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REGISTER

John R. Ashcroft Secretary of State

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Missouri Register

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September 16, 2024	**October 15, 2024**	October 31, 2024	November 30, 2024

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

HOW TO CITE RULES AND RSMO

RULES

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

Title	CSR	Division	Chapter	Rule
3	*Code of*	10-	4	115
Department	*State*	Agency	General area	Specific area
	Regulations	division	regulated	regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation; for example, 3 CSR 10-4.115, NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

Code and *Register* on the Internet

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

The *Code* address is sos.mo.gov/adrules/csr/csr

The *Register* address is sos.mo.gov/adrules/moreg/moreg

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

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

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

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10 – Health Care Plan

Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2) and (8).

PURPOSE: This amendment clarifies eligibility for retiree coverage for Public Higher Education Entities and retirees employed with a Public Entity and adds that retirees can cancel dental and vision coverage when voluntarily canceling medical coverage.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023, becomes effective January 1, 2024, and expires June 28, 2024.*

(2) Eligibility Requirements.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he receives a monthly retirement benefit from either MOSERS or from Public School Retirement System (PSRS) for state employment**, or if the employee is an employee of a Public Higher Education Entity (PHEE) and the PHEE offers coverage to retirees.** The employee may elect coverage for him/herself and his/her spouse/child(ren), provided the employee and his/her spouse/child(ren) have been continuously covered for health care benefits –

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of persons covered) is required.

2. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MOSERS and was employed by the Missouri Department of Conservation.

3. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.

4. If the retiree's spouse is a state active employee or retiree and enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

5. If a retiree who is eligible for coverage elects not to be continuously covered for him/herself and spouse/child(ren) with MCHCP from the date first eligible, or does not apply for coverage for him/herself and spouse/child(ren) within thirty-one (31) days of his/her eligibility date, the retiree and his/her spouse/child(ren) shall not thereafter be eligible for coverage unless specified elsewhere herein.

6. An individual enrolled in another non-MCHCP Medicare Advantage (Part C) and/or Medicare Prescription Drug Plan (Part D) is not eligible for medical coverage.

7. A retiree who is employed with a participating Public Entity may elect to return to state coverage as a retiree as long as coverage with MCHCP is continuous and retiree coverage was elected.

(8) Voluntary cancellation of coverage.

(D) A subscriber may only cancel dental and/or vision coverage during the year for him/herself or his/her dependents for one (1) of the following reasons:

1. Upon retirement;
2. When beginning a leave of absence;
3. No longer eligible for coverage;
4. When new coverage is taken through other employment; *[or]*
5. When the member enrolls in Medicaid*[.]; or*
6. When a retiree cancels medical coverage.

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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment adds one hundred percent (100%) coverage of diagnostic breast examinations and colorectal screenings at a network provider.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023, becomes effective January 1, 2024, and expires June 28, 2024.*

(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:

(E) Sterilization procedure for men; *[and]*

(F) Virtual visits offered through the vendor's telehealth tool*[.]*;

(G) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings; and

(H) Diagnostic colorectal screenings.

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. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment adds one hundred percent (100%) coverage of diagnostic breast examinations and colorectal screenings at a network provider.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023, becomes effective January 1, 2024, and expires June 28, 2024*

(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:

(E) Sterilization procedure for men; *[and]*

(F) Virtual visits offered through the vendor's telehealth tool*[.]*;

(G) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings; and

(H) Diagnostic colorectal screenings.

*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. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: filed Oct. 27, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (7), (10), (11), (12), and (24) and renumbering as necessary.

PURPOSE: This amendment makes a technical correction for nutritional counseling to nutrition counseling, revises coverage of virtual visits, adds one hundred percent (100%) coverage after deductible is met of diagnostic breast examinations and colorectal screenings at a network provider, and revises MCHCP Health Savings Account contribution amounts.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023, becomes effective January 1, 2024, and expires June 28, 2024.*

(7) Nutrition*[al]* counseling is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(10) Virtual visits offered through the vendor's telehealth tool are covered at one hundred percent (100%) *[after deductible is met]*.

(11) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings are covered at one

hundred percent (100%) after deductible is met.

(12) Diagnostic colorectal screenings are covered at one hundred percent (100%) after deductible is met.

*[(11)]***(13)** Newborn's claims will be subject to deductible and coinsurance.

*[(12)]***(14)** 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.

*[(13)]***(15)** Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

*[(14)]***(16)** 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.

*[(15)]***(17)** 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.

*[(16)]***(18)** 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.

*[(17)]***(19)** 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.

*[(18)]***(20)** 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 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.

*[(19)]***(21)** 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 (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.

*[(20)]***(22)** 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.

*[(21)]***(23)** 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.

*[(22)]***(24)** 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)]* **one thousand dollars ($1,000)** 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)]* **five hundred dollar ($500)** contribution to each spouse to total a maximum of *[six hundred dollars ($600)]* **one thousand dollars ($1,000)**.

(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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will cost state agencies or political subdivisions one million seven hundred thousand dollars ($1,700,000) in the time the emergency is effective.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

FISCAL NOTE
PUBLIC COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Health Care Plan
Chapter Title: State Membership

Rule Number and Name:	22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	$1,700,000

III. WORKSHEET

Estimated cost is based on current enrollment in the Health Savings Account Plan and reflects the increase in the annual amount MCHCP will contribute for individual coverage from $300 to $500 and for family coverage from $600 to $1,000. MCHCP's contributions are made annually in January, while the emergency rule is in effect. MCHCP's actuary conducted the cost estimate for this change.

