to hold authority to receive or use explosives under statutes or regulations administered by the U.S. Department of Justice, Bureau of Alcohol, Tobacco, Firearms and Explosives and who employs licensed blasters;

(W) “Scaled distance,” a value determined by dividing the linear distance, in feet, from the blast to a specified location, by the square root of the maximum weight of explosives, in pounds, to be detonated in any eight- (8-)/- millisecond period;

(X) “Seismograph,” an instrument that measures ground vibration and acoustic effects;

(Y) “Stemming,” inert material that is placed above explosives that have been placed in a blast hole in preparation for detonation or vertically between columnar decks of explosives that have been placed in a hole in preparation for detonation; and

(Z) “Uncontrolled structure,” any dwelling, public building, school, church, commercial building, or institutional building that is not owned or leased by the person using explosives, or otherwise under the direct contractual responsibility of the person using explosives.

(2) The following fees shall apply for the licensing of blasters, registration of persons using explosives, explosives use reporting, and testing:

(A) Individual Blaster’s License: one hundred dollars (\$100) for a three- (3-)/- year license;

(B) Registration fee for a person using explosives (one- (1-)/- time fee): two hundred dollars (\$200);

(C) Annual explosive use fee: five hundred dollars (\$500) plus *[two dollars (\$2)] five dollars (\$5)* per ton of explosives or explosive materials used within the state.

1. When the total pounds of explosive materials used results in a portion of a ton, the tonnage reported shall be rounded to the nearest ton.

2. Per ton fees shall not include any items defined by statute as “detonators”; and

(D) Testing/retesting fee: twenty-five dollars (\$25) per individual test.

(5) Each registered person using explosives in Missouri shall, by January 31 of each year after registering, file an annual report with the division for the preceding calendar year.

(D) The person using explosives shall submit with the report, an explosive use fee of five hundred dollars (\$500) plus *[two dollars (\$2)] five dollars (\$5)* per ton of explosives or explosive materials used within the state.

(E) Any initial increase of the explosive use fee promulgated by

rule shall be only on those explosives used from July 1 of the calendar year preceding the annual report required in section (5) above unless the report is an initial report pursuant to subsection (5)(A).

1. If the report of total pounds used results in a portion of a ton, the cumulative total of the fee shall be rounded to the nearest ton.

2. In the event that less than one (1) ton of explosives has been used in the reporting period, the five hundred dollar (\$500) annual fee shall be submitted with the annual report to the division.

((E))/(F) The division may audit the records of any person using explosives required to report annually to determine the accuracy of the number of pounds of explosives reported.

((F))/(G) In connection with such audit, the division may also require any distributor of explosives to provide a statement of sales during the year to persons required to report.

(9) It shall be the duty of each licensed blaster and each person using explosives to assure that the requirements of this section are met.

(F) Each seismograph recording and the accompanying records shall include the—

1. Maximum ground vibration and acoustics levels recorded;

2. Specific **geographic information system data (GIS)** of the location of the seismograph equipment, its distance from the detonation of the explosives, the date of the recording, and the time of the recording;

3. Name of the individual responsible for operation of the seismograph equipment and performing an analysis of each recording; and

4. Type of seismograph instrument, its sensitivity and calibration signal, or certification date of the last calibration.

(J) A record of use of explosives shall be made and retained for at least three (3) years.

1. Licensed blasters shall create the record required in this section and provide such record to the person using explosives, who shall be responsible for maintaining records required in this section.

2. The record shall be completed on a form provided or approved by the division and completed by the end of the business day following the day in which the explosives were detonated.

3. Such records shall be made available to the division, upon request, within twenty four (24) hours of the request.

4. Each record shall include the—

A. Name of the person using the explosives;

B. Location, **geographic information system data (GIS)**, date, and time of the detonation;

C. Name of the licensed blaster responsible for use of the explosives;

D. Type of material blasted;

E. Number of bore holes, burden, and spacing;

F. Diameter and depth of bore holes;

G. Type of explosives used;

H. Weight of explosives used per bore hole and total weight of explosives used;

I. Maximum weight of explosives detonated within any eight- (8-)/-/ millisecond period;

J. Maximum number of bore holes or decks detonated within any eight- (8-)/-/ millisecond period;

K. Initiation system, including number of circuits and the timer interval, if a sequential timer is used;

L. Type and length of stemming;

M. Type of detonator and delay periods used, in milliseconds;

N. Sketch of delay pattern, including decking;

O. Distance and scaled distance to the nearest uncontrolled structure; and

P. Location of the nearest uncontrolled structure, using the best available information.

5. If the type of blasting being recorded by a seismograph does not involve bore holes, then the record required in paragraph (9)(J)4.

shall contain the:

A. Name of the person using the explosives;

B. Location, **geographic information system data (GIS)**, date, and time of the detonation;

C. Name of the licensed blaster responsible for use of the explosives;

D. Type of material blasted;

E. Type of explosives used;

F. Weight of explosives used per shot and total weight of explosives used;

G. Maximum weight of explosives detonated within any eight- (8-)/-/ millisecond period;

H. Initiation system, including number of circuits and the timer interval, if a sequential timer is used;

I. Type of detonator and delay periods used, in milliseconds;

J. Sketch of delay pattern;

K. Distance and scaled distance, if required under the provisions of section 319.309, RSMo, to the nearest uncontrolled structure; and

L. Location of the nearest uncontrolled structure, using the best available information.

AUTHORITY: section 319.306, RSMo 2016. Emergency rule filed April 1, 2008, effective July 1, 2008, expired Jan. 1, 2009. Original rule filed April 2, 2008, effective Jan. 1, 2009. Amended: Filed Oct. 16, 2019.

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

PRIVATE COST: This proposed amendment will cost private entities sixty-five thousand eight hundred ninety-two dollars (\$65,892) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Blasting Safety Board, Attn: Administrative Rules, Division of Fire Safety, PO Box 844, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**FISCAL NOTE
 PRIVATE COST**

- I. Department Title: 11 – Department of Public Safety
 Division Title: 40 – Division of Fire Safety
 Chapter Title: 7 - Blasting**

Rule Number and Title:	11 CSR 40-7.010 Blasting---Licensing, Registration, Notification, Requirements, and Penalties
Type of Rulemaking:	Amended Rulemaking

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
85 “Persons using explosives”	Blasting Companies (Users of Explosives)	\$66,000 in FY2020

III. WORKSHEET

\$3 (increase) x 21,964 (tons/yr) = \$65,892 (~\$66,000) per FY.

IV. ASSUMPTIONS

- 1) Number of companies will not decrease.
- 2) Amount of explosives used will not significantly decrease.
- 3) Fees collected at the increased rate shall begin with the FY.
- 4) The Division of Fire Safety (DFS) is charged with administering the Missouri Explosives Safety Act which regulates and provides oversight of all above-ground blasting conducted in our State. This industry was impacted by the economic downturn in 2009-10, and program revenues have never regained their strength. As a result, the program has struggled with a poor fund balance while supporting two FTE: a blast-safety investigator and one clerical position.

Section 319.318.4(3), RSMo, was revised through the passage of HB 1286 (2018). This bill allowed for the increase in fees per ton of explosives used from \$2.00 to up to \$7.50 per ton. This amendment would raise the fee to \$5.00 per ton used. Pursuant to HB 1286, the fee may not exceed the cost to administer the program.

Following passage of HB 1286, the State Blasting Safety Board, DFS and industry partners agree to an initial increase to \$5.00 per ton of explosives used in order to cover the cost of administering the program.

HB 1286 also exempted surface coal mining companies from the blasting fee contained in section 319.318.4(3), RSMo. With the average of 21,924 remaining tons used annually, this fee increase would result in approximately \$65,772 of additional revenue annually.

The proposed legislation does allow for an increase up to \$7.50 per ton. Section 319.318.4(3), RSMo, requires that the State Blasting Safety Board review the fee schedule on a biennial basis and approve or disapprove adjustments in the fees by rule.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests**

PROPOSED AMENDMENT

11 CSR 45-40.010 Definitions. The commission is amending sections (3), (4), and (6); removing section (12); adding new sections (8), and (9); and renumbering accordingly.

PURPOSE: This amendment changes and adds definitions for terms used relating to fantasy sports contests (FSCs) to make the definitions consistent with SB 87, 100th General Assembly.

(3) Fantasy sports contest (FSC)—any fantasy or simulated game or contest with an entry fee~~f~~, *conducted on an internet website or any platform,* in which:

(A) The value of all prizes and awards offered to the winning participants is established and made known in advance of the contest;

(B) All winning outcomes reflect in part the relative knowledge and skill of the participants and are determined predominantly by the accumulated statistical results of the performance of individuals, including athletes in the case of sports events; and

(C) No winning/s/ outcomes are based on the score, point spread, or any performance of any single actual team or combination of teams or solely on any single performance of an individual athlete or player in any single actual event.

(4) Fantasy sports contest operator (FSCO)—any person *[or]*, entity, or division of a corporate entity that offers *[FSCs for a prize]* a platform for the playing of fantasy contests, administers one (1) or more fantasy contests with an entry fee, and awards a prize of value.

(6) Key person—an officer, director, trustee, *[or]* principal salaried executive staff officer, or any person so designated by the commission or director.

(8) Location—the geographical position of a person as determined within a degree of accuracy consistent with generally available internet protocol address locators.

(9) Location percentage—for all fantasy sports contests, the percentage, rounded to the nearest one-tenth of one percent (.1%), of the total entry fees collected from registered players located in the state of Missouri at the time of entry into a fantasy contest, divided by the total entry fees collected from all players, regardless of the players' locations, of the fantasy sports contests.

~~[(8)]~~(10) Net revenue—for all FSCs, the amount equal to the total entry fees collected from all participants entering such FSCs less winnings paid to participants in the contests, multiplied by the *[resident]* location percentage.

~~[(9)]~~(11) Officer—the president, vice-president, treasurer, secretary, and other officer identified in an entity's bylaws or incorporation documents, a member or manager of a limited liability company, a sole proprietor, or a partner.

~~[(10)]~~(12) Principal salaried executive staff officers—means the president, any vice president in charge of a principal business unit, division, or function (such as sales, administration, or finance), any other officer who performs a policy making function, or any other person who performs similar policy making functions for the FSCO. Executive officers of subsidiaries may be deemed executive officers of the FSCO if they perform such policy making functions for the FSCO.

~~[(11)]~~(13) Prize—anything of value including, but not limited to, cash or a cash equivalent, contest credits, merchandise, or admission to another contest in which a prize may be awarded.

[(12) Resident percentage—for all fantasy sports contests, the percentage, rounded to nearest one-tenth of one percent (.1%), of the total entry fees collected from Missouri residents divided by the total entry fees collected from all players, regardless of the players' location, of the fantasy sports contests.]

AUTHORITY: sections 313.950 and 313.955, RSMo [2016] Supp. 2019. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed Oct. 31, 2019.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests**

PROPOSED AMENDMENT

11 CSR 45-40.020 Application for Fantasy Sports Contest Operator License. The commission is amending sections (1), (2), and (7); adding a new section (4); and renumbering accordingly.

PURPOSE: This amendment incorporates a form for the renewal of a fantasy sports contest operator's license, incorporates amendments to the Fantasy Sports Contest Operator Application, and modifies the rule to be consistent with SB 87, 100th General Assembly.

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. The Fantasy Sports Contest Operator Application~~[and]~~, the FSCO Personal Disclosure Form, and the FSCO Renewal Form may also be accessed at <http://www.mgc.dps.mo.gov>.

(1) A fantasy sports contest operator (FSCO) license is a license granted by the Missouri Gaming Commission (commission) to allow a person *[or]*, entity, or division of a corporate entity to offer fantasy sports contests (FSCs) for play by persons located in Missouri *[residents]* in accordance with the Missouri Fantasy Sports Consumer Protection Act (The Act).

(2) Application for licensure shall be made on the Fantasy Sports Contest Operator Application (application), which the commission adopts and incorporates by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102, and which may be accessed at <http://www.mgc.dps.mo.gov>. The application does not incorporate any subsequent amendments or additions as adopted by the commission on *[December 7, 2016]* **October 30, 2019**.

(4) Notice of renewal shall be made on the FSCO Renewal Form, which the commission adopted on October 30, 2019 and incorporates by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102, and which may be accessed at <http://www.mgc.dps.mo.gov>. The FSCO Renewal Form does not incorporate any subsequent amendments or additions.

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

[(5)](6) The commission may require an affidavit, signed on behalf of the applicant or licensee, to be submitted as an addendum to the Application, regarding matters related to the applicant or licensee or the proposed operation, including, but not limited to, the involvement of any individual in the proposed or licensed operations of the applicant or licensee.

[(6)](7) No license shall be issued to an applicant until the applicant has provided all of the required forms and requested documents pursuant to this rule.

[(7)](8) *[The FSCO license expires one (1) year after the date of issuance.]* The licensed FSCO shall submit the **notice of renewal [application]** at least *[four (4)]* **two (2)** months prior to the expiration date of the FSCO license.

AUTHORITY: *section[s] 313.910, RSMo 2016, and sections 313.925, 313.935, 313.950, and 313.955, RSMo [2016] Supp. 2019. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed Oct. 31, 2019.*

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests**

PROPOSED AMENDMENT

11 CSR 45-40.050 Operational Requirements for Fantasy Sports Contest Operators. The commission is adding subsection (1)(H); amending section (4); removing section (3); and renumbering accordingly.

PURPOSE: *This amendment adds the requirement for fantasy sports operators to describe the method used to determine the location of a player at time of entry into any fantasy sports contest to be consistent with SB 87, 100th General Assembly.*

(1) Each licensed operator shall maintain on file with the commission the following:

(F) A detailed description of its procedures and measures taken to clearly and conspicuously identify highly experienced players in FSC by a symbol attached to a player's username, or by other easily visible means, on the licensed operator's authorized internet website; *[and]*

(G) A detailed description of its online self-exclusion process*[/];* **and**

(H) A detailed description of the method used to determine the geographical position of a player at the time of entry into any FSC.

[(3) Upon request, each licensed operator shall provide the commission with a current and accurate list of Missouri residents who have submitted the operator's online self-exclusion form, which the licensed operator developed pursuant to section 313.920, RSMo.]

[(4)](3) Each licensed operator shall take commercially and technologically reasonable measures to comply with the provisions of sections 313.915 and 313.920, RSMo, regarding the verification of each FSC player's true identity, date of birth, and address, including, but not limited to, independent verification of age using information obtained from independent sources outside of the player seeking to open an account. Third party services may be used to verify the age **and location** of a player. Each licensed operator shall use such information, at a minimum, to prevent underage individuals from establishing accounts, *[to verify state of residence,]* and to prevent players from establishing more than one (1) account or username or playing anonymously.

[(5)](4) Upon discovery of a registered account held by a minor, the FSCO shall promptly refund any money held in a minor's account, whether or not the minor has engaged in or attempted to engage in game play. A FSCO may refuse to award a prize to a minor upon a good-faith determination, following reasonable investigation, that the minor misrepresented his or her age in order to enter the FSC, provided, however, that such prize must then be awarded to another participant in the contest who would have won the prize had the minor not participated.

[(6)](5) Prior to conducting any individually targeted advertising or marketing, but not more than once a week, the licensed operator shall do the following:

(A) Download the current List of Disassociated Persons (DAP List) and the MGC Excluded Persons List from the designated MGC server;

(B) For email marketing campaigns, compare the email addresses from the marketing list to the DAP List and the MGC Excluded Persons List and remove anyone whose email address is found to be on either List (DAP or Excluded);

(C) For direct mail marketing campaigns to non-registered players, search and remove from the marketing list any person who has the same name and address of any person found to be on either List (DAP or Excluded); and

(D) For direct mail marketing campaigns to registered players, search and remove from the marketing list any player who has the same date of birth, first or last name, and address of an individual on either List (DAP or Excluded).

[(7)](6) If a licensed operator ceases offering fantasy sports contests in Missouri, the licensed operator shall notify the commission of the date of cessation. Notice shall be provided within ten (10) days of the cessation.

AUTHORITY: sections 313.915, 313.920, 313.925, 313.950, and 313.955, RSMo [2016] Supp. 2019. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed Oct. 31, 2019.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m. in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests**

PROPOSED AMENDMENT

11 CSR 45-40.060 [Cash Reserve and] Segregated Account Requirements. The commission is amending the title, the purpose, and sections (1), (3), (4), and (5); removing section (2); and renumbering accordingly.

PURPOSE: This amendment changes the requirement that describes how fantasy sports contest operators segregate player funds from operational funds for fantasy sports contest operators to be consistent with SB 87, 100th General Assembly.

PURPOSE: This rule addresses the [minimum cash reserve and] segregated account requirements [and the required procedures and documentation for those reserves and segregated accounts] for the protection of player funds.

(1) The licensed operator shall maintain [in the form of cash or cash equivalents the amount of the deposits made to the accounts of Missouri fantasy sports contest players for the benefit and protection of the funds held in such accounts. For purposes of this rule cash equivalents are investments with an original maturity of three (3) months or less] a special purpose entity approved by the commission to segregate player funds from operational funds as required by section 313.915, RSMo.

[(2) Funds held in player accounts of Missouri residents shall be protected as set forth herein. A fantasy sports operator shall maintain a reserve in the form of cash, cash equivalents, or a combination thereof to protect player funds.

(A) The amount of the reserve shall be equal to, at a minimum, the sum of all registered players' funds held in player accounts of Missouri residents.

(B) The reserve agreements must reasonably protect the reserve against claims of the operator's creditors other than the authorized players for whose benefit and protection the reserve is established, and must provide the following:

1. The reserve shall be established and held in trust for the benefit and protection of authorized players to the extent the licensed operator holds money in player accounts for players;

2. The reserve must not be released, in whole or in part, except upon written instruction or approval of the commission. The reserve must be available within ninety (90) days of written demand or written instruction. If the reserve is released to the commission, the commission may interplead the funds in the circuit court of Cole County for distribution to the authorized players for whose protection and benefit the account was established and to the other such persons as the court determines are entitled thereto, or shall take such other steps as necessary to effect the proper distribution of the funds, or may do both;

3. The licensed operator may receive income accruing on the reserve, without obtaining permission from the commission; and

4. The licensed operator has no interest or title to the reserve.

(C) The reserve must be held or issued by a federally insured financial institution and must be established pursuant to a written agreement between the licensed operator and the financial institution.

(D) The proposed reserve arrangement is not effective for purposes of complying with section 313.930.3(4), RSMo, until the commission's written approval has been obtained.

(E) The reserve arrangement agreements may be amended only with the prior written approval of the commission.

(F) The account shall be maintained and controlled by a properly constituted corporate entity that is not the fantasy sports contest operator and whose governing board includes one (1) or more corporate directors who are independent of the fantasy sports contest operator and of any corporation related to or controlled by the fantasy sports contest operator. The corporate entity must meet the following requirements:

1. The corporate entity must require a unanimous vote of all corporate directors to file bankruptcy;

2. The corporate entity must obtain permission from the Missouri Gaming Commission prior to filing bankruptcy or entering into receivership;

3. The corporate entity must have articles of incorporation that prohibit commingling of funds with that of the fantasy sports contest operator except as necessary to reconcile the accounts of players with sums owed by those players to the fantasy sports contest operator;

4. The corporate entity must be restricted from incurring debt other than to fantasy sports players pursuant to the rules that govern their accounts for contests;

5. The corporate entity must be restricted from taking on obligations of the fantasy sports contest operator other than obligations to players pursuant to the rules that govern their accounts for contests; and

6. The corporate entity must be prohibited from dissolving, merging, or consolidating with another company without the written approval of the Missouri Gaming Commission

while there are unsatisfied obligations to fantasy sports contest players.]

[(3)](2) If, at any time, the [licensed operator's total available cash and cash equivalent reserve is] **funds held by the special purpose entity** are less than the amount required by section 313.915, RSMo, the licensee shall notify the commission of this deficiency within forty-eight (48) hours.

[(4)](3) Each licensed operator shall continuously monitor and maintain a record of all [player deposits and its cash reserves] **funds held in player accounts and the amount held by the special purpose entity** to ensure compliance with [the cash reserves requirement] **section 313.915, RSMo.**

[(5)](4) The licensed operator shall provide the commission with documentation of both the amount of [deposits in players' accounts and the amount in cash reserves] **funds held in player accounts and the amount held by the special purpose entity** as of the last day of each month by the fifteenth day of the following month.

AUTHORITY: sections 313.915, 313.950, and 313.955, RSMo [2016] Supp. 2019. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed May 31, 2018, effective Jan. 30, 2019. Amended: Filed Oct. 31, 2019.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

Title 11—DEPARTMENT OF PUBLIC SAFETY Division 45—Missouri Gaming Commission Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.070 Operational Fees. The commission is amending section (1).

PURPOSE: This amendment changes the date to submit the Annual Operation Fee report for fantasy sports contest operators to be consistent with SB 87, 100th General Assembly.

(1) The applicant or licensed operator shall file an Annual Operation Fee (AOF) report and all required supporting documentation with the commission by [January 15] **September 1** of each year for the previous calendar year. The annual operation fee shall be reported on the AOF report, which the commission [adopts] **adopted on October 30, 2019** and incorporates by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102, and which may be accessed at

<http://www.mgc.dps.mo.gov>. The AOF report does not incorporate any subsequent amendments or additions [as approved by the commission on February 28, 2018].

AUTHORITY: section[s] 313.910, RSMo 2016, and sections 313.935, 313.950, and 313.955, RSMo [2016] Supp. 2019. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed March 1, 2018, effective Oct. 30, 2018. Amended: Filed Oct. 31, 2019.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

Title 11—DEPARTMENT OF PUBLIC SAFETY Division 45—Missouri Gaming Commission Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.090 Records and Record Retention. The commission is amending sections (1) and (4).

PURPOSE: This amendment changes language to be consistent with SB 87, 100th General Assembly.

(1) Each licensed operator shall maintain complete, accurate, legible, and permanent records of all transactions pertaining to its revenues, expenses, assets, liabilities, and equity. Records shall be sufficient to adequately reflect total entry fees, entry fees collected from **players located in Missouri [residents]**, net revenue, winnings paid, prizes awarded, and other fantasy sports contest transactions which accurately reflect the requirements and restrictions contained in this chapter and in Chapter 313, RSMo.

(4) Each licensed operator shall maintain a record, by date, of the total entry fees received from players [residing] **located** in the United States, grouped by [resident] state, and the total entry fees received from players [residing] **located** outside the United States.

AUTHORITY: section[s] 313.910, RSMo 2016, and sections 313.930, 313.950, and 313.955, RSMo [2016] Supp. 2019. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed Oct. 31, 2019.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov, or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission’s Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests**

PROPOSED AMENDMENT

11 CSR 45-40.100 Audits. The commission is amending section (2); removing section (1); and renumbering accordingly.

PURPOSE: This amendment changes language to be consistent with SB 87, 100th General Assembly.

[(1) Independent certified public accountants (C.P.A.s), shall conduct annual financial and authorized internet website audit of each licensed operator.]

[(2)](1) The annual financial [and authorized internet website] audit shall be conducted by an independent certified public accountant (C.P.A.) in accordance with generally accepted auditing standards as follows:

(A) Audit the licensed operator’s annual financial statements in order to report on the fair representation of such amounts. The C.P.A. shall reconcile these audited amounts to similar amounts on the annual financial reports and system reports; and

(B) Audit the annual total entry fees, entry fees from players located in Missouri [residents], [resident] location percentage calculation, winnings paid, net revenue, and the annual operation fee from the most recently filed Annual Operation Fee report, in order to report on the fair representation of such amounts. The C.P.A. shall reconcile these audited amounts to similar amounts on the annual financial reports and system reports; and].

[(C) Audit the licensed operator and its authorized internet website for compliance with each requirement set forth in sections 313.900 to 313.955, RSMo, and Chapter 11 CSR 45-40.]

AUTHORITY: *section[s] 313.910, RSMo 2016, and sections 313.915, 313.940, 313.950, and 313.955, RSMo [2016] Supp. 2019. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed March 1, 2018, effective Oct. 30, 2018. Amended: Filed Oct. 31, 2019.*

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed amendment via email to MGCPolicy@mgc.dps.mo.gov,*

or by mail to the Missouri Gaming Commission, Policy Section, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for Thursday, January 2, 2020, at 10:00 a.m., in the Missouri Gaming Commission’s Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 41—General Tax Provisions**

PROPOSED AMENDMENT

12 CSR 10-41.010 Annual Adjusted Rate of Interest. The Director of Revenue proposes to amend section (1) to reflect the interest to be charged on unpaid, delinquent taxes.

PURPOSE: This proposed amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2020.

(1) Pursuant to section 32.065, RSMo, the director of revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governors of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year has set by administrative order the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%
2017	4%
2018	4%
2019	5%
2020	5%

AUTHORITY: *section 32.065, RSMo 2016. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 21, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 21, 2019.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE
 PUBLIC COST**

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Counties	<i>This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate. The 2020 interest rate imposed on delinquent taxes will be the same as the rate imposed in 2019.</i>
Cities	
Special Taxing Districts	

III. WORKSHEET

The proposed amendment establishes the rate of interest for 2020 at five percent (5%), remaining the same as the rate in 2019.

The future amount of past due taxes is unknown. With the 2020 interest rate imposed upon delinquent taxes remaining the same as that imposed in 2019, public entities realize no additional fiscal impact. This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 5.00%	Proposed Amendment 5.00%
Past due tax amount	\$100.00	\$100.00
Interest Amount (%)	x 5.00	x 5.00
Total Amount Due	\$105.00	\$105.00

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2019 was 5.25 percent.

**FISCAL NOTE
PRIVATE COST**

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Any taxpayer with delinquent tax.	Any taxpayer with delinquent tax.	<i>This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate. The 2020 interest rate imposed on delinquent taxes remains the same as that imposed in 2019. The actual number of affected taxpayers is unknown.</i>

III. WORKSHEET

The proposed amendment establishes the rate of interest for 2020 at five percent (5%), the same as the rate in 2019.

This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate. Because the 2020 interest rate imposed on delinquent taxes remains at the same rate as that imposed in 2019, the interest rate remains the same on each \$100 of delinquent taxes to private entities. The actual number of affected taxpayers is unknown.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 5.00%	Proposed Amendment 5.00%
Past due tax amount	\$100.00	\$100.00
Interest Amount (%)	x 5.00	x 5.00
Total Amount Due	\$105.00	\$105.00

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of

Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2019 was 5.25 percent.

**Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program**

PROPOSED AMENDMENT

13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services. The division is amending sections (2), (3), (4), (7), (8), and (10), deleting section (6), and renumbering and amending the remaining sections.

PURPOSE: This proposed amendment provides for a rebasing of per diem rates for nonstate-operated intermediate care facilities for individuals with intellectual disabilities (ICF/IID), clarifies the process for determining reimbursement rates, removes and/or replaces obsolete processes and language, and combines and removes duplicative language.

(2) General Principles.

(B) Effective November 1, 1986, the Title XIX per diem rate for all ICF/IID facilities participating on or after October 31, 1986, shall be the lower of—

1. The average private pay charge;

2. The Medicare per diem rate, if applicable;

3. The rate paid to a facility on October 31, 1986, as adjusted by updating its base year to its 1985 fiscal year. Facilities which do not have a full twelve- (12-) month 1985 fiscal year shall not have their base years updated to their 1985 fiscal years. Changes in ownership, management, control, operation, leasehold interests by whatever form for any facility previously certified for participation in the MO HealthNet program at any time that results in increased capital costs for the successor owner, management, or leaseholder shall not be recognized for purposes of reimbursement; and

4. However, any provider who does not have a rate on October 31, 1986, and whose facility meets the definition in subsection (3)(J) of this rule, will be exempt from paragraph (2)(B)3., and the rate shall be determined in accordance with applicable provisions of this rule.]

1. The Medicare per diem rate, if applicable; or

2. The reimbursement rate as determined in accordance with this regulation.

(E) All illustrations and examples provided throughout this rule are for illustration purposes only and are not meant to be actual calculations.

(3) Definitions.

(A) “Allowable cost areas[.]” means [T]those cost areas [which] that are allowable for allocation to the MO HealthNet program based upon the principles established in this rule. The allowability of cost areas, not specifically addressed in this rule, will be based upon criteria of the Medicare Provider Reimbursement Manual (HIM-15) and section [(7)](6) of this rule.

(B) “Average private pay charge[.]” means [T]the [average private pay charge is the] usual and customary charge for non-MO HealthNet patients determined by dividing total non-MO HealthNet days of care into total revenue collected for the same service that is included in the MO HealthNet per diem rate, excluding negotiated payment methodologies with the Veterans Administration and the Missouri Department of Mental Health.

[(C)](C) Committee. The advisory committee defined in subsection (6)(A) of this rule.]

[(D)](C) “Cost report[.]” [The cost report shall detail] means a report detailing the cost of rendering covered services for the fiscal reporting period. Providers must file the cost report on forms provided by and in accordance with the procedures of the [department] Department of Social Services.

[(E)](D) “Department[.] The department, unless otherwise specified, refers to]” means the Missouri Department of Social Services, unless otherwise specified.

[(F)](E) “Director[.] The director, unless otherwise specified, refer to]” means the director of the Missouri Department of Social Services, unless otherwise specified.

[(G)](F) “Effective [date.] Date” means [1. The plan effective date shall be] November 1, 1986.

[2. The effective date for rate adjustments granted in accordance with section (6) of this rule shall be for dates of service beginning the first day of the month following the director’s, or his/her designee’s, final determination on the rate.]

[(H)](G) “ICF/IID[.] Nonstate-operated]” means nonstate-operated facilities certified to provide intermediate care for individuals with intellectual disabilities under the Title XIX program.

[(I)](H) “Medicare [rate. This is] Rate” means the allowable cost of care permitted by Medicare standards and principles of reimbursement.

[(J)](I) “New [construction. Newly] Construction” means newly built facilities or parts, for which an approved Certificate of Need (CON) or applicable waivers were obtained and which were newly completed and operational on or after November 1, 1986.

[(K)](J) “New [owners. Original] Owners” means the original owners of new construction.

[(L)](K) “Providers[.] A provider]” means, under the Prospective Reimbursement Plan [is], a nonstate-operated ICF/IID facility with a valid participation agreement, in effect on or after October 31, 1986, with the Missouri Department of Social Services for the purpose of providing long-term care (LTC) services to Title XIX-eligible participants. Facilities certified to provide intermediate care services to individuals with intellectual disabilities under the Title XIX program may be offered a MO HealthNet participation agreement on or after January 1, 1990, only if 1) the facility has no more than fifteen (15) beds for individuals with intellectual disabilities, and 2) there is no other licensed residential living facility for individuals with intellectual disabilities within a radius of one-half (1/2) mile of the facility seeking participation in the MO HealthNet program.

[(M)](L) “Reasonable and [adequate reimbursement. Reimbursement] Adequate Reimbursement” means reimbursement levels which meet the needs of an efficiently and economically operated facility and which in no case exceed normal market costs.

[(N)](M) “Related parties[.] Parties are related when—]” means—

1. An individual or group, regardless of the business structure of either, where, through their activities, one (1) individual’s or group’s transactions are for the benefit of the other and the benefits exceed those which are usual and customary in the dealings;

2. One (1) or more persons [has] have an ownership or controlling interest in a party, and the person(s) or one (1) or more relatives of the person(s) has an ownership or controlling interest in the other party. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity, directly or through a subsidiary, operates a facility; or

3. As used in section (3), the following terms mean:

A. “Indirect [ownership/interest] Ownership” or “Indirect Interest” means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. “Ownership [interest] Interest” means the possession of equity in the capital, in the stock, or in the profits of an entity;

C. “Ownership [or controlling interest is when] Interest” or “Controlling Interest” means a person or corporation(s)—

(I) Has an ownership interest *[totalling]* totaling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity, if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from the obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership;

D. "Relative" means persons related by blood or marriage to the fourth degree of consanguinity; and

E. "Entity" means any person, corporation, partnership, or association.

[(O)](N) "Rural *[. Those]*" means those counties *[which]* that are not defined as urban.

[(P)](O) "Urban *[. The urban counties are]*" means counties that are standard metropolitan statistical areas including Andrew, Boone, Buchanan, Cass, Christian, Clay, Franklin, Greene, Jackson, Jasper, Jefferson, Newton, Platte, Ray, St. Charles, St. Louis, and St. Louis City.

(4) *[Prospective Reimbursement]* ICF/IID Rate Computation. Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/IID services certified to participate in Missouri's MO HealthNet program. Rate determination shall be based on reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level-of-care provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require those uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be determined.

(A) *[Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/IID services certified to participate in Missouri's MO HealthNet program.]* Prospective Reimbursement Rate Determination through December 31, 2018.

1. *[ICF/IID facilities]*

A. *Except in accordance with other provisions of this rule, the MO HealthNet program shall reimburse providers of these LTC services based on the individual MO HealthNet-participant days of care multiplied by the Title XIX prospective per diem rate less any payments collected from participants.]* The Title XIX prospective per diem reimbursement rate for the remainder of state Fiscal Year 1987 shall be the facility's per diem reimbursement payment rate in effect on October 31, 1986, as adjusted by updating the facility's allowable base year to its 1985 fiscal year. Each facility's per diem costs as reported on its Fiscal Year 1985 Title XIX cost report will be determined in accordance with the principles set forth in this rule. If a facility has not filed a 1985 fiscal year cost report, the MO HealthNet Division will use the most current cost report on file with the department *[will be used]* to set *[its]* a facility's per diem rate. Facilities with less than a full twelve-(12-) month 1985 fiscal year will not have their base year rates updated.

[B.]2. For state FY-88 and dates of service beginning July 1, 1987, the negotiated trend factor shall be equal to two percent (2%)

to be applied in the following manner: Two percent (2%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1987, shall be added to each facility's rate.

[C.]3. For state FY-89 and dates of service beginning January 1, 1989, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1988, shall be added to each facility's rate.

[D.]4. For state FY-91 and dates of service beginning July 1, 1990, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1990, shall be added to each facility's rate.

5. Prospective payment adjustment (PPA). A FY92 PPA will be provided prior to the end of the state fiscal year for nonstate-operated ICF/IID facilities with a current provider agreement on file with the MO HealthNet Division as of October 1, 1991.

A. For providers that qualify, the PPA shall be the lesser of—

(I) The provider's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjustment factor (PPAF) times the nonstate-operated intermediate care facility for individuals with intellectual disabilities ceiling (ICFIIDC) on October 1, 1991 (FPGF × PPD × PPAF × ICFIIDC). For example: A provider having nine hundred twenty (920) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of twenty-eight thousand five hundred sixty-one (28,561) represents an FPGF of three and twenty-two hundredths percent (3.22%). So using the FPGF of 3.22% × 114,244 × 24.5% × \$156.01 = \$140,607; or

(II) The provider FPGF times one hundred forty-five percent (145%) of the amount credited to the intermediate care revenue collection center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

B. FPGF—is determined by using each ICF/IID facility's paid days for the service dates in May 1991 through July 1991 as of September 20, 1991, divided by the sum of the paid days for the same service dates for all providers qualifying as of the determination date of October 16, 1991.

C. ICFIIDC—is one hundred fifty-six dollars and one cent (\$156.01) on October 1, 1991.

D. PPAF—is equal to twenty-four and one half percent (24.5%) for fiscal year 1992 which includes an adjustment for economic trends.

E. PPD—is the projection of one hundred fourteen thousand two hundred forty-four (114,244) patient days made on October 1, 1991, for the adjustment year.

6. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of eight dollars and eighty-six cents (\$8.86) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents (\$118.14) for all nonstate-operated ICF/IID facilities.

7. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of one dollar and sixty-six cents (\$1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents (\$118.14) for all nonstate-operated

ICF/IID facilities.

/E./8. FY-96 negotiated trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning January 1, 1996, of six dollars and seven cents (\$6.07) per patient day for the negotiated trend factor. This adjustment is equal to four and six-tenths percent (4.6%) of the weighted average per diem rates paid to nonstate-operated ICF/IID facilities on June 1, 1995, of one hundred and thirty-one dollars and ninety-three cents (\$131.93).

/F./9. State FY-99 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1998, of four dollars and forty-seven cents (\$4.47) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 1998, of one hundred forty-eight dollars and ninety-nine cents (\$148.99).

/G./10. State FY-2000 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1999, of four dollars and sixty-three cents (\$4.63) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on April 30, 1999, of one hundred fifty-four dollars and forty-three cents (\$154.43). This increase shall only be used for increases for the salaries and fringe benefits for direct care staff and their immediate supervisors.

/H./11. State FY-2001 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 2000, of four dollars and eighty-one cents (\$4.81) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on April 30, 2000, of one hundred sixty dollars and twenty-three cents (\$160.23). This increase shall only be used for increases for salaries and fringe benefits for direct care staff and their immediate supervisors.