IV. ASSUMPTIONS

2024 enrollment in the Health Savings Account Plan will be similar to 2023.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges The Missouri Consolidated Health Care Plan is amending section (3) and renumbering as necessary.

PURPOSE: This amendment adds coverage of cryopreservation cycles and infertility treatment, makes a technical correction for nutritional counseling to nutrition counseling, and revises preventive services.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023, becomes effective January 1, 2024, and expires June 28, 2024.*

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250, and HSA Plan.

(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;

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;

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;

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;

9. Chelation therapy;

10. Chiropractic services – manipulation and adjunct therapeutic procedures/modalities;

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;

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 and auditory brainstem implant;

13. Cryopreservation cycles.

A. Oocyte cryopreservation cycles including one year of storage from the initial date of cryopreservation when

a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes); and

B. Sperm cryopreservation including one year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes);

*[13.]***14.** 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 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.]***15.** Diabetes self-management education;

*[15.]***16.** Dialysis is covered when received through a network provider;

*[16.]***17.** 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 nonfunctional 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.]***18.** 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;

*[18.]***19.** 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.]***20.** 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;

(III) Peripheral neuropathy; or

(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.]***21.** 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;

*[21.]***22.** 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.]***23.** Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

*[23.]***24.** 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.]***25.** 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. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone anchoring hearing aid (BAHA): three thousand five hundred dollars ($3,500);

*[25.]***26.** Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

*[26.]***27.** 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.]***28.** 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;

*[28.]***29.** 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; and

(V) Outpatient mental health services;

30. Infertility coverage for members with a diagnosis of infertility, including in vitro fertilization (IVF) oocyte retrievals limited to two (2) cycles as a lifetime maximum, per member;

*[29.]***31.** 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.]***32.** 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;

*[31.]***33.** 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.]***34.** 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 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.]***35.** Nutrition*[al]* 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.]***36.** Nutrition therapy;

*[35.]***37.** 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.]***38**. 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.]***39.** 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. Tumors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical abnormality;

*[38.]***40.** 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 agoniometer 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.

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.]***41.** 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 preventive 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]* **Digital diabetes prevention** program offered through the plan's *[exclusive provider arrangement]* **claims administrator**.

H. The following services permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan:

(I) Blood pressure monitors for individuals diagnosed with hypertension;

(II) Retinopathy screenings for individuals diagnosed with diabetes;

(III) Hemoglobin A1c (HbA1c) testing for individuals diagnosed with diabetes;

(IV) Peak flow meters for individuals diagnosed with asthma; and

(V) International normalized ratio (INR) testing for individuals diagnosed with liver disease and/or bleeding disorders;

*[40.]***42.** 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.]***43.** 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.]***44.** Skilled nursing facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

*[43.]***45.** 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.]***46.** 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, postoperative vocal cord surgery);

*[45.]***47.** 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.]***48.** Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

*[47.]***49.** 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will cost state agencies or political subdivisions five hundred eighty-eight thousand dollars ($588,000) in the time the emergency is effective.

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

FISCAL NOTE
PUBLIC COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Health Care Plan
Chapter Title: State Membership

Rule Number and Name:	22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	$588,000

III. WORKSHEET

This estimate reflects anticipated administrative and claims costs during the time the emergency rule is in effect. MCHCP's actuary conducted the cost estimate for this change.

IV. ASSUMPTIONS

Member utilization is as projected.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.061 Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1) and renumbering as necessary.

PURPOSE: This amendment removes the limitation on infertility treatment.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023, becomes effective January 1, 2024, and expires June 28, 2024.*

(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.

[(AA) Infertility treatment beyond the covered services to diagnose the condition.]

*[(BB)]***(AA)** Infusions received through a non-network provider.

*[(CC)]***(BB)** Level of care, greater than is needed for the treatment of the illness or injury.

*[(DD)]***(CC)** Long-term care.

*[(EE)]***(DD)** Maxillofacial surgery.

*[(FF)]***(EE)** 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.

*[(GG)]***(FF)** 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.

*[(HH)]***(GG)** Military service-connected injury or illness – including expenses relating to Veterans Affairs or a military hospital.

*[(II)]***(HH)** Never events – never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

*[(JJ)]***(II)** 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.

*[(KK)]***(JJ)** Non-medically necessary services.

*[(LL)]***(KK)** Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

*[(MM)]***(LL)** Non-reusable disposable supplies.

*[(NN)]***(MM)** Online weight management programs.

*[(OO)]***(NN)** 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.

*[(PP)]***(OO)** 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.

*[(QQ)]***(PP)** Physical and recreational fitness.

*[(RR)]***(QQ)** Private-duty nursing.

*[(SS)]***(RR)** Routine foot care without the presence of systemic disease that affects lower extremities.

*[(TT)]***(SS)** Services obtained at a government facility if care is provided without charge.

*[(UU)]***(TT)** Sex therapy.

*[(VV)]***(UU)** Surrogacy – pregnancy coverage is limited to plan member.

*[(WW)]***(VV)** Telehealth site origination fees or costs for the provision of telehealth services are not covered.

*[(XX)]***(WW)** Travel expenses.