/I./12. State FY-2007 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase of seven percent (7%) to their per diem rates effective for dates of service billed for state fiscal year 2007 and thereafter. This adjustment is equal to seven percent (7%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2006.

/J./13. State FY-2008 trend factor. Effective for dates of service beginning July 1, 2007, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2007.

/K./14. State FY-2009 trend factor. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2008.

/L./15. State FY-2009 catch up increase. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of thirteen and ninety-five hundredths percent (13.95%). This adjustment is equal to thirteen and ninety-five hundredths percent (13.95%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2008. This increase is intended to provide compensation to providers for the years where no trend factor was given. The catch up increase was based on the CMS PPS Skilled Nursing Facility Input Price Index (four- (4-) quarter moving average).

/M./16. State FY-2012 trend factor. Effective for dates of service beginning October 1, 2011, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one and four tenths percent (1.4%) for the trend factor. This adjustment is equal to one and four tenths percent (1.4%) of the per diem rate paid

to nonstate-operated ICF/IID facilities on September 30, 2011.

/N./17. State FY-2014 trend factor. Effective for dates of service beginning January 1, 2014, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/IID facilities on December 31, 2013.

/O./18. State FY-2016 trend factor. Effective for dates of service beginning February 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one percent (1%) for the trend factor. This adjustment is equal to one percent (1%) of the per diem rate paid to nonstate-operated ICF/IID facilities on January 31, 2016.

/P./19. State FY-2017 trend factor. Effective for dates of service beginning September 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/IID facilities on August 31, 2016.

/Q./20. State FY-2018 per diem adjustment. Effective for dates of service beginning September 1, 2017, all nonstate-operated ICF/IID facilities shall be subject to a decrease to their per diem rates of two and eighty-two hundredths percent (2.82%). This adjustment is equal to two and eighty-two hundredths percent (2.82%) of the per diem rate paid to nonstate-operated ICF/IID facilities on August 31, 2017.

(B) Per Diem Rate Calculation Effective for Dates of Service Beginning January 1, 2019. Effective for dates of service beginning January 1, 2019, the MO HealthNet Division shall rebase nonstate-operated ICF/IID facilities' per diem rates using the facilities' 2017 fiscal year end cost reports. The rebased rates are contingent upon approval of the state plan amendment by the Centers for Medicare and Medicaid Services.

1. Prospective Rate Calculation.

A. Each nonstate-operated ICF/IID shall have its prospective rate recalculated based on its 2017 fiscal year end cost report using the same principles and methodology as detailed throughout sections (1)-(13) of this regulation.

(I) The costs from the 2017 fiscal year end cost reports shall be trended using the indices from the most recent publication of the Healthcare Cost Review available to the division using the "CMS Nursing Home without Capital Market Basket" table. The costs shall be trended using the four (4) quarter moving average. The costs shall be trended for the years following the cost report year, up to and including the state fiscal year corresponding to the effective date of the rates. For SFY 2019, the trends are as follows:

- (a) 2018=3.025%**
- (b) 2019=2.65%**

(II) If a facility's total calculated per diem set forth in this section is less than the facility's current rate, the facility shall continue to receive its current rate.

(III) The division will use the FY 2017 cost report to determine the ICF/IID prospective rate, set forth as follows:

(a) Total Routine Service Cost. Total routine service cost includes patient care, ancillary, dietary, laundry, housekeeping, plant operations, and administration. Each ICF/IID's Title XIX Routine Service Cost per diem shall be calculated as follows:

I. The total routine service costs as reported on the cost report shall be adjusted for minimum utilization, if applicable, trended to the current state fiscal year, and divided by the total patient days to determine the per diem. The minimum utilization adjustment will be determined by applying the unused capacity percent to the sum of the laundry, housekeeping, plant operations, and administration expenses. The following is an illustration of how this item (4)(B)1.A.(III)(a)I. is calculated:

Licensed/Certified Bed Days (9 beds x 365 days)	3,285
Total Patient Days	2,900
Percent Occupied (2,900/3,285)	88%
Bed Days @ Minimum Occupancy of 90% (3,285 x 90%)	2,957
Unused Capacity (90% of Bed Days Less Total Patient Days)	57
Unused Capacity Percent for Minimum Utilization	
Adjustment(Unused Capacity / 90% of Bed Days)	1.93%
Minimum Utilization Days for Return on Owner's Equity(Greater of 90% of Bed Days or Total Patient Days)	2,957
* Minimum Utilization Adjustment	
Laundry	\$5,000
Housekeeping	\$8,000
Plant Operations	\$46,000
Administration	\$165,000
Total Expense	\$224,000
Unused Capacity Percent	1.93%
Minimum Utilization Adjustment (Unused Capacity Percent x Total Expense)	\$4,323
Patient Care	\$400,000
Ancillary	\$10,000
Dietary	\$25,000
Laundry	\$5,000
Housekeeping	\$8,000
Plant Operations	\$46,000
Administration	\$165,000
Total Routine Service Cost	\$659,000
Less: Minimum Utilization Adjustment*	(\$4,323)
Routine Service Cost, Adjusted for Minimum Utilization	\$654,677
SFY 2018 Trend	3.025%
SFY 2019 Trend	2.65%
Trended Routine Service Cost	\$692,355
Total Patient Days	2,900
Routine Service Cost Per Diem	\$238.74

(b) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The SFY 2019 ICF/IID FRA provider assessment as determined in accordance with 9 CSR 10-31.030 is divided by total patient days to determine the ICF/IID FRA per diem.

I. The following is an illustration of how the ICF/IID FRA assessment is calculated:

SFY 2019 ICF/IID FRA Assessment	\$40,000
Total Patient Days	2,900
ICF/IID FRA Per Diem	\$13.79

(c) Return on Equity. An owner's net equity consists of investment capital and working capital as indicated in subsection (6)(S). Each ICF/IID's Return on Equity per diem is calculated as follows:

I. Investment Capital. Investment capital includes the investment in building, property, and equipment (cost of land, mortgage payments toward principal, and equipment purchase less the accumulated depreciation).

II. Working Capital. Working capital represents

the amount of capital which is required to ensure proper operation of the facility and shall be calculated as 1.1 months of the total expenses less depreciation.

III. The total net equity shall be multiplied by the rate of return as set forth in Section (6)(S) to determine the return on equity. The return on equity is subject to the minimum occupancy percent of 90% in determining the per diem.

IV. The following is an illustration of how this item (4)(B)1.A.(III)(c) is calculated:

Investment Capital			
	<u>Equipment</u>	<u>Building</u>	<u>Total</u>
Cost	\$130,000	\$300,000	\$430,000
Less: Prior Years Depreciation	(\$120,000)	(\$225,000)	(\$345,000)
Less: Current Year Depreciation	(\$2,400)	(\$8,500)	(\$10,900)
Total Investment Capital	\$7,600	\$66,500	\$74,100
Working Capital			
Total Expenses			\$659,000
Less: Current Year Depreciation Expense			(\$10,900)
			\$648,100
Divided by 12 Months			12
			\$54,008
Times 1.1 Months			1.1
Total Working Capital			\$59,409
Net Equity (Investment Capital + Working Capital)			\$133,509
Rate of Return			5.125%
Return on Equity			\$6,842
Minimum Utilization Days			2,957
Return on Equity Per Diem			\$2.31

(c) Rebased Per-Diem Rate. The total calculated Per-Diem is the sum of the Routine Service Cost per diem, the ICF/IID FRA per diem and the Return on Equity per diem. To determine the rebased per diem rate, the total calculated per diem is compared to the current per diem rate and the facility will be held harmless if the total calculated per diem is less than the current per diem rate (i.e., if the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem).

Routine Service Cost per diem	\$238.74
ICF/IID FRA per diem	\$13.79
Return on Equity per diem	\$2.31
Total Calculated Per Diem	\$254.84
Current Per Diem Rate	\$200.00

Rebased Per Diem Rate \$254.84
(If the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem rate)

2. Interim Rate Calculation.

A. In the case of a newly certified facility where a valid Title XIX participation agreement has been executed, a request for an interim rate must be submitted in writing to the MO HealthNet Division.

(I) The interim rate shall be determined based on the projected estimated operating costs. The facility's request must specifically and clearly identify the interim rate and be supported by complete and accurate documentation satisfactory to the single state agency. Documentation submitted must include a budget of the projected estimated operating costs. Other documentation may also be required to be submitted upon the request of the division.

(II) The establishment of the prospective rate for all new construction facility providers shall be based on the second full facility fiscal year cost report (i.e., rate setting cost report) prepared in accordance with the principles of this rule. This cost report shall be based on actual operating costs and shall be prepared and submitted in accordance with the reporting requirements in section (7) of this rule.

(III) Prior to establishment of a prospective rate for newly certified facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services or authorized representative to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

(IV) The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and a prospective reimbursement rate shall be determined on the allowable per diem cost as set forth in section (4) of this rule. The prospective reimbursement rate shall be effective on the first day of the facility's rate setting cost report and payment adjustments shall be made for claims paid at the interim rate.

[2.]3. Adjustments to rates. The prospectively determined reimbursement rate may be adjusted only under the following conditions:

A. When information contained in a facility's cost report is found to be fraudulent, misrepresented, or inaccurate, the facility's reimbursement rate may be reduced, both retroactively and prospectively, if the fraudulent, misrepresented, or inaccurate information as originally reported resulted in establishment of a higher reimbursement rate than the facility would have received in the absence of this information. No decision by the MO HealthNet agency to impose a rate adjustment in the case of fraudulent, misrepresented, or inaccurate information in any way shall affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rule. The fact that fraudulent, misrepresented, or inaccurate information reported did not result in establishment of a higher reimbursement rate than the facility would have received in the absence of the information also does not affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rules;

[B. In accordance with subsection (6)(B) of this rule, a newly constructed facility's initial reimbursement rate may be reduced if the facility's actual allowable per diem cost for its first twelve (12) months of operation is less than its initial rate;]

[C.]B. [When a facility's MO HealthNet reimbursement rate is higher than either its private pay rate or its Medicare rate, the MO HealthNet rate will be reduced in accordance with subsection (2)(B) of this rule] Extraordinary circumstances. A participating facility that has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request should be submitted in writing to the division within one (1) year of the occurrence of the extraordinary circumstance. The request should clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment should be supported by complete and accurate documentation satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information

may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

[D.](I) When the provider can show that it incurred higher costs due to circumstances beyond its control, and the circumstances are not experienced by the nursing home or ICF/IID industry in general, and the [request must] circumstances have a substantial cost effect[. These circumstances include, but are not limited to:];

(II) Extraordinary circumstances, which are beyond the reasonable control of the ICF/IID and are not a product or result of the negligence or malfeasance of the ICF/IID, include:

[(I)](a) Unavoidable [A]acts of nature[, such as] are natural wildfire, earthquakes, hurricane, tornado, lightning, [and flood] flooding, or other natural disasters for which no one can be held responsible, that are not covered by insurance and that occur in a federally declared disaster area; or

[(I)](b) Vandalism, civil disorder, or both that are not covered by insurance; or

[(I)](c) Replacement of capital depreciable items not built into existing rates that are the result of circumstances not related to normal wear and tear or upgrading of existing system[.];

[E. When an adjustment to a facility's rate is made in accordance with the provisions of section (6) of this rule; or]

[F.]C. When an adjustment is based on an Administrative Hearing Commission or court decision.

D. New, expanded, or terminated services may be subject to rate review.

E. Disallowance of federal financial participation.

F The following will not be subject to review:

(I) The negotiated trend factor;

(II) The use of prospective reimbursement rate; and

(III) The cost base for the per diem rates except as specified in this rule.

[(B) In the case of newly constructed nonstate-operated ICF/IID facilities entering the MO HealthNet program after October 31, 1986, and for which no rate has previously been set, the director or his/her designee may set an initial rate for the facility as in his/her discretion s/he deems appropriate. The initial rate shall be subject to review by the advisory committee under the provisions of section (6) of this rule.]

(5) Covered Services and Supplies.

(A) ICF/IID services and supplies covered by the per diem reimbursement rate under this plan, and which the ICF/IID must [be provided] provide, as required by federal or state law or rule and include, among other services, the regular room, dietary and nursing services, or any other services that are required for standards of participation or certification. Also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service, and enemas;

2. Items [which] that are furnished routinely and relatively uniformly to all participants, for example, gowns, water pitchers, soap, basins, and bed pans;

3. Items such as alcohol, applicators, cotton balls, bandaids, and tongue depressors;

4. All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners, and nonlegend vitamins. Any nonlegend drug in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; *[all must be provided]* **facilities must provide all** as needed within the existing per diem rate;

5. Items which are utilized by individual participants but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable, nondepreciable medical equipment;

6. Additional items as specified in the appendix to this plan when required by the patient;

7. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, including dietary supplements written as a prescription item by a physician;

8. All laundry services except personal laundry, which is a non-covered service;

9. All general personal care services *[which are furnished]* **that the facility furnishes** routinely and relatively uniformly to all participants for their personal cleanliness and appearance shall be covered services, for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos, and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service;

10. All consultative services as required by state or federal law or regulation or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report. Failure to do so will result in the penalties specified in section *[(9)](8)* of this rule;

11. Semiprivate room and board and private room and board when necessary to isolate a participant due to a medical or social condition, such as contagious infection, irrational loud speech, and the like. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service, and a MO HealthNet participant or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. MO HealthNet participants may not be placed in private rooms and charged any additional amount above the facility's MO HealthNet per diem unless the participant or responsible party in writing specifically requests a private room prior to placement in a private room and acknowledges that an additional amount not payable by MO HealthNet will be charged for a private room;

12. Twelve (12) days per any period of six (6) consecutive months during which a participant is on a temporary leave of absence from the facility. *[Temporary leave of absence days must be specifically provided for]* **The provider shall specifically provide for temporary leave of absence days** in the participant's plan of care. Periods of time during which a participant is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence; and

13. Days when participants are away from the facility overnight on facility-sponsored group trips under the continuing supervision and care of facility personnel.

[(6) Rate Determination. All nonstate-operated ICF/IID providers of LTC services under the MO HealthNet program who desire to have their rates changed or established must apply to the MO HealthNet Division. The department may request the participation of the Department of Mental Health in the analysis for rate determination. The procedure and conditions for rate reconsideration are as follows:

(A) Advisory Committee. The director, Department of Social Services, shall appoint an advisory committee to review and make recommendations pursuant to provider requests for rate determination. The director may accept, reject, or modify the advisory committee's recommendations.

1. Membership. The advisory committee shall be composed of four (4) members representative of the nursing home industry in Missouri, three (3) members from the Department of Social Services, and two (2) members which may include, but are not limited to, a consumer representative, an accountant or economist, or a representative of the legal profession. Members shall be appointed for terms of twelve (12) months. The director shall select a chairman from the membership who shall serve at the director's discretion.

2. Procedures.

A. The committee may hold meetings when five (5) or more members are present and may make recommendations to the department in instances where a simple majority of those present and voting concur.

B. The committee shall meet no less than one (1) time each quarter, and members shall be reimbursed for expenses.

C. The MO HealthNet Division will summarize each case and, if requested by the advisory committee, make recommendations. The advisory committee may request additional documentation as well as require the facility to submit to a comprehensive operational review to determine if there exists an efficient and economical delivery of patient services. The review will be made at the discretion of the committee and may be performed by it or its designee. The findings from a review may be used to determine the per diem rate for the facility. Failure to submit requested documentation shall be grounds for denial of the request.

D. The committee, at its discretion, may issue its recommendation based on written documentation or may request further justification from the provider sending the request.

E. The advisory committee shall have ninety (90) days from the receipt of each complete request, provided the request is on behalf of a facility which has executed a valid Title XIX participation agreement, or the receipt of any additional documentation to submit its recommendations in writing to the director. If the committee is unable to make a recommendation within the specified time limit, the director or his/her designee, if the committee establishes good cause, may grant a reasonable extension.

F. Final determination on rate adjustment. The director's, or his/her designee's, final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the committee's recommendation.

G. The director's, or his/her designee's, final determination on the advisory committee's recommendation shall become effective on the first day of the month in which the request was made, providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective the first day of the following month;

(B) In the case of new construction where a valid Title XIX participation agreement has been executed, a request for a rate must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. Until an initial per diem rate is established, the MO HealthNet Division shall

grant a tentative per diem rate for that period. In no case may a facility receive a per diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of newly built facility or part of the facility which is less than two (2) years of age and enters the Title XIX Program on or after November 1, 1986, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for new construction. Owners of new construction which have an approved CON are certified for participation and which have a valid Title XIX participation agreement shall submit a budget in accordance with the principles of section (7) of this rule and other documentation as the committee may request.

2. The establishment of the permanent rate for all new construction facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7) of this rule. This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety- (90-) day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for new construction facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

4. The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and each facility's actual allowable per diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per diem cost is less than its initial per diem reimbursement rate, the facility's rate will be reduced to its actual allowable per diem cost. This reduction will be effective on the first day of the second full facility fiscal year.

5. If a facility's actual allowable per diem cost is higher than its initial per diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost report and actual operating costs;

(C) In the case of existing facilities not previously certified to participate in the Title XIX program, a request for a per diem reimbursement rate must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. Until the time as a per diem rate is established, the MO HealthNet Division shall grant a tentative per diem rate for that period. In no case may a facility receive a per diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of a facility described in subsection (6)(C) of this rule and entering the Title XIX program on or after March 1, 1990, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for first full facility's fiscal year.

2. The establishment of the permanent rate for all existing facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the prin-

ciples of section (7) of this rule. This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety- (90-) day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for existing facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

4. The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and each facility's actual allowable per diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per diem cost is less than its initial per diem reimbursement rate, the facility's rate will be reduced to its actual allowable per diem cost. This reduction will be effective on the second day of the first full facility fiscal year.

5. If a facility's actual allowable per diem cost is higher than its initial per diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost report and actual operating costs;

(D) Rate Reconsideration.

1. The committee may review the following conditions for rate reconsideration:

A. Those costs directly related to a change in a facility's case mix; and

B. Requests for rate reconsideration which the director, in his/her discretion, may refer to the committee due to extraordinary circumstances contained in the request and as defined in subparagraph (4)(A)2.D. of this rule.

2. The request for an adjustment must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. The facility must demonstrate that the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services.

3. However, for state fiscal years after Fiscal Year 1987, in no case may a facility receive a per diem reimbursement rate higher than the class ceiling for that facility in effect on June 30 of the preceding fiscal year adjusted by the negotiated trend factor.

4. The following will not be subject to review:

A. The negotiated trend factor;

B. The use of prospective reimbursement rate; and

C. The cost base for the June 30 per diem rate except as specified in this rule;

(E) Rate Adjustments. The department may alter a facility's per diem rate based on—

1. Court decisions;

2. Administrative Hearing Commission decisions;

3. Determination through desk audits, field audits, and other means, which establishes misrepresentations in or the inclusion of unallowable costs in the cost report used to establish the per diem rate. In these cases, the adjustment shall be applied retroactively; or

4. Adjustments determined by the department without the advice of the rate advisory committee.

A. *Prospective payment adjustment (PPA).* A FY-92 PPA will be provided prior to the end of the state fiscal year for nonstate-operated ICF/IID facilities with a current provider agreement on file with the MO HealthNet Division as of October 1, 1991.

(I) For providers which qualify, the PPA shall be the lesser of—

(a) The provider's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjustment factor (PPAF) times the nonstate-operated intermediate care facility for individuals with intellectual disabilities ceiling (ICFIIDC) on October 1, 1991 ($FPGF \times PPD \times PPAF \times ICFIIDC$). For example: A provider having nine hundred twenty (920) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of twenty-eight thousand five hundred sixty-one (28,561) represents an FPGF of three and twenty-two hundredths percent (3.22%). So using the FPGF of 3.22% \times 114,244 \times 24.5% \times \$156.01 = \$140,659; or

(b) The provider FPGF times one hundred forty-five percent (145%) of the amount credited to the intermediate care revenue collection center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

(II) FPGF—is determined by using each ICF/IID facility's paid days for the service dates in May 1991 through July 1991 as of September 20, 1991, divided by the sum of the paid days for the same service dates for all provider's qualifying as of the determination date of October 16, 1991.

(III) ICFIIDC—is one hundred fifty-six dollars and one cent (\$156.01) on October 1, 1991.

(IV) PPAF—is equal to twenty-four and five-tenths percent (24.5%) for fiscal year 1992 which includes an adjustment for economic trends.

(V) PPD—is the projection of one hundred fourteen thousand two hundred forty-four (114,244) patient days made on October 1, 1991, for the adjustment year;

5. *FY-92 trend factor and Workers' Compensation.* All facilities with either an interim rate or a prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of eight dollars and eighty-six cents (\$8.86) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents (\$118.14) for all nonstate-operated ICF/IID facilities; or

6. *FY-93 negotiated trend factor.* All facilities with either an interim rate or prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of one dollar and sixty-six cents (\$1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents (\$118.14) for all nonstate-operated ICF/IID facilities; and

(F) Rate determination shall be based on a determination of reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level-of-care provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require those uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be

determined by the advisory committee with the consent of the director.]

[(7)](6) Allowable Cost Areas.

(A) Compensation of Owners.

1. Allowance of compensation of services of owners shall be an allowable cost area, provided the [services are actually performed] owner actually performs the services and the services are necessary [services].

2. "Compensation" [shall mean] means the total benefit to the owner, within the limitations set forth in this rule, [by the owner] of the services s/he renders to the facility [including]. Compensation includes direct payments to the owner for managerial, administrative, professional, and other services[,]; amounts paid by the provider for the personal benefit of the owner[,]; the cost of assets and services [which] that the owner receives from the provider[,]; and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described.

3. [Reasonableness] MO HealthNet auditors may determine the reasonableness of compensation [may be determined by] by reference to or in comparison with compensation paid for comparable institutions or it may be determined by other appropriate means such as the Medicare and Medicaid Provider Reimbursement Manual (HIM-15) or by other means.

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility, had the provider not rendered these services, then employment of another person(s) to perform the service would be necessary.

(B) Covered services and supplies as defined in section (5) of this rule.

(C) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings, and equipment [which] that are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight-line method of depreciation from the date initially put into service.

3. The basis of assets at the time placed in service shall be the lower of—

A. The book value of the provider;

B. Fair market value at the time of acquisition;

C. The recognized Internal Revenue Service (IRS) tax basis; and

D. In the case of the change in ownership, the cost basis of acquired assets of the owner of record on or after July 18, 1984, as of the effective date of the change of ownership; or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program.

4. The MO HealthNet Division will allow the basis of donated assets [will be allowed] to the extent of [recognition of income resulting] the recognized income resulting from the donation of the asset. Should a dispute arise between a provider and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the MO HealthNet program and the facility in ratio to MO HealthNet participant reimbursable patient days to total patient days.

5. Allowable methods of depreciation shall be limited to the straight-line method. The depreciation method used for an asset under the MO HealthNet program need not correspond to the method used by a provider for non-MO HealthNet purposes; however, useful life shall be in accordance with the American Hospital Association's Guidelines. Component part depreciation is optional and allowable under this plan.

6. "Historical cost" *[is]* means the cost incurred by the provider in acquiring the asset and preparing it for use, except as provided in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees and related legal fees. Where a provider has elected, for federal income tax purposes, to expense certain items such as interest and taxes during construction, the historical cost basis for MO HealthNet depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this rule, any asset costing less than five hundred dollars (\$500) or having a useful life of one (1) year or less, may be expensed and not capitalized at the option of the provider, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program.

7. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of **the** undepreciated cost basis of the traded asset plus the cash paid.

8. For the purpose of determining allowance for depreciation, the cost basis of the asset shall be as prescribed in paragraph *[(7)](6)(C)3*.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars (\$150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if these capital expenditures fail to comply with any other federal or state law or regulation, such as Certificate of Need (CON).

10. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this plan.

(D) Interest and Finance Costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for those purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as **the** acquisition of facilities and capital improvements, and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost item, interest (including finance charges, prepaid costs, and discounts) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claims, and necessary and proper for the operation, maintenance, or acquisition of the provider's facilities.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to participant care. Loans *[which]* **that** result in excess funds or investments are not considered necessary.

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made, and provided further the department shall not reimburse for interest and finance charges any amount in excess of the prime rate current at the time the loan was obtained.

7. Interest on loans to providers by proprietors, partners, and any stockholders shall not be an allowable cost item because the loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity. If a facility operated by a religious order borrows from the order, interest paid to the order shall be an allowable cost.

8. If loans for capital indebtedness exceed the asset cost basis as defined in subsection *[(7)](6)(C)* of this rule, the interest associated with the portion of the loan(s) which exceed the asset cost basis as defined in subsection *[(7)](6)(C)* of this rule shall not be allowable.

9. Income from a provider's qualified retirement fund shall be excluded in consideration of the per diem rate.

10. A provider shall amortize finance charges, prepaid interest, and discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

11. Usual and customary costs, excluding finder's fees, incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

12. Usual and customary costs shall be limited to the lender's title and recording fees, appraisal fees, legal fees, escrow fees, and closing costs.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars (\$150,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost item if the capital expenditure fails to comply with other federal or state law or rules such as CON.

(E) Rental and Leases.

1. Rental and leases of land, buildings, furnishings, and equipment are allowable cost areas *[provided that]* if the rented items are necessary and not in essence a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those *[which]* **that** are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those *[which]* **that** are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and amounts, except in the case of related parties *[which]* **that** is subject to other provisions of this rule, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to CON approval must have that approval before a rate is determined.

7. If rent or lease costs increase solely as a result of change in ownership, the resulting increase which exceeds the allowable capital cost of the owner of record as of July 18, 1984, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program, shall be a nonallowable cost.

(F) Taxes. Taxes levied on or incurred by providers shall be allowable cost areas with the exceptions of the following items:

1. Federal, state, or local income and excess profit taxes including any interest and penalties paid;

2. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bond, property transfer, issuance of transfer of stocks;

3. Taxes for which exemptions are available to the provider;

4. Special assessments on land *[which]* **that** represent capital improvements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid;

5. Taxes on property which are not a part of the operation of the provider;

6. Taxes which are levied against a resident and collected and remitted by the provider; and

7. Self-employment Federal Insurance Contributions Act (FICA) taxes applicable to individual proprietors, partners, or members of a joint venture to the extent the taxes exceed the amount which would have been paid by the provider on the allowable compensation of the persons had the provider organization been an incorporated rather than unincorporated entity.

(G) Issuance of Revenue Bond and Tax Levies by District and County Facilities. Those nursing home districts and county facilities whose funding is through the issuance of revenue bonds, that interest which is paid per the revenue bond will be an allowable cost item. Depreciation on the plant and equipment of these facilities also shall be an allowable cost item. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

(H) Value of Services of Employees.

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers, such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals, and similar organizations, shall not be included as an allowable cost area, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis, and similar type professionals shall be an allowable cost area; provided, that the services are not of a religious nature. An example of an allowable cost area under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. **[Costs/ The MO HealthNet Division considers costs for wardrobe and similar items likewise *are considered* nonallowable.**

(I) Fringe Benefits.

1. Life insurance.

A. Types of insurance *[which are not considered]* that the **MO HealthNet Division does not consider** an allowable cost area; premiums related to insurance on the lives of officers and key employees are not allowable cost areas under the following circumstances:

(I) Where, upon the death of an insured officer or key employee, the insurance proceeds are payable directly to the provider. In this case, the provider is a direct beneficiary. Insurance of this type is referred to as key-man insurance; and

(II) Where insurance on the lives of officers is voluntarily taken out as part of a mortgage loan agreement entered into for building construction and, upon the death of an insured officer, the proceeds are payable directly to the lending institution as a credit against the loan balance. In this case, the provider is an indirect beneficiary.

B. Types of insurance which are considered an allowable cost area—

(I) Where credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs; and

(II) Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. **[This type of insurance is considered to be] The MO HealthNet Division considers this type of insurance a fringe benefit and is an allowable cost area to the extent that the amount of coverage is reasonable.**

2. Retirement plans.

A. Contributions to qualified retirement plans for the benefit of employees excluding stockholders, partners, and proprietors of the provider shall be allowable cost areas. **[Interest] Facilities shall exclude interest** income from funded pensions or retirement plans **[shall be excluded]** from consideration in determining the allowable cost area.

B. Amounts funded to pension and retirement plans, together with associated income, shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

3. Deferred compensation plans.

A. Contributions for the benefit of employees, excluding stockholders, partners, and proprietors, under deferred compensation plans shall be all allowable cost areas when, and to the extent that, the costs are actually paid by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered as an allowable cost area only when paid to the participating employee and only to the extent considered reasonable.

B. Amounts paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans, together with associated income *[shall be recaptured]* if not actually paid when due, as an offset to expenses on the cost report form.

(J) Education and Training Expenses.

1. The cost of on-the-job training *[which]* that directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost item only when specifically authorized in advance by the department.

2. Cost of education and training shall include incidental travel costs, but will not include leaves of absence or sabbaticals.

(K) Organizational Cost Items.

1. Organizational cost items may be included as an allowable cost area on an amortized basis.

2. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations, necessary accounting fees, expenses of temporary directors, and organizational meetings of directors and stockholders, and fees paid to states of incorporation.

3. **[Organizational costs shall be amortized] The provider shall amortize organizational costs** ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

4. Where a provider did not capitalize organizational costs and has written off those costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five- (5-) year period prior to entering the program and has properly capitalized organizational costs using a sixty- (60-) month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost area under the program and shall be amortized over the remaining part of the sixty- (60-) month period.

6. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(L) Advertising Costs. Advertising costs *[which]* that are reasonable, appropriate, and helpful in developing, maintaining, and furnishing services shall be an allowable cost area. The costs must be common and accepted occurrence in the field of the activity of the provider.

(M) Cost of Suppliers Involving Related Parties. Costs applicable to facilities, goods, and services furnished to a provider by a supplier related to the provider shall not exceed the lower of the cost to the supplier or the prices of comparable facilities, goods, or services obtained elsewhere. A provider shall identify suppliers related to it in the uniform cost report and the type-quantity and costs of facilities, goods, and services obtained from each supplier.

(N) Utilization Review. Incurred cost for the performance of required utilization review for ICF/IID is an allowable cost area. The expenditures must be for *[the purpose of]* providing utilization review on behalf of a Title XIX participant. *[Utilization]* **The provider shall apportion utilization** review costs incurred for Title XVIII and Title XIX *[must be apportioned on the basis of]* based on reimbursable participant days recorded for each program during the reporting period.

(O) Minimum Utilization. In the event the occupancy of a provider is below ninety percent (90%), the **provider will calculate** the following cost centers *[will be calculated]* as if the provider experienced ninety percent (90%) occupancy: laundry, housekeeping, general, administrative, and plant operation costs. In no case may **the provider carry forward** costs disallowed under this provision *[be carried forward]* to succeeding periods.

(P) Nonreimbursable Costs.

1. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included as allowable costs.

2. Those services that are specifically provided by Medicare and MO HealthNet must be billed to those agencies.

3. Any costs incurred that are related to fund drives are not reimbursable.

4. Costs incurred for research purposes shall not be included as allowable costs.

5. The cost of services provided under the Title XX program, by contract or subcontract, is specifically excluded as an allowable item.

6. Attorney fees related to litigation involving state, local, or federal governmental entities and attorneys' fees which are not related to the provision of LTC services, such as litigation related to disputes between or among owners, operators, or administrators.

7. Costs, such as legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition of merger for which any payment has been previously made under the program.

(Q) Other Revenues. Other revenues, including those listed that follow and excluding amounts collected under paragraph (5)(A)8. will be deducted from the total allowable cost and must be shown separately in the cost report by use of a separate schedule if included in the gross revenue: income from telephone services; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time, and other discounts; purchase rebates and refunds; recovery on insured loss; parking lot revenues; vending machine commissions or profit; sales from drugs to other than participants; income from investments of whatever type; and room reservation charges for temporary leave of absence days which are not covered services under section (5) of this rule. **Failure by the provider to, in a readily ascertainable manner, separately account for any of the revenues specifically set out previously [in this rule in a readily ascertainable manner] in this rule, shall result in the provider's termination** from the program.

1. Interest income received from a funded depreciation account will not be deducted from allowable operating costs *[provided that]* if interest is applied to the replacement of the asset being depreciated.

2. Cost centers or operations specified by the provider in *[paragraph (7)(R)3.] subsection (6)(R)* of this rule shall not have their associated cost or revenues included in the covered costs or revenues of the facility.

3. Restricted and unrestricted funds.

A. "Restricted funds," as used in this rule, mean those funds, cash or otherwise, including grants, gifts, taxes, and income from endowments, which **the provider [must be used only] shall only use** for a specific purpose designated by the donor. Those restricted funds *[which] that* are not transferred funds and are designated by the donor for paying operating costs will be offset from the total allowable expenses. If an administrative body has the authority to re-restrict restricted funds designated by the donor for paying operating costs, the *[funds] provider* will not *[be]* offset the funds from the total allowable expenses.

B. "Unrestricted funds," as used in this rule, mean those funds, cash or otherwise, including grants, gifts, taxes, and income from endowments, that *[are given] a donor gives* to a provider without restriction *[by the donor]* as to their use. *[These funds can be used]* **The provider can use these funds** in any manner *[desired by the provider]*. However, those unrestricted funds *[which] that* are not transferred funds and *[are used for paying]* that the provider uses to pay operating costs will be offset from total allowable expenses.

C. Transferred funds, as used in this rule, are those funds appropriated through a legislative or governmental administrative body's action, state or local, to a state or local government provider. The transfer can be state-to-state, state-to-local, or local-to-local provider. *[These funds are not considered]* **The MO HealthNet Division does not consider these funds** a grant or gift for reimbursement purposes, so *[having]* have no effect on the provider's allowable cost under this plan.

(R) Apportionment of Costs to MO HealthNet Participant Residents.

1. *[Provider's] Providers shall apportion their* allowable cost areas *[shall be apportioned]* between MO HealthNet program participant residents and other *[patients] residents* so that the share of **allowable cost areas** borne by the MO HealthNet program is based upon actual services received by **MO HealthNet** program participants.

2. To accomplish this apportionment, **providers shall apply** the ratio of *[participant residents' charges] patient days for MO HealthNet participants to the* total patient *[charges for the service of each ancillary department may be applied to the cost of this department. To this shall be added the cost of routine services for MO HealthNet program participant residents determined on the basis of a separate average cost per diem for general routine care areas or at the option of the provider on the basis of overall routine care area.*

3. *So that its charges may be allowable for use in apportioning costs under the program, each provider shall have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonable and consistently related to the cost of providing these services] days.*

[4.]3. Average cost per diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

[5.]4. A patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (5) of this rule, the day of discharge being counted only when the patient was admitted the same day. *[A census log shall be maintained]* **The provider shall maintain a census log** in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a participant is away from the facility on a facility-sponsored group trip and remains under the supervision and care of facility personnel.

[6.]5. ICF/IID facilities that provide intermediate care services to MO HealthNet participants may establish distinct part cost centers in their facility provided that adequate accounting and statistical data

required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share the common services and facilities, such as management services, dietary, housekeeping, building maintenance, and laundry.

[7.16. In no case may a provider's allowable costs allocated to the MO HealthNet program include the cost of furnishing services to persons not covered under the MO HealthNet program.

(S) Return on Equity.

1. A return on a provider's net equity shall be an allowable cost area.

2. The amount of return on a provider's net equity shall *[not exceed twelve percent (12%)]* be calculated using the nursing home allowable percentage as defined in 13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services.

3. An owner's net equity is comprised of investment capital and working capital. Investment capital includes the investment in building, property, and equipment (cost of land, mortgage payments toward principle, and equipment purchase less the accumulative depreciation). Working capital represents the amount of capital *[which]* that is required to *[insure]* ensure proper operation of the facility.

4. The return on owner's net equity shall be payable only to proprietary providers.

5. *[A provider's]* The provider shall apportion its return on the owner's net equity *[shall be apportioned]* to the MO HealthNet program *[on the basis of]* based on the provider's MO HealthNet program reimbursable participant resident days of care to total resident days of care during the cost-reporting period. For the purpose of this calculation, total resident days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy during the cost year.

(T) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The fee assessed to ICF/IIDs in the state of Missouri for the privilege of doing business in the state will be an allowable cost.

[(8)](7) Reporting Requirements.

(A) Annual Cost Report.

1. Each provider shall establish a twelve- (12-) month fiscal period which is to be designated as the provider's fiscal year. *[An]* The provider shall submit an annual cost report for the fiscal year *[shall be submitted by the provider]* to the department on forms to be furnished by the department for that purpose. *[The]* Each provider shall submit the completed cost report *[shall be submitted by each provider]* by the first day of the sixth month following the close of the fiscal period.

2. Unless the provider has previously filed adequate and current documentation in the following areas *[has been filed previously]* with the department, authenticated copies of the following documents must be submitted by the provider with the cost reports: authenticated copies of all leases related to the activities of the facility; all management contracts, all contracts with consultants; federal and state income tax returns for the fiscal year; and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.