*[(YY)]***(XX)** 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, expired June 28, 2020. Amended: Filed Oct. 30, 2019, effective May 30, 2020. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same

*material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.070 Coordination of Benefits The Missouri Consolidated Health Care Plan is amending section (4).

PURPOSE: This amendment revises effect on the benefits of MCHCP when MCHCP is a secondary plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023, becomes effective January 1, 2024, and expires June 28, 2024.*

(4) Effect on the Benefits of MCHCP. This section applies, which in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans.

(A) In the event that MCHCP is a secondary plan as to one (1) or more other plans, the benefits of MCHCP's PPO plans and Health Savings Account Plan may be reduced under this section so as not to duplicate the benefits of the other plan. The other plan's payment is subtracted from what MCHCP or its claims administrator would have paid in absence of this COB provision using the following criteria. If there is any balance, MCHCP or its claims administrator will pay the difference not to exceed what it would have paid in absence of this COB provision.

1. In the case where Medicare is primary for physician and outpatient facility claims, Medicare's allowed amount is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

2. In the case where Medicare is primary for inpatient facility claims, the amount the facility billed is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision. Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicare paid amount. Effective April 1, 2013, Medicare's allowed amount will be used as MCHCP's allowed amount for inpatient facility claims to determine what MCHCP would have paid in absence of this COB provision and the Medicare paid amount will no longer be combined with the provider's Medicare contractual write off.

[3. In the case where another plan is primary, the lower allowed amount of either the primary plan or MCHCP is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.]

*AUTHORITY: sections 103.059 and 103.089, 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment updates the telephone number for Anthem expedited appeals and the mailing address and website for external review requests.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan

year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023, becomes effective January 1, 2024, and expires June 28, 2024.*

(3) Appeal Process for Medical and Pharmacy Determinations for PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(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 decided within twenty (20) business days 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 thirty (30) days. The vendor must notify the member prior to the expiration of the first 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 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) 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 will be decided within twenty (20) days 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 thirty (30) days. The vendor must notify the member prior to the expiration of the first 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 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 Anthem –

(a) First and second level pre-service, first and second level post-service, and concurrent claim appeals must be submitted in writing to –

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 105568
Atlanta, Georgia 30348-5568
or by fax to (800) 859-3046

(b) Expedited appeals may be submitted by calling *[(877) 333-7488]* **(844) 516-0248** or by submitting a written fax to (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
Federal External Review Process (FERP)
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/] **externalappeal.cms.gov**

(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.

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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY 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 revises Medicare Part D coverage stage and copayment amounts.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023, becomes effective January 1, 2024, and expires June 28, 2024.*

(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 hereinafter 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 *[four thousand six hundred sixty dollars ($4,660)]* **five thousand thirty dollars ($5,030)**, 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 dollar ($80) copayment; ninety- (90-) day supply at retail has a one hundred twenty dollar ($120) copayment; and a ninety- (90-) day supply through home delivery has a one hundred dollar ($100) 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 *[four thousand six hundred sixty dollars ($4,660)]* **five thousand thirty dollars ($5,030)** and remain below *[seven thousand four hundred dollars ($7,400)]* **eight thousand dollars ($8,000)**, 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 *[seven thousand four hundred dollars ($7,400)]* **eight thousand dollars ($8,000)** ;

4. Catastrophic coverage stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[seven thousand four hundred dollars ($7,400)]* **eight thousand dollars ($8,000)**, the member will pay *[the greater of—*

A. Five percent (5%) coinsurance or a four dollar and fifteen cent ($4.15) 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 a ten dollar and thirty-five cent ($10.35) copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the initial coverage stage] **zero dollars ($0)**; 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.140 Strive for Wellness® Health Center Provisions, Charges, and Services. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (3).

PURPOSE: This amendment clarifies eligibility for and services available at the Strive for Wellness® Health Center.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023, becomes effective January 1, 2024, and expires June 28, 2024.*

(1) Eligibility. *[Non-Medicare primary members over]* **Members aged** eighteen (18) years *[old enrolled in an MCHCP medical plan]* **and older** shall be eligible for and able to access the services available at the health center as described in this rule.

(2) Available Services. The health center provides access to **contracted services for** treatment for uncomplicated minor illnesses and *[to]* preventive health care services**.** *[including, but not limited to, the following:*

(A) Sore throats/ears/headache;
(B) Strains/sprains/musculoskeletal problems;
(C) Non-specific abdominal pain;
(D) Non-specific chest pain;
(E) Cough;
(F) Sinus conditions;
(G) Allergies;
(H) Hormone injections;
(I) Vaccinations including influenza vaccine;
(J) Rashes;
(K) Acute urinary complaints;
(L) Personal hygiene related problems;
(M) Acute injuries/acute routine office procedures;
(N) Minor surgical procedures, such as sutures for laceration treatment;
(O) Ordinary and routine care of the nature of a visit to the health care provider's office; and
(P) Clinical Laboratory Improvement Amendments (CLIA)-waived lab services.]

(3) Limitations and exclusions.

(A) The following *[employees are not eligible for]* **MCHCP eligibles are not able to utilize** the health center:

1. Active employees **and members** who are not enrolled in *[an]* MCHCP medical *[plan]* **coverage**; and

2. *[Medicare primary retirees and their Medicare primary dependents]* **Members enrolled in the Medicare Advantage plan**.