3. *[Adequate]* The facility shall maintain adequate documentation for all line items on the uniform cost reports *[must be maintained by the facility]* and must *[be submitted]* submit the document to the department upon request.

4. If a cost report is more than ten (10) days past due, payment *[shall]* may be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, the department will release the withheld payments *[that were withheld will be released]* to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's MO HealthNet participation agreement and if terminated, retain all payments which have

been withheld pursuant to this provision.

5. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division *[will]* may withhold all remaining payments from the selling provider until the provider files the cost report *[is filed]*. The fully completed cost report with all required attachments and documentation is due the first day of the sixth month after the date of change of control, ownership, or termination. Upon receipt of a cost report prepared in accordance with this regulation, the department will release any withheld payment *[that was withheld will be released]* to the selling provider.

(B) Certification of Cost Reports.

1. The facility must certify the accuracy and validity of any cost report *[must be certified]*. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make the certification and will furnish proof of the authorization): an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report must also be notarized by a licensed notary public.

2. Certification statement.

Form of Certification

Misrepresentation or falsifications of any information contained in this report may be punishable by fine, imprisonment, or both, under state or federal law.

Certification by officer or administrator of provider:

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by _____

(Provider's name(s) and number(s))

for the cost report period beginning,

_____, 20____ and ending _____, 20____, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

(Signature) *(Title)* *(Date)*

(C) Adequacy of Records.

1. The provider must make available to the department or its duly authorized agent, including federal agents from Health and Human Services (HHS), at all reasonable times, the records as are necessary to permit review and audit of provider's cost reports. Failure to do so may lead to sanctions *[stated in section (8) of this rule or other sanctions]* available in section **[(9)](8)** of this rule.

2. *[All]* The provider shall retain all records associated with the preparation and documentation of the data associated with the cost report *[must be retained]* for seven (7) years from the cost report filing date.

(D) Accounting Basis.

1. The provider shall base the submitted cost report *[submitted must be based]* on the accrual basis of accounting.

2. Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods, provided *[appropriate treatment of capital expenditures is made]* the governmental institution treats capital expenditures appropriately.

(E) Audits.

1. *[Cost reports shall be based]* The provider shall base cost reports upon the provider's financial and statistical records *[which]* that must be capable of verification by audit.

2. If the provider has included the cost of a certified audit of the facility as an allowable cost item to the plan, a copy of that audit report and accompanying letter shall be submitted without deletions.

3. The annual cost report for the fiscal year of the provider may be subject to audit by the Department of Social Services or its contracted agents. Twelve- (12-) month cost reports for new construction facilities required to be submitted under section (4) of this rule may be audited by the department or its contracted agents prior to establishment of a permanent rate.

4. The department or **authorized agent** will conduct a desk review of all cost reports after submission by the provider and shall provide for on-site audits of facilities wherever **their personnel notes** a cost variance or exception *[are noted by their personnel]*.

5. The department shall retain the annual cost report and any working papers relating to the audits of those cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

6. Those providers having an annual Title XIX bed-day ratio on total bed days or certified beds of greater than sixty percent (60%) or an annual Title XIX payment of two hundred thousand dollars (\$200,000) or more, or both, shall be required, for at least the first two (2) fiscal years of participation in the plan, to have an annual audit of their financial records by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmations of accounts receivable and accounts payable are not required by the plan. For the purposes of the paragraph, the Department of Social Services will *[only]* accept *[an]* unqualified opinion **only if they are** from a certified public accounting firm. A copy of the audit report must be submitted to the department to support the annual cost report of the facility.

[(9)](8) Sanctions and Overpayments.

(A) *[Sanctions may be imposed]* **The department may impose sanctions** against a provider in accordance with 13 CSR 70-3.030 and other federal or state statutes and regulations.

(B) In the case of overpayments to providers based on, but not limited to, field or audit findings or determinations based on a comprehensive operational review of the facility, the provider shall repay the overpayment in accordance with the provisions as set forth in 13 CSR 70-3.030.

[(10)](9) Exceptions.

(A) For those MO HealthNet-eligible participant-patients who have concurrent Medicare Part A skilled nursing facilities benefits available, MO HealthNet reimbursement for covered days of stay in a qualified facility will be based on the coinsurance as may be imposed under the Medicare Program.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided **prior authorized** services of fewer than one thousand (1,000) patient days for Missouri Title XIX participants, the reimbursement rate shall be the rate paid for comparable services and level-of-care by the state in which the provider is located; and

2. For providers *[which]* that provide **prior authorized** services of one thousand (1,000) or more patient days for Missouri Title XIX participants, the reimbursement rate shall be the lower of—

A. The rate paid for comparable services and level-of-care by the state in which the provider is located; or

B. The rate calculated in *[sections (4) and (6)]* **section (4)** of this rule.

[(11)](10) Payment Assurance.

(A) The state will pay each provider, which furnished the services in accordance with the requirements of the state plan, the amount determined for services furnished by the provider according to the standards and methods set forth in these rules.

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

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

[(13)](12) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full for covered services rendered to MO HealthNet participants, the amount paid in accordance with these rules and applicable copayments.

[(14)](13) Plan Evaluation. *[Documentation will be maintained]* **The provider will maintain documentation** to effectively monitor and evaluate experience during administration of this rule.

AUTHORITY: sections 208.153, 208.159, [and] 208.201, and 660.017, RSMo 2016. This rule was previously filed as 13 CSR 40-81.083. Original rule filed Aug. 13, 1982, effective Nov. 11, 1982. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 25, 2019, effective Nov. 8, 2019, expires May 5, 2020. Amended: Filed Oct. 25, 2019.

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately four hundred ten thousand dollars (\$410,000) for SFY 2019 and eight hundred twenty thousand dollars (\$820,000) annually thereafter.

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

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

**FISCAL NOTE
PUBLIC COST**

- I. Department Title:** Title 13 - Department of Social Services
Division Title: Division 70 – MO HealthNet Division
Chapter Title: Chapter 10 - Nursing Home Program

Rule Number and Name:	13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Mental Health	SFY 2019 Cost – approximately \$410,000 Annual Fiscal Year Cost – approximately \$820,000

III. WORKSHEET

The annual cost of the rate rebase is approximately \$820,000 (\$285,000 general revenue and \$535,000 federal funds). The rate rebase is scheduled to begin January 1, 2019; thus, the SFY 2019 cost is approximately \$410,000 (\$143,000 general revenue and \$267,000 federal funds).

Nonstate Operated ICF/IIDs	Estimated Days	Est. Rate Increase/ Hold Harmless *	Estimated Impact
Facility 1	3,172	\$ 33.51	\$ 106,294
Facility 2	2,671	\$ 69.87	\$ 186,623
Facility 3	2,342	\$ 78.08	\$ 182,863
Facility 4	11,429	\$ 29.98	\$ 342,641
Facility 5	3,283	\$ 0.00	\$ 0.00
Facility 6	3,285	\$ 0.00	\$ 0.00
Facility 7	2,652	\$ 0.00	\$ 0.00
Total	28,834		\$ 818,421

* Facilities that are "Hold Harmless" will not receive a rate increase but will continue to receive their current rate. See IV. Assumptions below for additional information.

IV. ASSUMPTIONS

The rebased rates are based on 2017 cost report data trended to 2019, the year that the rates become effective. A facility whose preliminary, recalculated rate is less than its current rate will continue to receive its current rate (i.e., Hold Harmless).

The estimated days are from the 2017 data. Since the nonstate-operated ICF/IIDs have a stable census from year to year the days from the 2017 base year do not require a utilization adjustment.

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

PROPOSED RESCISSION

13 CSR 70-15.090 Procedures for Evaluation of Appropriate Inpatient Hospital Admissions and Continued Days of Stay. This rule established the basis on which hospitals furnishing inpatient care to Medicaid recipients were audited to determine that admissions/lengths of stay were medically necessary, of appropriate duration and setting, and in compliance with Medicaid rules and policies.

PURPOSE: This rule is being rescinded as the MO HealthNet Division (MHD) no longer needs or utilizes this regulation.

AUTHORITY: sections 208.153 and 208.201, RSMo 2016. This rule was previously filed as 13 CSR 40-81.162. Original rule filed May 3, 1985, effective Sept. 1, 1985. For intervening history, please consult the Code of State Regulations. Rescinded: Filed Oct. 25, 2019.

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

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

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

**Title 16—RETIREMENT SYSTEMS
Division 20—Missouri Local Government Employees'
Retirement System (LAGERS)
Chapter 2—Administrative Rules**

PROPOSED AMENDMENT

16 CSR 20-2.010 Definitions. The Retirement System amending section (1) by adding definitions of three new terms as a result of the adoption of section 70.631, RSMo and amending the purpose to include section 70.631, RSMo.

PURPOSE: The proposed amendment defines the terms “emergency medical service personnel,” “emergency telecommunicator,” and “jailor” as those terms are used in section 70.631, RSMo.

PURPOSE: The purpose of this rule is to expand on and clarify definitions of terms found in sections 70.600 and 70.631, RSMo [(1986)].

(1) Employee.

(E) The term “emergency medical service personnel” means any regular or permanent employee of a political subdivision possessing the duty and power to provide Advanced Life Support or Basic Life Support treatment, and who is required to be certified by the Missouri Bureau of Emergency Medical Services as an Emergency Medical Technician Basic (EMT-B), Advanced Emergency Medical Technician (AEMT) or an Emergency Medical Technician-Paramedic (EMT-P), or whose duties include direct supervision of EMT-B, AEMT and/or EMT-P personnel.

1. The term “emergency medical service personnel” shall not include volunteer EMT-Bs, AEMTs or EMT-Ps or any person temporarily employed as an EMT-B, AEMT or EMT-P for an emergency.

(F) The term “emergency telecommunicator” means any regular or permanent employee of a political subdivision employed as an emergency telephone or telecommunications worker, call taker, or public safety dispatcher whose duties include receiving, processing, or transmitting public safety information received through a Public Safety Answering Point, or whose duties include direct supervision of emergency telecommunicator personnel.

1. The term “emergency telecommunicator” shall not include any volunteer emergency telecommunicators or any person temporarily employed as an emergency telecommunicator for an emergency.

(G) The term “jailor” means any regular or permanent employee of a political subdivision employed for the duty of monitoring, transporting, or detaining inmates or other detainees held in the jail or other correctional facility of the political subdivision or whose duties include direct supervision of jailor personnel.

1. The term “jailor” shall not include any volunteer jailors or any person temporarily employed as jailor for an emergency.

AUTHORITY: section 70.605.21, RSMo [Supp. 2007] 2016. Original rule filed Dec. 29, 1975, effective Jan. 8, 1976. Amended: Filed Feb. 16, 1999, effective July 30, 1999. Amended: Filed Feb. 28, 2008, effective Aug. 30, 2008. Amended: Filed Oct. 28, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Any interested person or entity may submit written comments in support of or in opposition to the proposed amendment. Comments should be directed to the Missouri Local Government Employees Retirement System (LAGERS), Attn: Jason A. Paulsmeyer, Chief Counsel, PO Box 1665, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

**Division 20—Division of Community and Public Health
Chapter 2—Protection of Drugs and Cosmetics**

PROPOSED RESCISSION

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

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

AUTHORITY: section 196.045, RSMo 1986. This rule previously filed as 13 CSR 50-72.010. Original rule entitled Missouri Division of Health E 1.20 was filed on Nov. 17, 1949, effective Nov. 27, 1949. Rescinded: Filed Oct. 18, 2019.

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

aggregate.

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with PO Box 570, Jefferson City, MO 651002-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

**Division 20—Division of Community and Public Health
Chapter 3—General Sanitation**

PROPOSED RESCISSION

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

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

AUTHORITY: section 192.020, RSMo 1986. This rule previously filed as 13 CSR 50-83.010. Original rule filed May 12, 1949, effective May 22, 1949. Rescinded: Filed Oct. 18, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with PO Box 570, Jefferson City, MO 651002-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

Division 40—Division of Maternal, Child and Family Health

Chapter 4—Early Periodic Screening, Diagnosis and Treatment (EPSDT)

PROPOSED RESCISSION

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

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

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

effective April 11, 1985. Rescinded: Filed Oct. 18, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with PO Box 570, Jefferson City, MO 651002-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

Division 40—Division of Maternal, Child and Family Health

Chapter 7—Metabolic Formula Program

PROPOSED RESCISSION

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

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

AUTHORITY: sections 191.300-191.380, RSMo (1994 and Supp. 1995). Emergency rule filed Aug. 19, 1996, effective Aug. 29, 1996, expired Feb. 24, 1997. Original rule filed Aug. 15, 1996, effective Jan. 30, 1997. Rescinded: Filed Oct. 18, 2019.

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

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

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

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

Division 40—Division of Maternal, Child and Family Health

Chapter 7—Metabolic Formula Program

PROPOSED RESCISSION

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

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

AUTHORITY: sections 191.300-191.380, RSMo (1994 and Supp. 1995). Original rule filed Aug. 15, 1996, effective Jan. 30, 1997. Rescinded: Filed Oct. 18, 2019.

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

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

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

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

Division 40—Division of Maternal, Child and Family Health

Chapter 7—Metabolic Formula Program

PROPOSED RESCISSION

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

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

AUTHORITY: sections 191.300-191.380, RSMo (1994 and Supp. 1995). Emergency rule filed Aug. 19, 1996, effective Aug. 29, 1996, expired Feb. 24, 1997. Original rule filed Aug. 15, 1996, effective Jan. 30, 1997. Rescinded: Filed Oct. 18, 2019.

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

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

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

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE

Division 2040—Office of Athletics

Chapter 4—Licensees and Their Responsibilities

PROPOSED AMENDMENT

20 CSR 2040-4.015 Promoters. The office is adding section (14).

PURPOSE: This amendment adds language regarding access to national databases.

(14) A promoter of an event for professional boxing, professional and amateur kickboxing, professional full-contact karate, professional and amateur mixed martial arts events, are responsible to register their event with the certified registry as approved by the

Association of Boxing Commissions for their respective sport. The promoter of an event is responsible for all fees associated with registering their event with the respective database. No bouts will be approved until such time that a promoter provides proof that the proposed event is registered with the respective database.

AUTHORITY: section 317.006, RSMo Supp. [2018] 2019, and section 317.015, RSMo 2016. This rule originally filed as 4 CSR 40-4.015. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: Filed March 2, 1989, effective May 11, 1989. Rescinded and readopted: Filed Nov. 15, 2001, effective May 30, 2002. Moved to 20 CSR 2040-4.015, effective Aug. 28, 2006. Amended: Filed March 20, 2018, effective Sept. 30, 2018. Amended: Filed Jan. 25, 2019, effective Aug. 30, 2019. Amended: Filed Oct. 25, 2019.

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

PRIVATE COST: This proposed amendment will cost private entities six thousand six hundred dollars (\$6,600) annually thereafter for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at 573-751-5649, or via email at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

PRIVATE FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Commerce and Insurance
Division 2040 - Office of Athletics
Chapter 4 - Licensees and Their Responsibilities
Proposed Amendment - 20 CSR 2040-4.015 Promoters

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the amendment by affected entities:
44	Promoters (Per Event Fee @ 150)	\$6,600
Estimated Annual Cost of Compliance for the Life of the Rule		\$6,600

III. WORKSHEET

See Table Above

IV. ASSUMPTION

1. The figures reported above are based on calendar year 2018 actuals.
2. During calendar year 2018, the office regulated 44 events which would be subject to this new rule. The office averaged the cost to the promoter for an event to be \$150 per event. Some events will be much less since most boxing events average about 6 to 8 bouts which will range in cost from \$90 to \$120 per event. Most martial arts events average between 8 and 15 bouts which will range in cost from \$120 to \$195 the cap amount.
3. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

**Title 20—DEPARTMENT OF COMMERCE AND
INSURANCE
Division 2233—State Committee of Marital and Family
Therapists
Chapter 1—General Rules**

PROPOSED AMENDMENT

20 CSR 2233-1.040 Fees. The committee is adding section (3).

PURPOSE: This amendment allows the change of supervision fee to be waived under certain criteria.

(3) A change of supervision fee shall not be required for supervised experience in marital and family therapy upon request by the applicant, accompanied by a letter from the graduate program documenting the following:

(A) Licensure supervision is part of a doctoral or specialist degree or thirty (30) hours of post master's degree course work in marital and family therapy or a mental health discipline as defined in 20 CSR 2233-2.010;

(B) Licensure supervisor is a faculty member of the educational institution in which the applicant is currently enrolled; and

(C) Licensure supervisor is not reimbursed by the applicant for licensure supervision.

AUTHORITY: sections 337.712 and 337.727, RSMo Supp.2019. This rule originally filed as 4 CSR 233-1.040. Original rule filed Dec. 31, 1997, effective July 30, 1998. For intervening history, please consult the Code of State Regulations. Amended: Filed Oct. 25, 2019.

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions one hundred twenty-five dollars (\$125) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will save private entities agencies one hundred twenty-five dollars (\$125) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with State Committee of Marital and Family Therapists, Gloria Lindsey, Executive Director, PO Box 1335, Jefferson City, MO 65102, by faxing comments to (573) 751-0735, or by emailing comments to maritalfam@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

PUBLIC FISCAL NOTE

I. RULE NUMBER

**Title 20 -Department of Commerce and Insurance
Division 2233 - State Committee of Marital and Family Therapists
Chapter 1 - General Rules
Proposed Amendment to 20 CSR 2233-1.040 - Fees**

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Loss of Revenue	
State Committee of Marital and Family Therapists		\$125
	Total Loss of Revenue Annually for the Life of the Rule	\$125

III. WORKSHEET

See Private Entity Fiscal Note.

IV. ASSUMPTION

1. The total loss of revenue is based on the cost savings to private entities reflected in the Private Fiscal Note filed with this rule.

PRIVATE FISCAL NOTE

I. RULE NUMBER

**Title 20 -Department of Insurance, Financial Institutions and Professional
Division 2233 - State Committee of Marital and Family Therapists
Chapter 1 - General Rules
Proposed Amendment to 20 CSR 2233-1.040 - Fees**

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated savings for the life of the rule by affected entities:
5	Change of Supervision Fee (Fee Cost Savings @ \$25)	\$125
	Estimated Annual Savings for the Life of the Rule	\$125

III. WORKSHEET

See Table Above.

IV. ASSUMPTION

1. The board anticipates 5 supervisees will request the fee waiver to change supervisors.
2. It is anticipated that the total fiscal savings will occur beginning in FY2020, may vary with inflation, and is expected to increase at the rate projected by the Legislative Oversight Committee.