(B) Services that are beyond the scope *[of practice]* of the health center including, but not limited to, the following:

1. Emergency services;
2. Urgent care services;
3. Radiology services;
4. Specialist services;
5. Pharmacy services;
6. Occupational, speech, and physical therapy services; and
7. Chiropractic services.

*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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.020 General Membership Provisions The Missouri Consolidated Health Care Plan is amending section (8).

PURPOSE: This amendment adds that retirees can cancel dental and vision coverage when voluntarily canceling medical coverage.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023 becomes effective January 1, 2024 and expires June 28, 2024.*

(8) Voluntary Cancellation of Coverage.

(D) A subscriber may only cancel dental and/or vision coverage during the year for him/herself or his/her dependents for one (1) of the following reasons:

1. Upon retirement;
2. When beginning a leave of absence;
3. No longer eligible for coverage;
4. When new coverage is taken through other employment; *[or]*
5. When the member enrolls in Medicaid*[.]*; **or**
6. **When a retiree cancels medical coverage.**

*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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10 – Health Care Plan
Chapter 3 – Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (7), (10), (11), and (12) and renumbering as necessary.

PURPOSE: This amendment makes a technical correction for nutritional counseling to nutrition counseling, revises coverage of virtual visits, and adds one hundred percent (100%) coverage after deductible is met of diagnostic breast examinations and colorectal screenings at a network provider.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023 becomes effective January 1, 2024 and expires June 28, 2024.*

(7) Nutrition*[al]* counseling is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(10) Virtual visits offered through the vendor's telehealth tool are covered at one hundred percent (100%) *[after the deductible is met]*.

(11) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings are covered at one hundred percent (100%) after deductible is met.

(12) Diagnostic colorectal screenings are covered at one hundred percent (100%) after deductible is met.

*[(11)]***(13)** Newborn's claims will be subject to deductible and coinsurance.

*[(12)]***(14)** Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

*[(13)]***(15)** 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.

*[(14)]***(16)** 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.

*[(15)]***(17)** 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 time frame 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.

*[(16)]***(18)** 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.

*[(17)]***(19)** 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 (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.

*[(18)]***(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.

*[(19)]***(21)** 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 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges The Missouri Consolidated Health Care Plan is amending section (3) and renumbering as necessary.

PURPOSE: This amendment adds coverage of cryopreservation cycles and infertility treatment, makes a technical correction for nutritional counseling to nutrition counseling, and revises preventive services.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust

fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023 becomes effective January 1, 2024 and expires June 28, 2024.*

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250, and HSA Plan.

(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;

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;

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;

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;

9. Chelation therapy;

10. Chiropractic services – manipulation and adjunct therapeutic procedures/modalities;

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;

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 and auditory brainstem implant;

13. Cryopreservation cycles.

A. Oocyte cryopreservation cycles including one year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes); and

B. Sperm cryopreservation including one year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes);

[13.]**14.** 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 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.]**15.** Diabetes self-management education;

[15.]**16.** Dialysis is covered when received through a network provider;

[16.]**17.** 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 nonfunctional 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.]***18.** 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;

*[18.]***19.** 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.]***20.** 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;

(III) Peripheral neuropathy; or

(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.]***21.** 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;

*[21.]***22.** 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.]***23.** Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

*[23.]***24.** 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.]***25.** 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. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone anchoring hearing aid (BAHA): three thousand five hundred dollars ($3,500);

*[25.]***26.** Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

*[26.]***27.** 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.]***28.** 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;

*[28.]***29.** 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; and

(V) Outpatient mental health services;

30. Infertility coverage for members with a diagnosis of infertility, including in vitro fertilization (IVF) oocyte retrievals limited to two (2) cycles as a lifetime maximum, per member;

*[29.]***31.** 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.]***32.** 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;

*[31.]***33.** 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.]***34.** 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 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.]***35.** Nutrition*[al]* 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.]***36.** Nutrition therapy;

*[35.]***37.** 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.]***38.** 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.]***39.** 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. Tumors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical abnormality;

*[38.]***40.** 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 agoniometer 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.

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.]***41.** 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 preventive 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]* **Digital diabetes prevention** program offered through the plan's *[exclusive provider arrangement]* **claims administrator**.

H. The following services permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan:

(I) Blood pressure monitors for individuals diagnosed with hypertension;

(II) Retinopathy screenings for individuals diagnosed with diabetes;

(III) Hemoglobin A1c (HbA1c) testing for individuals diagnosed with diabetes;

(IV) Peak flow meters for individuals diagnosed with asthma; and

(V) International normalized ratio (INR) testing for individuals diagnosed with liver disease and/or bleeding disorders;

*[40.]***42.** 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.]***43.** 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.]***44.** Skilled nursing facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

*[43.]***45.** 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.]***46.** 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, postoperative vocal cord surgery);

***[45.]*47.** 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.]*48.** Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

***[47.]*49.** 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will cost state agencies or political subdivisions twelve thousand dollars ($12,000) in the time the emergency is effective.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

FISCAL NOTE
PUBLIC COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Health Care Plan
Chapter Title: Public Entity Membership

Rule Number and Name:	22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	$12,000

III. WORKSHEET

This estimate reflects anticipated administrative and claims costs during the time the emergency rule is in effect. MCHCP's actuary conducted the cost estimate for this change.

IV. ASSUMPTIONS

Member utilization is as projected.

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

EMERGENCY AMENDMENT

22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment adds one hundred percent (100%) coverage of diagnostic breast examinations and colorectal screenings at a network provider.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023 becomes effective January 1, 2024 and expires June 28, 2024*

(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:

(E) Sterilization procedure for men; *[and]*

(F) Virtual visits offered through the vendor's telehealth tool*[.]*;

(G) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings; and

(H) Diagnostic colorectal screenings.

*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. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment adds one hundred percent (100%) coverage of diagnostic breast examinations and colorectal screenings at a network provider.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023 becomes effective January 1, 2024 and expires June 28, 2024.*

(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:

(E) Sterilization procedure for men; *[and]*

(F) Virtual visits offered through the vendor's telehealth tool*[.]*;

(G) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings; and

(H) Diagnostic colorectal screenings.

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. For intervening history, please consult the ***Code of State Regulation****. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.061 Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1) and renumbering as necessary.

PURPOSE: This amendment removes the limitation on infertility treatment.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023 becomes effective January 1, 2024 and expires June 28, 2024.*

(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.

[(AA) Infertility treatment beyond the covered services to diagnose the condition.]

*[(BB)]***(AA)** Infusions received through a non-network provider.

*[(CC)]***(BB)** Level of care, greater than is needed for the treatment of the illness or injury.

*[(DD)]***(CC)** Long-term care.

*[(EE)]***(DD)** Maxillofacial surgery.

*[(FF)]***(EE)** 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.

*[(GG)]***(FF)** 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.

*[(HH)]***(GG)** Military service-connected injury or illness – including expenses relating to Veterans Affairs or a military hospital.

*[(II)]***(HH)** Never events – never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

*[(JJ)]***(II)** 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.

*[(KK)]***(JJ)** Non-medically necessary services.

*[(LL)]***(KK)** Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

*[(MM)]***(LL)** Non-reusable disposable supplies.

*[(NN)]***(MM)** Online weight management programs.

*[(OO)]***(NN)** 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.

*[(PP)]***(OO)** 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.

*[(QQ)]***(PP)** Physical and recreational fitness.

*[(RR)]***(QQ)** Private-duty nursing.

*[(SS)]***(RR)** Routine foot care without the presence of systemic disease that affects lower extremities.

*[(TT)]***(SS)** Services obtained at a government facility if care is provided without charge.

*[(UU)]***(TT)** Sex therapy.

*[(VV)]***(UU)** Surrogacy—pregnancy coverage is limited to plan member.

*[(WW)]***(VV)**Telehealth site origination fees or costs for the provision of telehealth services are not covered.

*[(XX)]***(WW)**Travel expenses.

*[(YY)]***(XX)** 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, expired June 28, 2020. Amended: Filed Oct. 30, 2019, effective May 30, 2020. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (4).

PURPOSE: This amendment revises effect on the benefits of MCHCP when MCHCP is a secondary plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023 becomes effective January 1, 2024 and expires June 28, 2024.*

(4) Effect on the benefits of MCHCP. This section applies, which in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans.

(A) In the event that MCHCP is a secondary plan as to one (1) or more other plans, the benefits of MCHCP's PPO plans and Health Savings Account Plan (HSA Plan) may be reduced under this section so as not to duplicate the benefits of the other plan. The other plan's payment is subtracted from what MCHCP or its claims administrator would have paid in absence of this COB provision using the following criteria. If there is any balance, MCHCP or its claims administrator will pay the difference not to exceed what it would have paid in absence of this COB provision.

1. In the case where Medicare is primary for physician and outpatient facility claims, Medicare's allowed amount is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

2. In the case where Medicare is primary for inpatient facility claims, the amount the facility billed is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision. Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicare paid amount. Effective April 1, 2013, Medicare's allowed amount will be used as MCHCP's allowed amount for inpatient facility claims to determine what MCHCP would have paid in absence of this COB provision and the Medicare paid amount will no longer be combined with the provider's Medicare contractual write off.

[3. In the case where another plan is primary, the lower allowed amount of either the primary plan or MCHCP is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.]

AUTHORITY: sections 103.059 and 103.089, 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment updates the telephone number for Anthem expedited appeals and the mailing address and website for external review requests.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2024, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 27, 2023 becomes effective January 1, 2024 and expires June 28, 2024.*

(3) Appeal Process for Medical and Pharmacy Determinations.

(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.

(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 decided within twenty (20) business days 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 thirty (30) days. The vendor must notify the member prior to the expiration of the first 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 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) 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 will be decided within 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 thirty (30) days. The vendor must notify the member prior to the expiration of the first 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 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 Anthem –

(a) First and second level pre-service, first and second level post-service, and concurrent claim appeals must be submitted in writing to –

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 105568
Atlanta, Georgia 30348-5568
or by fax to (888) 859-3046

(b) Expedited appeals may be submitted by calling *[(877) 333-7488]* **(844) 516-0248** or by submitting a written fax to (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
Federal External Review Process (FERP)
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/] **externalappeal.cms.gov**

(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 time frame 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.

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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

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

EXECUTIVE ORDER
23-09

TO ALL DEPARTMENTS AND AGENCIES:

This is to advise that state offices of the executive branch under the purview of the Governor will be closed on Friday, November 24, 2023.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 9th day of November, 2023.