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

PROPOSED AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (3), (5), and (13).

PURPOSE: This amendment revises plan change criteria for Medicare Advantage Plan members, default enrollment procedures, clarifies disabled dependent eligibility, reporting of other health coverage, and renumbers as necessary.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov or through another designated enrollment system within thirty-one (31) days of his/her hire date or the date the employer notifies the employee that s/he is an eligible variable-hour employee. If enrolling a spouse or child(ren), proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period that runs October 1 through October 31 of each year.

3. An active employee may elect or change coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. An employee or his/her spouse/child(ren) may enroll within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a child, the active employee may enroll the child in an MCHCP plan within sixty (60) days of the court order.

4. Default enrollment.

A. If an active employee is enrolled in the PPO [300 or] 750, PPO [600] 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the same plan enrolled in the prior year at the same level of coverage [in the PPO 1250 Plan provided through the vendor the employee is enrolled in, effective the first day of the next calendar year].

[B. If an active employee is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the HSA Plan at the same level of coverage.]

[C./B. If an active employee is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

[D./C. Married state employees who are both MCHCP members who do not complete enrollment during the open enrollment period, will continue to meet one (1) family deductible and out-of-pocket maximum if they chose to do so during the previous plan year.

[E./D. If an active employee is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents or spouse/child(ren) at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date even if the retiree is continuing coverage as a variable-hour employee after retirement. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment, but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical,

dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A retiree enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as “vendor coverage”; and

C. Not a Qualified Medicare Beneficiary.

[5.]6. Default enrollment.

A. A retiree with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the retiree or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the retiree *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period,]* is not able to be enrolled in the Medicare Advantage Plan, the retiree and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]* same plan enrolled in the prior year at the same level of coverage.

B. If a retiree with Medicare *[is] has a non-Medicare dependent* enrolled in the PPO *[300] 750, [or] PPO [600] 1250, or HSA Plan* and does not complete enrollment during the open enrollment period, *[and has dependents who are not covered by Medicare,]* his/her dependents without Medicare will be enrolled in *[the PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* the same plan enrolled in the prior year with the same level of coverage.

C. If a retiree without Medicare is enrolled in the PPO *[300] 750, [or] PPO [600] 1250, or HSA Plan* and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* same plan enrolled in the prior year with the same level of coverage.

[D. If a retiree without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the retiree is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

[E.]D. If a retiree without Medicare is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage, effective the first day of the next calendar year.

[6.]7. If a retiree is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[7.]8. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage,

birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee’s responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A terminated vested member enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as “vendor coverage”; and

C. Not a Qualified Medicare Beneficiary.

[3.]4. Default enrollment.

A. A terminated vested subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the terminated vested subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the terminated vested subscriber *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period]* is not able to be enrolled in the Medicare Advantage Plan, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year]* same plan enrolled in the prior year with the same level of coverage.

B. If a terminated vested subscriber without Medicare is enrolled in the PPO *[300] 750, [or] PPO [600] 1250, or HSA Plan* and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year]* same plan enrolled in the prior year with the same level of coverage.

[C. If a terminated vested subscriber without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the terminated vested subscriber is enrolled in effective the first day of the next calendar year, at the same level of coverage.]

[D.]C. If a terminated vested subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

[E.]D. If a terminated vested subscriber is enrolled in dental

and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[4.]5. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A long-term disability member enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

[3.]4. Default enrollment.

A. A long-term disability subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the long-term disability subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the long-term disability subscriber *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period]* is not able to be enrolled in the Medicare Advantage Plan, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* same plan enrolled in the prior year with the same level of coverage.

B. If a long-term disability subscriber without Medicare is enrolled in the PPO *[300] 750, [or] PPO [600] 1250, or HSA Plan* and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided*

through the vendor the long-term disability subscriber is enrolled in, effective the first day of the next calendar year] same plan enrolled in the prior year with the same level of coverage.

C. If a long-term disability subscriber with Medicare *[is] has a non-Medicare dependent* enrolled in the PPO *[300] 750, [or] PPO [600] 1250, or HSA Plan* and does not complete enrollment during the open enrollment period *[and has dependents who are not covered by Medicare]*, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* same plan enrolled in the prior year with the same level of coverage.

[D. If a long-term disability subscriber without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the long-term disability subscriber is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

[E.]D. If a long-term disability subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

[F.]E. If a long-term disability subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[4.]5. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor **without Medicare** must submit a survivor enrollment form *[and a copy of the death certificate]* within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor with Medicare will be automatically enrolled as a survivor following the death of the employee.

[2.]3. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days due to an

involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

- (I) Employer-sponsored medical, dental, or vision plan terminates;
- (II) Eligibility for employer-sponsored coverage ends;
- (III) Employer contributions toward the premiums end; or
- (IV) COBRA coverage ends.

[3./4. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A survivor enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

- A. A resident in a long-term nursing facility;**
- B. Eligible for Medicaid nursing home coverage, also known as “vendor coverage”; and**
- C. Not a Qualified Medicare Beneficiary.**

[4./6. Default enrollment.

A. A survivor with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the survivor or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the survivor *[does not have Medicare Part B, and does not complete enrollment during the open enrollment period]* is not able to be enrolled in the Medicare Advantage Plan, the survivor and his/her dependents without Medicare will be enrolled in the *[PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* same plan enrolled in the prior year with the same level of coverage.

B. If a survivor without Medicare is enrolled in the PPO *[300] 750, [or] PPO [600] 1250, or HSA Plan* and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the survivor is enrolled in, effective the first day of the next calendar year]* same plan enrolled in the prior year with the same level of coverage.

C. If a survivor with Medicare has a non-Medicare dependent *[is]* enrolled in the PPO *[300] 750, [or] PPO [600] 1250, or HSA Plan* and does not complete enrollment during the open enrollment period *[and has dependents who are not covered by Medicare]*, the survivor and his/her dependents without Medicare will be enrolled in the *[PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]* same plan enrolled in the prior year with the same level of coverage.

[D. If a survivor without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the survivor is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

[E./D. If a survivor without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

[F./E. If a survivor is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[5./7. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(G) Disabled Dependent.

1. An *[new]* employee may enroll his/her permanently disabled child **when first eligible** or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of *[a new employee and his/her]* the permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or will never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(13) Members are required to disclose to the claims administrator whether or not they have other health coverage and, if so, information about the coverage. *[A member may submit this information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied if the disclosure is not made.]* Once the information is received, claims will be reprocessed subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

in the aggregate.

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED RESCISSION

22 CSR 10-2.045 Plan Utilization Review Policy. This rule established the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded reflect changes due to a new third party administrator.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Rescinded: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED RULE

22 CSR 10-2.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan Medical Plans.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Preauthorization is to determine if the pro-

cedure or treatment is medically necessary. The claims administrator will determine what procedures or treatments are subject to preauthorization. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, or who are enrolled in the Medicare Advantage Plan are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. A list of medical services for which preauthorization is required may be obtained at any time from the claims administrator.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within thirty-six (36) hours, which will include one (1) business day of the receipt of the request. If the information necessary to make a benefit determination is not received, the claims administrator will notify the member and provider of any necessary extension. The provider will be given forty-five (45) calendar days from receipt of the extension notice to respond with additional information. Once the information is received or the forty-five (45) days have elapsed, a determination will be made within thirty-six (36) hours which will include one (1) business day.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than one (1) business day of the receipt of all necessary information;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision;

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a member. The retrospective review is not limited to an evaluation of medical necessity, reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review;

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment; and

(E) Case Management—A voluntary process to assess, coordinate, and evaluate options and services of members with catastrophic and complex illnesses. A case manager will help members understand what to expect during the course of treatment, help establish collaborative goals, complete assessments to determine needs, interface

with providers, and negotiate care. Members are identified for case management through claim information, length of hospital stay, or by referral. The case manager will dismiss the member from case management once the case manager determines that objectives have been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Rescinded and readopted: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 750 Plan.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *and*

(D) Four (4) Diabetes Self-Management Education visits [.] ; **and**
(E) Sterilization procedure for men.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and following the claim administrator's standard practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service, **unless otherwise specified in the network provider contract.** The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from

adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit] determined by the claims administrator.* If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 1250 Plan.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *and*

(D) Four (4) Diabetes Self-Management Education visits [.] ; **and**
(E) Sterilization procedure for men.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and following the claim administrator's standard practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months

following the date of service, **unless otherwise specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 30, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED AMENDMENT

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (3), (14), (15), (17), adding section (9), and renumbering as necessary.

PURPOSE: This amendment revises the Health Savings Account (HSA) Plan individual family member out-of-pocket maximum, adds one hundred percent (100%) coverage after deductible is met for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, services performed in another country, and renumbers as necessary.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—four thousand nine hundred fifty dollars (\$4,950);

2. Network out-of-pocket maximum for family—nine thousand nine hundred dollars (\$9,900). Any individual family member need

only incur a maximum of *[seven thousand nine hundred dollars (\$7,900)]* **eight thousand one hundred fifty dollars (\$8,150)** before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—nine thousand nine hundred dollars (\$9,900); and

4. Non-network out-of-pocket maximum for family—nineteen thousand eight hundred dollars (\$19,800).

(9) Sterilization procedure for men is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

[(9)](10) Newborn's claims will be subject to deductible and coinsurance.

[(10)](11) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

[(11)](12) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

[(12)](13) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

[(13)](14) Maximum plan payment—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement for **non-network professional claims and following the claims administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

[(14)](15) Any claim must be initially submitted within twelve (12) months following the date of service, **unless otherwise specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

[(15)](16) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

~~[[16]]~~(17) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

~~[[17]]~~(18) An active employee subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section ~~[[19]]~~ (20) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare (unless Medicare is secondary coverage to MCHCP);

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-purpose health FSA, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

~~[[18]]~~(19) If an active employee subscriber and/or his/her dependent(s) is enrolled in the HSA Plan and becomes ineligible for the HSA Plan during the plan year, the subscriber and/or his/her dependent(s) will be enrolled in the PPO 1250 Plan. The subscriber may enroll in a different non-HSA Plan within thirty-one (31) days of notice from MCHCP.

~~[[19]]~~(20) A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

~~[[20]]~~(21) Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the subscriber must be an active employee and HSA eligible as defined in the Internal Revenue Service Publication 969 on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Subscribers who enroll in the HSA Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends March 15.

(B) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP contribution will receive an applicable prorated contribution. Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.

(C) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP contribution will receive an applicable prorated contribution based on the increased level of coverage.

(D) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution, MCHCP will not request a re-payment of the contribution.

(E) If both spouses are state employees covered by MCHCP and they both enroll in an HSA Plan, they must each have a separate

HSA. The maximum contribution MCHCP will make for the family is six hundred dollars (\$600) regardless of the number of HSAs or the number of children covered under the HSA Plan for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a maximum three hundred dollar (\$300) contribution to each spouse to total a maximum of six hundred dollars (\$600).

(F) The MCHCP contributions will be deposited into the subscriber's HSA as follows:

1. The January deposit will be made on the third Monday of the month, or the first working day after the third Monday if the third Monday is a holiday;

2. The April deposit will be made on the first Monday in April; and

3. Other deposits will be made on the first Monday of the month in which coverage is effective, or the first working day after the first Monday of the month coverage is effective if the first Monday is a state holiday.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This amendment revises the medical plan benefits for transition of care, allergy testing and immunotherapy, bariatric surgery, bone growth stimulators, cardiac rehabilitation, chelation therapy, chiropractic services, cochlear implant, dental care, emergency room services, genetic counseling, hearing aids, hospice care and palliative services, hospital, injections, maternity coverage, nutrition therapy, orthognathic or jaw surgery, orthotics, and renumbers as necessary.

[[2] Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits

with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. Benefits eligible for transition of care include:

- (A) Upcoming surgery or prospective transplant;
- (B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;
- (C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;
- (D) Home nursing care;
- (E) Radiation therapy;
- (F) Dialysis;
- (G) Durable medical equipment;
- (H) Cancer treatment;
- (I) Clinical trials;
- (J) Physical, speech, or occupational therapy;
- (K) Hospice care;
- (L) Bariatric surgery, and follow-up per criteria covered under the plan;
- (M) Inpatient hospitalization at the time of the network change;
- (N) Mental health services; or
- (O) Related follow-up services within three (3) months of an acute injury or surgery.]

(2) **Transition of Care.** A transition of care option is available for members who seek to continue to remain under the care of a non-network provider who was treating them prior to the provider losing network status. A subscriber and his/her dependents may request to continue receiving care at the network benefit level. If approved, the member will be eligible to continue care with the current non-network provider at the network benefit level for a period of time until it is medically appropriate for the member to transfer care to a network provider. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. The following benefits are eligible for transition of care as determined by the claims administrator:

- (A) Upcoming surgery or prospective transplant;
 - (B) Services for women in their third trimester of pregnancy;
 - (C) Radiation therapy;
 - (D) Dialysis;
 - (E) Cancer treatment;
 - (F) Physical, speech, or occupational therapy;
 - (G) Hospice care;
 - (H) Inpatient hospitalization at the time of the network change;
- or
- (I) Mental health services.

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250, and HSA Plan.

[(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.]

[(E)](D) Plan benefits for the PPO 750 Plan, PPO 1250, and HSA

Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms[. The following tests and treatments are covered:]

[A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular

agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular

agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or
- (II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

- (I) Food or other substances; or
- (II) Drugs when all of the following are met:
 - (a) History of allergy to a particular drug;
 - (b) There is no effective alternative drug; and
 - (c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

- (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
- (II) Food allergy;
- (III) Hymenoptera venom allergy (stinging insects);
- (IV) Inhalant allergy; or
- (V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

- (I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;]

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery[. Bariatric surgery is covered when all of the following requirements have been met:];

[A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;]

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

6. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:];

[A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;]

7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:];

[A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;]

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:];

[A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;]

10. Chiropractic services. Chiropractic—manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:];

[A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed homecare program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);]

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial.

Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant [device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:] **and auditory brainstem implant;**

[A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate

auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;]

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. Treatment must be initiated within sixty (60) days of accident; and

(II) Restorative services limited to dental implants when needed as a result of [cancerous or non-cancerous] tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical

center;

14. Diabetes Self-Management Education;

15. Dialysis is covered when received through a network provider;

16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit/ *Hospital and ancillary charges are paid as a network benefit*];

18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing[.];

[A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azoospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an

X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;]

21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

23. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

24. Hearing aids (per ear). Hearing aids covered **once every two (2) years** for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

[A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years.] If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

[[I)]A. Conventional: one thousand dollars (\$1,000).

[[III)]B. Programmable: two thousand dollars (\$2,000).

[(III)]C. Digital: two thousand five hundred dollars (\$2,500).

[(IV)]D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill *[and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.]*

[A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling

provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;]

28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services *[are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:]; and*

[(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and]

(V) Outpatient mental health services [are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:]

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;]

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

30. Injections. See preventive services for coverage of vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit[.];

[A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;]

31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

32. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to [the] applicable copayments, deductible, and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

33. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

34. Nutrition therapy[.];

[A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;]

35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

- A. Acute traumatic injury, and post-surgical sequela;
- B. [Cancerous or non-cancerous t/Tumors and cysts, cancer, and post-surgical sequela;
- C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or
- D. Physical [or physiological] abnormality [when one (1) of the following criteria is met:];

(I) Anteroposterior Discrepancies—

- (a) *Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);*
- (b) *Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or*

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

38. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is

an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered [for members who meet the following criteria:].

(I) Member with skeletally mature feet who has any of the following conditions:

- (a) Acute plantar fasciitis;
- (b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;
- (c) Calcaneal bursitis (acute or chronic);
- (d) Calcaneal spurs (heel spurs);
- (e) Conditions related to diabetes;
- (f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);
- (g) Medial osteoarthritis of the knee;
- (h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);
- (i) Neurologically impaired feet including neuro-ma, tarsal tunnel syndrome, ganglionic cyst;
- (j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or
- (k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

- (a) Hallux valgus deformities;
- (b) In-toe or out-toe gait;
- (c) Musculoskeletal weakness such as pronation or pes planus;
- (d) Structural deformities such as tarsal coalitions; or
- (e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.]

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the hip;
- (II) To facilitate healing following an injury to the hip or related soft tissues;
- (III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or
- (IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the knee;
- (II) To facilitate healing following an injury to the knee or related soft tissues;
- (III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or
- (IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

- (a) Previous amputation of the other foot or part of either foot;
- (b) History of previous foot ulceration of either foot;
- (c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

- (e) Foot deformity of either foot; or
- (f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

- (I) To reduce pain by restricting mobility of the trunk;
- (II) To facilitate healing following an injury to the spine or related soft tissues;
- (III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or
- (IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

- (I) To reduce pain by restricting mobility of the joint(s);
- (II) To facilitate healing following an injury to the joint(s) or related soft tissues; or
- (III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

39. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

- (I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);
- (II) Pap smears—no age limit;
- (III) Prostate—no age limit; and
- (IV) Colorectal screening—no age limit.

G. Online weight management program offered through the plan's exclusive provider arrangement;

40. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal

wear and tear, if there is a change in medical condition, or if growth-related;

41. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_{2max}) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2)

weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

47. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

**Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.061 Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment revises the following benefits not payable by the plan: alternative therapies, assistant surgeon services, birthing center, home births, nocturnal enuresis alarm, therapy, vaccinations requested by a third party, and renumbers as necessary.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055 or 22 CSR 10-2.090.

(C) Alternative therapies—that are outside conventional medicine [including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback] as determined by the claims administrator.

[(E)] Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.]

[(F)](E) Athletic enhancement services and sports performance training.

[(G)](F) Autopsy.

[(H)] Birthing center.]

[(I)](G) Blood donor expenses.

[(J)](H) Blood pressure cuffs/monitors.

[(K)](I) Care received without charge.

[(L)](J) Charges exceeding the vendor contracted rate or benefit limit.

[(M)](K) Charges resulting from the failure to appropriately cancel a scheduled appointment.

[(N)](L) Childbirth classes.

[(O)](M) Comfort and convenience items.

[(P)](N) Cosmetic procedures.

[(Q)](O) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

[(R)](P) Dental care, including oral surgery.

[(S)](Q) Devices or supplies bundled as part of a service are not separately covered.

[(T)](R) Dialysis received through a non-network provider.

[(U)](S) Educational or psychological testing unless part of a treatment program for covered services.

[(V)](T) Examinations requested by a third party.

[(W)](U) Exercise equipment.

[(X)](V) Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

[(Y)](W) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

[(Z)](X) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

[(AA)](Y) Health and athletic club membership—including costs of enrollment.

[(BB)](Z) Hearing aid replacement batteries.

[(CC)] Home births.

[(DD)](AA) Infertility treatment beyond the covered services to diagnose the condition.

[(EE)](BB) Infusions received through a non-network provider.

[(FF)](CC) Level of care, greater than is needed for the treatment of the illness or injury.

[(GG)](DD) Long-term care.

[(HH)](EE) Maxillofacial surgery.

[(II)](FF) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

[(JJ)](GG) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

[(KK)](HH) Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

[(LL)](II) Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

[(MM)] Nocturnal enuresis alarm.]

[(NN)](JJ) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

[(OO)](KK) Non-medically necessary services.

[(PP)](LL) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

[(QQ)](MM) Non-reusable disposable supplies.

[(RR)](NN) Online weight management programs.

[(SS)](OO) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

[(TT)](PP) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

[(UU)](QQ) Physical and recreational fitness.

[(VV)](RR) Private-duty nursing.

[(WW)](SS) Routine foot care without the presence of systemic disease that affects lower extremities.

[(XX)](TT) Services obtained at a government facility if care is provided without charge.

[(YY)](UU) Sex therapy.

[(ZZ)](VV) Surrogacy—pregnancy coverage is limited to plan member.

[(AAA)](WW) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

[(BBB)] Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program

through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.]

[(CCC)](XX) Travel expenses.

[(DDD)] Vaccinations requested by third party.]

[(EEE)](YY) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment revises the order of benefit determination rules and renumbers as necessary.

(3) Order of Benefit Determination Rules.

(B) Rules. MCHCP determines its order of benefits [using the first of the following rules which applies] as follows:

[1. Active/inactive employee. The benefits of the plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of the plan which covers that person as a laid off or retired employee (or as that employee's dependent);

2. Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent;]

1. Non-Dependent/Dependent:

A. The plan which covers the member as an employee or subscriber is primary; and

B. The plan which covers the member as dependent is secondary;

2. Active/layoff. The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a laid off employee;

3. Retiree. The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a retiree;

[3.]4. Medicare.

A. If a member is an active employee and has Medicare, MCHCP is the primary plan for the active employee and his/her dependents. Medicare is the secondary plan except for members with end stage renal disease (ESRD) as defined in subparagraph (3)(B)/3./4.D.

B. If a member is a retiree and has Medicare, Medicare is the primary plan for the retiree and his/her Medicare-eligible dependents. MCHCP is the secondary plan.

C. If a terminated vested employee with Medicare maintains coverage through one (1) of the MCHCP plans, Medicare is the primary plan and MCHCP is secondary.

D. If a member or his/her dependents are eligible for Medicare solely because of ESRD, the member's MCHCP plan is primary to Medicare during the first thirty (30) months of Medicare eligibility for home peritoneal dialysis or home hemodialysis and thirty-three (33) months for in-center dialysis. After the thirty (30) or thirty-three (33) months, Medicare becomes primary, and claims

are submitted first to Medicare, then to MCHCP for secondary coverage. The member is responsible for notifying MCHCP of his/her Medicare status.

E. If a member is on long-term disability through the Missouri State Employees' Retirement System or the Public School Retirement System and is eligible for Medicare, Medicare is the primary plan and MCHCP plan is secondary;

[4.]5. Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different *[persons, called]* parents—

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;

[5.]6. Dependent child/separated, divorced, or never married. If two (2) or more plans cover a person as a dependent child of divorced, separated, or never married parents, benefits for the child are determined in this order—

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody of the child;

C. Then, the plan of the parent not having custody of the child; and

D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

[6.]7. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)**[4.]5.**;

[7.]8. Dependent child/parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits with itself;

[8.]9. *[The plan that covers the member as a spouse is primary over the plan that covers the member as a dependent child]* **When an adult dependent is covered by both spouse and parent, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term;** and

[9.]10. Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

AUTHORITY: sections 103.059, [RSMo 2000], and [section] 103.089, RSMo [Supp. 2013] 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (5).

PURPOSE: This amendment revises the claim submission and initial benefit determinations time frames and updates the name and appeal contact information for the third party administrator.

(1) Claims Submissions and Initial Benefit Determinations PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than *[fifteen (15) days] twenty (20) business days* from the date the vendor receives the claim. The vendor may extend the time period up to an additional *[fifteen (15)] thirty (30)* days if, for reasons beyond the vendor's control, the decision cannot be made within the first *[fifteen (15)] twenty (20)* days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)] twenty-(20)-* day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)] thirty (30)* days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor *[as soon as possible thereafter] within three (3) business days.*

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than *[thirty (30) days] twenty (20) business days* after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional *[fifteen (15)] thirty (30)* days. The vendor must notify the member

prior to the expiration of the first *[fifteen- (15-) day] twenty- (20-) day* period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15) days/ thirty (30) days]* after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously-approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously-approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(3) Appeal Process for Medical and Pharmacy Determinations for PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by *[UMR, Aetna] Anthem*, and Express Scripts, Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review deci-

sion means a determination rendered under the external review process at the conclusion of an external review; and

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; or

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be *[responded to in writing to the member] decided* within *[thirty (30)] twenty (20) business days [for post-service claims and fifteen (15) days for pre-service claims]* from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional *[fifteen (15)] thirty (30)* days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)] twenty- (20-) day* period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the

information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)] thirty (30)* days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. **Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.**

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) *[working]* business days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals *[shall]* **will be [responded to in writing to the member] decided** within *[thirty (30)] twenty (20)* days *[for post-service claims and within fifteen (15) days for pre-service claims]* from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional *[fifteen (15)] thirty (30)* days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)] twenty- (20-)* day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)] thirty (30)* days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. **Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.**

(V) For members with medical coverage through *[UMR]* Anthem—

(a) First and second level pre-service, **first and second level post-service**, and concurrent claim appeals must be submitted in writing to—

*[UMR Appeals
PO Box 400046
San Antonio, TX 78229
or by fax to (888) 615-6584]*
**Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 105568
Atlanta, Georgia 30348-5568
or by fax to (800) 859-3046**

[(b) First and second level post-service appeals must be sent in writing to—

*UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248]*

[(c)](b) Expedited [pre-service] appeals [must] may be [communicated] submitted by calling *[(800) 808-4424, ext. 15227] (877) 333-7488* or by submitting a written fax to *[(888) 615-6584, Attention: Appeals Unit] (800) 368-3238.*

[(VI) For members with medical coverage through Aetna—

(a) First and second level appeals must be submitted in writing to—

*Aetna
Appeals Resolution Team
PO Box 14463
Lexington, KY 40512
or by fax to (859) 425-3379*

(b) Expedited appeals must be communicated by calling (800) 245-0618 or by submitting a written fax to (859) 425-3379, Attention: Appeals Resolution Team.]

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

*Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070*

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

*Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121*

(IV) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
<http://www.externalappeal.com/>

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. Decisions concerning eligibility for Medicare primary members may not be able to be granted pursuant to these guidelines if the decision is contrary to the rules controlling eligibility for Medicare Advantage plan as put forth by Centers for Medicare and Medicaid. Valid proof of eligibility must be included with the appeal if the enrollment request includes addition of dependent(s). Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(J) MCHCP may approve an appeal regarding plan changes retroactively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier, except that no changes will be considered for HSA Plan elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan; **and**

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated; *and*].

[(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.]

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired

Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment updates the Medicare Part D coverage stage amounts and copayment amounts.

(1) The pharmacy benefit for Medicare primary non-active members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non-Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicaid Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach *[three thousand eight hundred twenty dollars (\$3,820)]* **four thousand twenty dollars (\$4,020)**, the member will pay the following copayments:

A. Preferred Formulary Generic Drugs: thirty-one- (31-) day supply has a ten dollar (\$10) copayment; sixty- (60-) day supply has a twenty dollar (\$20) copayment; ninety- (90-) day supply at retail has a thirty dollar (\$30) copayment; and a ninety- (90-) day supply through home delivery has a twenty-five dollar (\$25) copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a forty dollar (\$40) copayment; sixty- (60-) day supply has an eighty (\$80) dollar copayment; ninety- (90-) day supply at retail has a one hundred twenty (\$120) dollar copayment; and a ninety- (90-) day supply through home delivery has a one hundred (\$100) dollar copayment; and

C. Non-preferred Formulary Drugs and approved excluded drugs: thirty-one- (31-) day supply has a one hundred dollar (\$100) copayment; sixty- (60-) day supply has a two hundred dollar (\$200) copayment; ninety- (90-) day supply at retail has a three hundred dollar (\$300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar (\$250) copayment;

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[three thousand eight hundred twenty dollars (\$3,820)] four thousand twenty dollars (\$4,020)* and remain below *[five thousand one hundred dollars (\$5,100)] six thousand three hundred fifty dollars (\$6,350)*, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[five thousand one hundred dollars (\$5,100)] six thousand three hundred fifty dollars (\$6,350)*;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[five thousand one hundred dollars (\$5,100)] six thousand three hundred fifty dollars (\$6,350)*, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[three dollar and forty cent (\$3.40)] three dollar and sixty cent (\$3.60)* copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or an *[eight dollar and fifty cent (\$8.50)] eight dollar and ninety-five cent (\$8.95)* copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage; and

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment adds coinsurance dollar limits for the Health Savings Account (HSA) Plan, revises services covered at one hundred percent (100%), makes a technical correction to (1)(B)2.B., and renumbers as necessary.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO 750 Plan and PPO 1250 Plan.

1. Network:

A. Preferred formulary generic drug copayment: Ten Dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and thirty dollars (\$30) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Preferred formulary brand drug copayment: Forty dollars (\$40) for up to a thirty-one- (31-) day supply; eighty dollars (\$80) for up to a sixty- (60-) day supply; and one hundred twenty dollars (\$120) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Specialty drug copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

E. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: Ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: Forty dollars (\$40) for up to a thirty-one- (31-) day supply; eighty dollars (\$80) for up to a sixty- (60-) day supply; and one hundred dollars (\$100) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary;

(d) Specialty drug copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply; one hundred fifty (\$150) for up to sixty (60-) day supply; and two hundred twenty-five (\$225) for up to ninety- (90-) day supply for a specialty drug on the formulary;

G. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

H. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

I. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

K. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum;

L. Preferred select brand drugs, as determined by the PBM: Ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply; and

M. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Vaccine recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[(III)] *Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;*

[(III)](II) Prescribed preferred diabetic test strips and lancets; and

[(IV)](III) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Network individual—four thousand one hundred fifty dollars (\$4,150).

D. Network family—eight thousand three hundred dollars (\$8,300).

E. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053.

1. Network:

A. Preferred formulary generic drug: Ten percent (10%) coinsurance **up to fifty dollars (\$50) per thirty-one- (31-) day supply** after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance **up to one hundred dollars (\$100) per thirty-one- (31-) day supply** after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met, **not to exceed:**

(I) Twenty-five dollars (\$25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars (\$50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars (\$100) per thirty-one- (31-) day supply for non-preferred formulary drug;

E. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. *[The following are also covered at one hundred percent (100%) when filled at a network pharmacy:]*

[(I)](G). Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention **are covered at one hundred percent (100%) when filled at a network pharmacy;** *[and]*

[(III)] *Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;*

/G./H. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

- (I) Prescribed preferred diabetic test strips and lancets; and
- (II) One (1) preferred glucometer; **and**

/H./I. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (3), (5), and (14).

PURPOSE: This amendment revises default enrollment procedures, clarifies disabled dependent eligibility, reporting of other health coverage, and renumbers as necessary.

(3) Enrollment Procedures.

(C) An eligible foster parent may elect or change coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

1. Occurrence of a life event, which includes marriage, birth,

adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the eligible foster parent's responsibility to notify MCHCP of the life event;

A. If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

2. Employer-sponsored group coverage loss. An eligible foster parent or his/her spouse/child(ren) may enroll within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances:

A. Employer-sponsored medical, dental, or vision plan terminates;

B. Eligibility for employer-sponsored coverage ends;

C. Employer contributions toward the premiums end; or

D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

3. If an eligible foster parent or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

4. If an eligible foster parent or eligible foster parent's spouse receives a court order stating s/he is responsible for covering a child, the eligible foster parent may enroll the child in an MCHCP plan within sixty (60) days of the court order; or

5. Default Enrollment

A. If an eligible foster parent is enrolled in the PPO [300 or] 750, PPO [600] 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled **in the same plan enrolled in the prior year** at the same level of coverage [in the PPO 1250 Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year]; or

/B. If an eligible foster parent is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the HSA Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year;

/C./B. If an eligible foster parent is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year; or

6. If an eligible foster parent submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the foster parent of such by mail, phone, or secure message. The foster parent must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date MCHCP notifies the foster parent, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals

whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(E) Disabled Dependent.

1. An *[newly]* eligible foster parent may enroll his/her permanently disabled child **when first eligible** or an enrolled permanently disabled dependent turning age twenty-six (26) years, may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of *[a new foster parent and his/her]* the permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled child's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(14) Members are required to disclose to the claims administrator whether they have other health coverage and, if so, information about the coverage. *[A member may submit other coverage information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied until the information is received.]* Once the information is received, claims will be reprocessed subject to all applicable rules.

AUTHORITY: sections 103.059 and 103.078, RSMo 2016. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (5) and (13).

PURPOSE: This amendment clarifies disabled dependent eligibility and reporting of other health coverage.

(5) Proof of Eligibility.

(F) Disabled dependent.

1. An *[new]* employee may enroll his/her permanently disabled child **when first eligible** or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of *[a new employee and his/her]* the permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(13) Members are required to disclose to the claims administrator whether or whether not they have other health coverage and, if so, information about the coverage. *[A member may submit this information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied if the disclosure is not made.]* Once the information is received, claims will be reprocessed subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED RESCISSION

22 CSR 10-3.045 Plan Utilization Review Policy. This rule established the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded to reflect changes due to a new third party administrator.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 30, 2019, effective Jan. 1, 2020, expired June 28, 2020. Rescinded: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED RULE

22 CSR 10-3.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Preauthorization is to determine if the procedure or treatment is medically necessary. The claims administrator will determine what procedures or treatments are subject to preauthorization. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, or who are enrolled in the Medicare Advantage Plan are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. A list of medical services for which preauthorization is required may be obtained at any time from the claims administrator.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and

ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within thirty-six (36) hours, which will include one (1) business day of the receipt of the request. If the information necessary to make a benefit determination is not received, the claims administrator will notify the member and provider of any necessary extension. The provider will be given forty-five (45) calendar days from receipt of the extension notice to respond with additional information. Once the information is received or the forty-five (45) days have elapsed, a determination will be made within thirty-six (36) hours which will include one (1) business day.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than one (1) business day of the receipt of all necessary information;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision;

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a member. The retrospective review is not limited to an evaluation of medical necessity, reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review;

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment; and

(E) Case Management—A voluntary process to assess, coordinate, and evaluate options and services of members with catastrophic and complex illnesses. A case manager will help members understand what to expect during the course of treatment, help establish collaborative goals, complete assessments to determine needs, interface with providers, and negotiate care. Members are identified for case management through claim information, length of hospital stay, or by referral. The case manager will dismiss the member from case management once the case manager determines that objectives have been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Rescinded and readopted: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED AMENDMENT

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (3), (13), (14), (18), and adding section (9).

PURPOSE: This amendment revises the Health Savings Account (HSA) Plan individual family member out-of-pocket maximum, adds one hundred percent (100%) coverage after deductible is met for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, services performed in another country, and renumbers as necessary.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—four thousand nine hundred fifty dollars (\$4,950);

2. Network out-of-pocket maximum for family—nine thousand nine hundred dollars (\$9,900). Any individual family member need only incur a maximum of *seven thousand nine hundred dollars (\$7,900)* **eight thousand one hundred fifty dollars (\$8,150)** before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—nine thousand nine hundred dollars (\$9,900); and

4. Non-network out-of-pocket maximum for family—nineteen thousand eight hundred dollars (\$19,800).

(9) Sterilization procedure for men is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

[(9)](10) Newborn's claims will be subject to deductible and coinsurance.

[(10)](11) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

[(11)](12) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

[(12)](13) Maximum plan payment—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claims administrator's standard practice for non-network facility claims.** Members may be held liable for the amount of the fee above the allowed amount.

[(13)](14) Any claim must be initially submitted within twelve (12) months following the date of service, **unless otherwise specified in the network provider contract.** The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any

claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

[(14)](15) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

[(15)](16) A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section *[(16)] (17)* of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare (unless Medicare is secondary coverage to MCHCP);

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-purpose health FSA, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

[(16)](17) A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

[(17)](18) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator.** If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

PROPOSED AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This amendment revises the medical plan benefits for transition of care, allergy testing and immunotherapy, bariatric surgery, bone growth stimulators, cardiac rehabilitation, chelation therapy, chiropractic services, cochlear implant, dental care, emergency room services, genetic counseling, hearing aids, hospice care and palliative services, hospital, injections, maternity coverage, nutrition therapy, orthognathic or jaw surgery, orthotics, and renumbers as necessary.

[(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the same fee paid prior to leaving the network. Benefits eligible for transition of care include:

- (A) Upcoming surgery or prospective transplant;*
- (B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;*
- (C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;*
- (D) Home nursing care;*
- (E) Radiation therapy;*
- (F) Dialysis;*
- (G) Durable medical equipment;*
- (H) Cancer treatment;*
- (I) Clinical trials;*
- (J) Physical, speech, or occupational therapy;*
- (K) Hospice care;*
- (L) Bariatric surgery, and follow-up per criteria covered under the plan;*
- (M) Inpatient hospitalization at the time of the network change;*
- (N) Mental health services; or*
- (O) Related follow-up services within three (3) months of an acute injury or surgery.]*

(2) Transition of Care. A transition of care option is available for members who seek to continue to remain under the care of a non-network provider who was treating them prior to the provider losing network status. A subscriber and his/her depen-

dents may request to continue receiving care at the network benefit level. If approved, the member will be eligible to continue care with the current non-network provider at the network benefit level for a period of time until it is medically appropriate for the member to transfer care to a network provider. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. The following benefits are eligible for transition of care as determined by the claims administrator:

- (A) Upcoming surgery or prospective transplant;**
- (B) Services for women in their third trimester of pregnancy;**
- (C) Radiation therapy;**
- (D) Dialysis;**
- (E) Cancer treatment;**
- (F) Physical, speech, or occupational therapy;**
- (G) Hospice care;**
- (H) Inpatient hospitalization at the time of the network change; or**
- (I) Mental health services.**

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250, and HSA Plan.