MICHAEL L. PARSON
GOVERNOR

ATTEST:

JOHN R. ASHCROFT
SECRETARY OF STATE

The text of proposed rules and changes will appear under this heading. A 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 explanation is set out in the PURPOSE section of each rule. A citation of the legal authority to make rules is also required, and 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 that 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, 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 9 – DEPARTMENT OF MENTAL HEALTH
Division 30 – Certification Standards
Chapter 4 – Mental Health Programs

PROPOSED AMENDMENT

9 CSR 30-4.046 Psychosocial Rehabilitation (PSR) in Community Psychiatric Rehabilitation Programs. The department is amending section (7).

PURPOSE: This amendment changes the staffing ratios for children and youth.

(7) PSR for Children and Youth. A combination of goal-oriented and rehabilitative services shall be provided in a group setting to improve or maintain the child's ability to function as independently as possible within their family and/or in the community. Services are provided according to the individual treatment plan, with an emphasis on community integration, independence, and resiliency. Hours of operation are determined by the program based on capacity, staffing availability, geography, and space requirements, but shall be no more than six (6) hours daily, per child.

(A) The director must be a **qualified mental health professional (**QMHP**)** with two (2) years of experience working with children and youth. One (1) full-time mental health professional must be available during the provision of services.

(B) Staffing ratios shall be based on the ages and needs of the children being served. For individuals *[between the ages of three (3) and eleven (11), the staffing ratio shall be one (1) staff to four (4) participants (1:4)]* **aged eleven (11) and younger, the staffing ratio shall be one (1) staff to eight (8) participants (1:8)**. For individuals *[between the ages of twelve (12) and seventeen (17), the staffing ratio shall be one (1) staff to six (6) participants (1:6)]* **aged twelve (12) to seventeen (17), the staffing ratio shall be one (1) staff to ten (10) participants (1:10)**.

(C) Other staff of the PSR team shall include the following, based on the needs of individuals served:

1. Registered nurse;
2. Occupational therapist;
3. Recreational therapist;
4. Rehabilitation therapist;
5. Community support specialist;
6. *[Family support worker]* **Certified family support provider**; and
7. Certified peer specialist.

(D) Key service functions shall include*[,]* but are not limited to*[:]* –

1. Assisting the child in gaining or regaining skills for community/family living such as personal hygiene, completing age-appropriate household chores, and family, peer, and school activities;
2. Developing interpersonal skills which provide a sense of participation and personal satisfaction (opportunities should be age and culturally appropriate daytime and evening activities which offer the chance for companionship, socialization, and skill building); and
3. Assisting the child and family in developing normative behaviors and expectations of relationships*[,]* and providing the opportunity to practice affiliated skills which can be valuable to an individual reestablishing family and personal support relationships.

AUTHORITY: section 630.655, RSMo 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Oct. 18, 2023.*

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 Mental Health, Denise Thomas, PO Box 687, Jefferson City, MO 65102 or by email to denise.thomas@dmh.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 35 – Children's Division
Chapter 35 – Alternative Care

PROPOSED RULE

13 CSR 35-35.070 Alternative Care Review Board

PURPOSE: This rule defines the Alternative Care Review Board, discusses the purpose of the board, and explains the process for requesting an alternative care review hearing.

(1) Definitions.

(A) "Alternative care review board" or "ACRB" – The board before whom the alternative care resource provider may appeal any decision made by the Children's Division or its contractors regarding a case management decision involving a child who is, or has been, placed in foster care with the claimant.

(B) "Case management decision" – The activity of a case manager employed by the division or one of its contractors in assessing family problem(s), case planning, coordinating and linking services for children and families, monitoring service provisions and progress, and providing aftercare service. A case management decision shall not include a decision made by the family support team, adoption staffing team, a court of appropriate jurisdiction, or any matter that is the subject of litigation before a court of competent jurisdiction.

(C) "Resource provider" – A resource family providing care for children in state custody.

(2) This section establishes the process for providing a fair and impartial grievance process for review of case management decisions as required by section 210.566, RSMo.

(3) Alternative Care Review Board Composition. Each of the division's administrative regions shall establish an alternative care review board composed of seven (7) members and two (2) alternates. Members and alternates for an ACRB shall be selected as follows:

(A) Two (2) resource providers, of which one (1) shall be a licensed resource provider;

(B) Two (2) division employees;

(C) Three (3) members and two (2) alternates from the following fields or professions:

1. Community representative who has knowledge of the provision of alternative care services;
2. Professional school employee;
3. Juvenile officer or professional employee of the Juvenile Office;
4. Licensed child or family psychologist or other qualified mental health professional;
5. Physician, nurse, or other qualified medical professional; or
6. Child welfare professional that provides services to families and/or children; and

(D) A division regional director shall appoint the members of the ACRB in that director's region. The regional director shall nominate the chairperson of the board and forward the nomination to the division's director or director's designee for approval.

(4) ACRB Terms of Office.

(A) Members and alternates shall be appointed for two- (2-) year terms.

(B) The members of the ACRB shall have at least one (1) annual meeting regardless if any requests are filed. The members of the ACRB shall also meet at least one (1) time per month depending on the number of requests being filed. Other than the annual meeting, meetings are not required if there are no pending reviews.

(C) The members of the ACRB will receive payment for reasonable expenses associated with ACRB business, but will not receive compensation for the performance of their duties. If a member cannot attend, an alternate shall be notified and asked to attend.

(D) A quorum at any ACRB meeting will be three (3) members, of whom one (1) will be a resource provider and one (1) will be a division employee.

(E) A division regional director may remove and/or replace a member of an ACRB for the following reasons:

1. Death;
2. Resignation;
3. Mental or physical incapacitation that limits the member from actively serving; or
4. For good cause as determined by the division director.

(F) The information and deliberations of the ACRB shall be confidential and protected from disclosure to the extent permitted by law.

(5) Process for Requesting an ACRB Review.

(A) The resource provider shall email a written request for review of a case management decision to cd.acrb@dss.mo.gov, or mail such request to Program Development Specialist, Resource Licensing, Missouri Children's Division Central Office, PO Box 88, 205 Jefferson St., 10th Floor, Jefferson City, MO 65101, within ten (10) business days of being notified of the case management decision. The request for review shall specify the decision that is being contested and the basis of the grievance.

(B) Except as provided in this regulation, upon receipt of the grievance, division or contracted staff shall take no action to implement the decision being reviewed until the matter is resolved through the grievance process. The implementation of the following decisions, however, shall not be stayed pending resolution of the grievance:

1. Decisions that, in the division's or contracted staff's judgment, require immediate action to protect the health, safety, or well-being of the child in care; or
2. Decisions whose implementation has been ordered by a court of competent authority.

(C) Within ten (10) business days of receipt of the grievance, the division or contracted staff shall schedule an informal meeting/review with the resource provider to attempt to resolve the matter. In cases concerning a case management decision made by the division, the attendees of the informal meeting shall include the resource provider, the resource provider's attorney (if available), a regional division representative, and one (1) or more circuit division representatives. In cases concerning a case management decision made by a contracted agency, the attendees of the informal meeting shall include the resource provider, the resource provider's attorney (if available), an agency manager, and a manager representing the contract holder. Within five (5) business days of the informal review, the division or contracted management staff shall notify the resource provider in writing of its decision to uphold or reverse the case management decision and, if the decision is upheld, shall advise the resource provider of the resource provider's right to proceed with a request for an ACRB hearing.

(D) If the resource provider chooses to proceed with the

ACRB hearing, the resource provider shall email a completed hearing request form or other written request for an ACRB hearing, including all pertinent information and records, to cd.acrb@dss.mo.gov, or mail such written request, information, and records to Program Development Specialist, Resource Licensing, Missouri Children's Division Central Office, PO Box 88, 205 Jefferson St., 10th Floor, Jefferson City, MO 65101, within five (5) business days of the division's or contracted management staff's written decision. The division may extend the time frame for submitting information for good cause shown. The division will notify the resource provider of the date scheduled for the ACRB hearing within five (5) business days of receiving the resource provider's written request.

(E) The division or contracted staff shall submit all pertinent information and records to the resource provider's regional ACRB within five (5) business days of receiving the request for the review. The division may extend the timeframe for submitting information for good cause shown.

(F) The review should be scheduled to occur at the next scheduled ACRB meeting. The review may be continued if there is insufficient time for board members to prepare for the review.

(G) The review proceedings described in this subsection are informal and administrative in nature and are not subject to the Missouri Rules of Civil Procedure. The review proceedings are also not subject to common law or statutory evidentiary standards, apart from those regarding relevancy. The review proceedings shall not be governed by the procedures set forth in Chapter 536, RSMo, but shall instead be governed by the following procedures:

1. The division or contracted staff shall first present its case management decision and the rationale thereof. Division or contracted staff may participate in the review proceeding in person, telephonically, or virtually with or without legal counsel;

2. The resource provider and/or the provider's counsel shall next present a summary of the resource provider's grievance. The resource provider and/or the provider's counsel's presence is not mandatory for a review to be held. The provider or provider's counsel may submit a written statement and/or participate in the review telephonically or virtually if equipment is available;

3. The resource provider and the division or contracted staff may provide information at the review through the use of witnesses. Witness testimony will not be taken under oath; however, the parties may submit information by written statement. No party to the review proceeding, including the ACRB, shall have the power to compel the appearance of any witness through the use of a subpoena or other means;

4. The review hearing may, at the election of either party, be recorded through the use of a recording device or a court reporter. However, the review hearing shall not be a hearing on the record. All expenses associated with the recording of the hearing shall be the sole responsibility of the party desiring them; and

5. The information provided to the ACRB, and the ACRB's deliberations, shall be confidential and protected from disclosure to the extent permitted by law. The ACRB shall review and discuss all relevant materials and information and vote individually on whether to uphold, modify, or reverse the division or contracted staff's finding and/or decision. The ACRB shall prepare a written summary of its findings and recommended decision and present it to the division's deputy director for permanency within seven (7) business days of the ACRB hearing. The deputy director shall discuss the recommendation with the division's director. The division's director shall provide the final written decision to all parties within thirty (30) calendar days of receipt of the ACRB's recommendation. The division director's decision shall be the final decision of the division.

(6) If at any time the grievance pending before the ACRB becomes the subject of a motion or other proceeding before a court of competent authority, the ACRB proceedings shall be stayed pending the resolution of the issue before the court. In the event that the matter is decided by the court, the ACRB proceedings shall be dismissed by the ACRB.