[(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.]

[(E)](D) Plan benefits for the PPO 750 Plan, PPO 1250, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms[. The following tests and treatments are covered:]

[A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;*
- (II) Hymenoptera venom (stinging insects);*
- (III) Inhalants; or*
- (IV) Specific drugs (penicillins and macromolecular agents);*

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;*
- (II) Hymenoptera venom (stinging insects);*
- (III) Inhalants; or*
- (IV) Specific drugs (penicillins and macromolecular agents);*

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or*
- (II) Inhalants;*
- D. Skin Patch Testing: for diagnosing contact allergic dermatitis;*

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

- (I) Food or other substances; or
- (II) Drugs when all of the following are met:
 - (a) History of allergy to a particular drug;
 - (b) There is no effective alternative drug; and
 - (c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

- (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
- (II) Food allergy;
- (III) Hymenoptera venom allergy (stinging insects);
- (IV) Inhalant allergy; or
- (V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

- (I) Sensitivity to beryllium;
- (II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;
- (III) Thymoma; and
- (IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

- (I) Allergic (extrinsic) asthma;
- (II) Dust mite atopic dermatitis;
- (III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;
- (IV) Mold-induced allergic rhinitis;
- (V) Perennial rhinitis;
- (VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

- (a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;
- (b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

- (a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;
- (b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or
- (c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;]

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery[. *Bariatric surgery is covered when all of the following requirements have been met:;*

[A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

- (I) Roux-en-Y gastric bypass;
- (II) Sleeve gastrectomy;
- (III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);
- (IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;
- (V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

- (a) BMI greater than forty (40); or
- (b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is

available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;]

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

6. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit[. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:]

[A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;]

7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

8. Cardiac rehabilitation[. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of

the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:]

[A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;]

9. Chelation therapy[. The administration of FDA-approved chelating agents is covered for any of the following conditions:]

[A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;]

10. Chiropractic services[. Chiropractic]—manipulation and adjunct therapeutic procedures/modalities [(e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:]

[A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed homecare program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);]

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant [device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:] and auditory brainstem implant;

[A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional

and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;]

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. Treatment must be initiated within sixty (60) days of accident; and

(II) Restorative services limited to dental implants when needed as a result of [cancerous or non-cancerous] tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. Diabetes Self-Management Education;

15. Dialysis is covered when received through a network provider;

16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;]

18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing[.];

[A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azoospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;]

21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

23. Hair prostheses. Prostheses and expenses for scalp hair

protheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

24. Hearing aids (per ear). Hearing aids [are] covered **once every two (2) years** for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

[A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years.] If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

[(I)]A. Conventional: one thousand dollars (\$1,000).

[(II)]B. Programmable: two thousand dollars (\$2,000).

[(III)]C. Digital: two thousand five hundred dollars (\$2,500).

[(IV)]D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services,

including pre-hospice evaluation or consultation, are covered when the individual is terminally ill [and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.];

[A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;]

28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services [are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:]; and

[(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and]

(V) Outpatient mental health services [are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:];

[a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;]

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

30. Injections. See preventive services for coverage of vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit[.];

[A. B12 injections are covered for the following conditions:

- (I) Pernicious anemia;
- (II) Crohn's disease;
- (III) Ulcerative colitis;

- (IV) Inflammatory bowel disease;
- (V) Intestinal malabsorption;
- (VI) Fish tapeworm anemia;
- (VII) Vitamin B12 deficiency;
- (VIII) Other vitamin B12 deficiency anemia;
- (IX) Macrocytic anemia;
- (X) Other specified megaloblastic anemias;
- (XI) Megaloblastic anemia;
- (XII) Malnutrition of alcoholism;
- (XIII) Thrombocytopenia, unspecified;
- (XIV) Dementia in conditions classified elsewhere;
- (XV) Polyneuropathy in diseases classified else-

where;

- (XVI) Alcoholic polyneuropathy;
- (XVII) Regional enteritis of small intestine;
- (XVIII) Postgastric surgery syndromes;
- (XIX) Other prophylactic chemo-therapy;
- (XX) Intestinal bypass or anastomosis status;
- (XXI) Acquired absence of stomach;
- (XXII) Pancreatic insufficiency; and
- (XXIII) Ideopathic progressive polyneuropathy;]

31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

32. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to [the] **applicable copayments**, deductible, and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

33. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

34. Nutrition therapy[.];

[A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutritional needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral

feedings;

(III) *Intradialytic Parenteral Nutrition (IDPN)*. IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;]

35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

- A. Acute traumatic injury, and post-surgical sequela;
- B. [Cancerous or non-cancerous t/Tumors and cysts, cancer, and post-surgical sequela;
- C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or
- D. Physical [or physiological] abnormality [when one (1) of the following criteria is met:];

(I) *Anteroposterior Discrepancies—*

- (a) *Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);*
- (b) *Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or*

(c) *These values represent two (2) or more standard deviation from published norms;*

(II) *Vertical Discrepancies—*

- (a) *Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;*
- (b) *Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;*

(c) *Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or*

(d) *Supraeruption of a dentoalveolar segment due to lack of occlusion;*

(III) *Transverse Discrepancies—*

(a) *Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or*

(b) *Total bilateral maxillary palatal cusp to mandibularfossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or*

(IV) *Asymmetries—*

(a) *Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;*

(V) *Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);*

(VI) *Speech impairment; or*

(VII) *Obstructive sleep apnea or airway dysfunction;]*

38. Orthotics.

- A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot

Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

- I. Member is covered for AFO; and
- II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

- I. The member could not be fitted with a prefabricated AFO;
- II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;
- III. Knee, ankle, or foot must be controlled in more than one (1) plane;
- IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or
- V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

- (II) Venous insufficiency;
- (III) Varicose veins;
- (IV) Edema of lower extremities;
- (V) Edema during pregnancy; or
- (VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

- (I) Orthopedic footwear;
- (II) Other footwear such as high top, depth inlay, or custom;
- (III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;
- (IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or
- (V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered [for members who meet the following criteria:].

(I) Member with skeletally mature feet who has any of the following conditions:

- (a) Acute plantar fasciitis;*
- (b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;*
- (c) Calcaneal bursitis (acute or chronic);*
- (d) Calcaneal spurs (heel spurs);*
- (e) Conditions related to diabetes;*
- (f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);*
- (g) Medial osteoarthritis of the knee;*
- (h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);*
- (i) Neurologically impaired feet including neuroroma, tarsal tunnel syndrome, ganglionic cyst;*
- (j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or*
- (k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;*

(II) Member with skeletally immature feet who has any of the following conditions:

- (a) Hallux valgus deformities;*
- (b) In-toe or out-toe gait;*
- (c) Musculoskeletal weakness such as pronation or pes planus;*
- (d) Structural deformities such as tarsal coalitions; or*
- (e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.]*

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the hip;
- (II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the knee;
- (II) To facilitate healing following an injury to the knee or related soft tissues;
- (III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or
- (IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

- (a) Previous amputation of the other foot or part of either foot;
- (b) History of previous foot ulceration of either foot;
- (c) History of pre-ulcerative calluses of either foot;
- (d) Peripheral neuropathy with evidence of callus formation of either foot;
- (e) Foot deformity of either foot; or
- (f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

- (a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;
- (b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or
- (c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

- (I) To reduce pain by restricting mobility of the trunk;
- (II) To facilitate healing following an injury to the spine or related soft tissues;
- (III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or
- (IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

- (I) To reduce pain by restricting mobility of the joint(s);
- (II) To facilitate healing following an injury to the joint(s) or related soft tissues; or
- (III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

39. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. Online weight management program offered through the plan's exclusive provider arrangement;

40. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

41. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ($VO_2\max$) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, con-

genital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

47. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original

rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

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

PROPOSED AMENDMENT

22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 750 Plan.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *[and]*

(D) Four (4) Diabetes Self-Management Education visits [.] ; and
(E) **Sterilization procedure for men.**

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service, **unless otherwise specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10- $\text{[}2.055\text{]3.057}$. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as *[a non-network benefit]* **determined by the claims administrator.**

If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

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

PROPOSED AMENDMENT

22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (5), (11), (12), and (14).

PURPOSE: This amendment adds one hundred percent (100%) coverage for sterilization procedure for men, revises maximum plan payment, timely filing timeframe, and services performed in another country for the PPO 1250 Plan.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; *[and]*

(D) Four (4) Diabetes Self-Management Education visits [.] ; and
(E) **Sterilization procedure for men.**

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement **for non-network professional claims and following the claim administrator's standard practice for non-network facility claims**. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service, **unless otherwise specified in the network provider contract**. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.055/3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as [a non-network benefit] **determined by the claims administrator**. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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

22 CSR 10-3.061 Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment revises the following benefits not payable by the plan: alternative therapies, assistant surgeon services, birthing center, home births, nocturnal enuresis alarm, therapy, vaccinations requested by a third party, and renumbers as necessary.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-3.057 or 22 CSR 10-3.090.

(C) Alternative therapies—that are outside conventional medicine [including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback] **as determined by the claims administrator**.

[(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.]

[(F)](E) Athletic enhancement services and sports performance training.

[(G)](F) Autopsy.

[(H) Birthing center.]

[(I)](G) Blood donor expenses.

[(J)](H) Blood pressure cuffs/monitors.

[(K)](I) Care received without charge.

[(L)](J) Charges exceeding the vendor contracted rate or benefit limit.

[(M)](K) Charges resulting from the failure to appropriately cancel a scheduled appointment.

[(N)](L) Childbirth classes.

[(O)](M) Comfort and convenience items.

[(P)](N) Cosmetic procedures.

[(Q)](O) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

[(R)](P) Dental care, including oral surgery.

[(S)](Q) Devices or supplies bundled as part of a service are not separately covered.

[(T)](R) Dialysis received through a non-network provider.

[(U)](S) Educational or psychological testing unless part of a treatment program for covered services.

[(V)](T) Examinations requested by a third party.

[(W)](U) Exercise equipment.

[(X)](V) Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

[(Y)](W) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

[(Z)](X) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

[(AA)](Y) Health and athletic club membership—including costs of enrollment.

[(BB)](Z) Hearing aid replacement batteries.

[(CC) Home births.]

[(DD)](AA) Infertility treatment beyond the covered services to diagnose the condition.

[(EE)](BB) Infusions received through a non-network provider.

[(FF)](CC) Level of care, greater than is needed for the treatment of the illness or injury.

[(GG)](DD) Long-term care.

[(HH)](EE) Maxillofacial surgery.

[(II)](FF) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

[(JJ)](GG) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

[(KK)](HH) Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

[(LL)](II) Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

[(MM) Nocturnal enuresis alarm.]

[(NN)](JJ) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

[(OO)](KK) Non-medically necessary services.

[(PP)](LL) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

[(QQ)](MM) Non-reusable disposable supplies.

[(RR)](NN) Online weight management programs.

[(SS)](OO) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the

plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

[(TT)](PP) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

[(UU)](QQ) Physical and recreational fitness.

[(VV)](RR) Private-duty nursing.

[(WW)](SS) Routine foot care without the presence of systemic disease that affects lower extremities.

[(XX)](TT) Services obtained at a government facility if care is provided without charge.

[(YY)](UU) Sex therapy.

[(ZZ)](VV) Surrogacy—pregnancy coverage is limited to plan member.

[(AAA)](WW) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

[(BBB)] Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.]

[(CCC)](XX) Travel expenses.

[(DDD)] Vaccinations requested by third party.]

[(EEE)](YY) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan

Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment revises the order of benefit determination rules and renumbers as necessary.

(3) Order of Benefit Determination Rules.

(B) Rules. MCHCP determines its order of benefits [using the first of the following rules which applies] as follows:

[1. Active/inactive employee. The benefits of the plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of the plan which covers that person as a laid off or retired employee (or as that employee's dependent);

2. Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent;]

1. Non-Dependent/Dependent.

A. The plan which covers the member as an employee or subscriber is primary.

B. The plan which covers the member as dependent is secondary;

2. **Active/layoff.** The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a laid off employee;

3. **Retiree.** The plan that covers the member or dependent through the member's active employment is primary to a plan that covers the member or dependent through the member's status as a retiree;

/3./4. Medicare.

A. If a member is an active employee and has Medicare, MCHCP is the primary plan for the active employee and his/her dependents. Medicare is the secondary plan except for members with end stage renal disease (ESRD) as defined in subparagraph (3)(B)/3./4.C.

B. If a member is a retiree and has Medicare, Medicare is the primary plan for the retiree and his/her Medicare-eligible dependents. MCHCP is the secondary plan.

C. If a member or his/her dependents are eligible for Medicare solely because of ESRD, the member's MCHCP plan is primary to Medicare during the first thirty (30) months of Medicare eligibility for home peritoneal dialysis or home hemodialysis and thirty-three (33) months for in-center dialysis. After the thirty (30) or thirty-three (33) months, Medicare becomes primary, and claims are submitted first to Medicare, then to MCHCP for secondary coverage. The member is responsible for notifying MCHCP of his/her Medicare status;

/4./5. Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different *[persons, called]* parents—

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;

/5./6. Dependent child/separated or divorced, or never married. If two (2) or more plans cover a person as a dependent child of divorced, separated, or never married parents, benefits for the child are determined in this order—

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody of the child;

C. Then, the plan of the parent not having custody of the child; and

D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

/6./7. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)/4./5.;

/7./8. Dependent child/parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits with itself;

/8./9. *[The plan that covers the member as a spouse is primary over the plan that covers the member as a dependent child]* When an adult dependent is covered by both spouse and parent, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term; and

/9./10. Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

AUTHORITY: sections 103.059[, RSMo 2000,] and [section] 103.089, RSMo [Supp. 2013] 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (5).

PURPOSE: This amendment revises the claim submission and initial benefit determinations time frames, updates the name and appeal contact information for the third party administrator.

(1) Claims Submissions and Initial Benefit Determinations.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than *[fifteen (15) days] twenty (20) business days* from the date the vendor receives the claim. The vendor may extend the time period up to an additional *[fifteen (15)] thirty (30)* days if, for reasons beyond the vendor's control, the decision cannot be made within the first *[fifteen (15)] twenty (20)* days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)] twenty- (20-)* day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the

vendor. The vendor then must decide the claim no later than *[fifteen (15)] thirty (30) days* after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor *[as soon as possible thereafter] within three (3) business days*.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than *[thirty (30) days] twenty (20) business days* after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional *[fifteen (15)] thirty (30) days*. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-) day] twenty (20-) day* period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15) days] thirty (30) days* after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously approved course of treatment in sufficient time to allow the member, or the member's provider, to appeal and obtain a determination before the benefit is reduced or terminated.

(3) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by *[UMR] Anthem* and Express Scripts, Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review; and

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect, except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; or

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review, except as specifically provided in 22 CSR 10-3.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(1) First level appeals must identify the decision being

appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be *[responded to in writing to the member]* **decided** within *[thirty (30)]* **twenty (20)** business days *[for post-service claims and fifteen (15) days for pre-service claims]* from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)]* **twenty- (20-)** day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)]* **thirty (30)** days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. **Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.**

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) *[working]* business days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals *[shall]* **will be [responded to in writing to the member] decided** within *[thirty (30)]* **twenty (20)** days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional *[fifteen (15)]* **thirty (30)** days. The vendor must notify the member prior to the expiration of the first *[fifteen- (15-)]* **twenty- (20-)** day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than *[fifteen (15)]* **thirty (30)** days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. **Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.**

(V) For members with medical coverage through *[UMR]* **Anthem—**

(a) First and second level pre-service, **first and second level post-service**, and concurrent claim appeals must be submitted in writing to—

*[UMR Appeals
PO Box 400046
San Antonio, TX 78229*

or by fax to (888) 615-6584]

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 105568
Atlanta, Georgia 30348-5568
or by fax to (800) 859-3046

[(b) First and second level post-service appeals must be sent in writing to—

*UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248]*

[(c)](b) Expedited [pre-service] appeals [must] may be [communicated] submitted by calling *[(800) 808-4424, ext. 15227]* **(877) 333-7488** or by submitting a written fax to *[(888) 615-6584, Attention: Appeals Unit]* **(800) 368-3238**.

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

*Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070*

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

*Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121*

(IV) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
<http://www.externalappeal.com/>

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:

(I) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the cafeteria plan; **and**

(J) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated; *and*.

[(K) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.]

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

PRIVATE COST: This proposed amendment will not cost private enti-

ties more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment adds coinsurance dollar limits for the Health Savings Account (HSA) Plan, revises services covered at one hundred percent (100%), and renumbers as necessary.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) PPO 750 Plan and PPO 1250 Plan Prescription Drug Coverage.

1. Network.

A. Preferred formulary generic drug copayment: Ten Dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and thirty dollars (\$30) for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Preferred formulary brand drug copayment: Forty dollars (\$40) for up to a thirty-one- (31-) day supply; eighty dollars (\$80) for up to a sixty- (60-) day supply; and one hundred twenty dollars (\$120) for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Specialty drug (as designated as such by the PBM) copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

E. Diabetic drug (as designated as such by the PBM) copayment: Fifty percent (50%) of the applicable network copayment.

F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescription(s) will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has

been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: Ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: Forty dollars (\$40) for up to a thirty-one- (31-) day supply; eighty dollars (\$80) for up to a sixty- (60-) day supply; and one hundred dollars (\$100) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d) Specialty drug (as designated as such by the PBM) copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

G. Diabetic drug (as designated as such by the PBM) copayment: Fifty percent (50%) of the applicable network copayment.

H. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

I. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

K. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum.

L. Preferred select brand drugs, as determined by the PBM: Ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply;

M. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Vaccine recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[(III) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;]

[(III)](II) Prescribed preferred diabetic test strips and lancets; and

[(IV)](III) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Network individual—four thousand one hundred fifty dollars (\$4,150).

D. Network family—eight thousand three hundred dollars (\$8,300).

E. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Preferred formulary generic drug: Ten percent (10%) coinsurance **up to fifty dollars (\$50) per thirty-one- (31-) day supply** after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance **up to one hundred dollars (\$100) per thirty-one- (31-) day supply** after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met./, **not to exceed:**

(I) Twenty-five dollars (\$25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars (\$50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars (\$100) per thirty-one- (31-) day supply for non-preferred formulary drug;

E. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. *[The following are also covered at one hundred percent (100%) when filled at a network pharmacy:]*

[(I)]G. Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are covered at one hundred percent (100%) when filled at a network pharmacy; and

[(II)] Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

[G./H. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer;

[H./I. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: Fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expires June 28, 2020. Amended: Filed Oct. 30, 2019.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.