AUTHORITY: section 207.020, RSMo 2016, and section 210.566, RSMo Supp. 2023. Original rule filed Oct. 24, 2023. The material covered in this rule was previously covered in 13 CSR 35-36.010.

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

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 35 – Children's Division
Chapter 36 – Alternative Care Review Board

PROPOSED RESCISSION

13 CSR 35-36.010 Alternative Care Review Board. This rule defined the Alternative Care Review Board, discussed the purpose of the board, and explained the process for requesting an alternative care review hearing.

PURPOSE: This rule is being rescinded because a new Alternative Care Review Board rule, 13 CSR 35-35.070, is being promulgated in Chapter 35 of the Children's Division's regulations, titled "Alternative Care."

AUTHORITY: section 207.020, RSMo 2000, and section 210.566.6, RSMo Supp. 2013. Original rule filed Oct. 29, 2013, effective April 30, 2014. Rescinded: Filed Oct. 23, 2023.

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 Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527 Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after

*publication of this notice in the **Missouri Register**. No public hearing is scheduled*

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 15 – Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology. The division is amending subsections (1)(B), (2)(O), (6)(A), (8)(A), adding a new section (11), and renumbering sections (11)–(15).

PURPOSE: This proposed amendment adds a new supplemental payment paid to hospitals.

(1) General Reimbursement Principles.

(B) The Title XIX reimbursement for hospitals, excluding those located outside Missouri, shall include the payments as outlined below. Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Inpatient *per diem* reimbursement is established in accordance with sections (4) and (5).

2. Outpatient reimbursement is established in accordance with 13 CSR 70-15.160.

3. Acuity adjustment payment (AAP) is established in accordance with section (6).

4. Poison control (PC) payment is established in accordance with section (7).

5. Stop loss payment (SLP) is established in accordance with section (8).

6. Disproportionate share hospital (DSH) payment is established in accordance with 13 CSR 70-15.220.

7. Graduate medical education (GME) payment is established in accordance with section (9).

8. Upper payment limit (UPL) payment is established in accordance with 13 CSR 70-15.230.

9. Children's outlier (CO) payment is established in accordance with section (10).

10. Psych adjustment (PA) payment is established in accordance with section (11).

(2) Definitions.

(O) Incorporation by reference. This rule incorporates by reference the following:

1. The *Hospital Provider Manual* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at http://manuals.momed.com/manuals/, June 8, 2022. This rule does not incorporate any subsequent amendments or additions;

2. Medicare/Medicaid Cost Report CMS 2552-10, which is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services (CMS) at its website http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html, June 8, 2022. This rule does not incorporate any subsequent amendments or additions; **and**

[3. 42 CFR 405, which is incorporated by reference and made a part of this rule as published by the U.S. Government Publishing Office and available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405?toc=1, June 8, 2022. This rule does not incorporate any subsequent amendments or additions; and]

*[4.]***3.** 42 CFR 413, which is incorporated by reference and made a part of this rule as published by the U.S. Government Publishing Office and available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413?toc=1, June 8, 2022. This rule does not incorporate any subsequent amendments or additions. **Only the cost principles from 42 CFR 413 are incorporated by reference.**

(6) Acuity Adjustment Payment (AAP).

(A) Beginning with SFY 2023, hospitals that meet the requirements set forth below shall receive an AAP. A hospital that is designated as a long-term acute care hospital, free-standing psychiatric hospital, or a free-standing rehabilitation hospital does not qualify to receive an AAP. Ownership type of the hospital is determined based on the type of control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. For purposes of this section, Medicaid payments received shall include the following payments:

[1. For SFY 2022, the Medicaid per diem payments, direct Medicaid payments, GME payments, and CO payments;

2. For SFY 2023 and forward, the Medicaid per diem payments, AAP, PC payment, SLP, GME payments, and CO payments.]

1. The Medicaid per diem payments, AAP, PC payment, and SLP.

(8) Stop Loss Payment (SLP).

(A) Beginning with SFY 2023 hospitals that meet the requirements set forth below shall receive a**n** SLP. Ownership type of the hospital is determined based on the type of control reported on Schedule S-2, Part I, Line 21, Column 1 of the hospital's base year cost report. For purposes of this section, Medicaid payments received shall include the following payments:

[1. For SFY 2022, the Medicaid per diem payments, direct Medicaid payments, GME payments, and CO payments; and

2. For SFY 2023 and forward, the Medicaid per diem payments, AAP, PC payment, SLP, GME payments, and CO payments.]

1. The Medicaid *per diem* payments, AAP, PC payment, and SLP.

(11) Psych Adjustment (PA) Payment.

(A) Beginning with SFY 2024, hospitals that have FFS psychiatric hospital days as identified in the MMIS shall receive a PA payment.

1. The PA payment is a set dollar amount appropriated by the General Assembly pursuant to section 11.770, RSMo, and distributed to eligible hospitals proportionately as follows:

A. The FFS psychiatric hospital days for each hospital will be divided by the total FFS psychiatric hospital days for all hospitals to determine a percentage for each hospital. This percentage will then be multiplied by the set dollar amount in paragraph (11)(A)1. to determine the PA payment. The FFS psychiatric hospital days are paid days from the second prior calendar year.

2. The annual final PA payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

*[(11)]***(12)** Safety Net Hospitals.

(A) Inpatient hospital providers may qualify as a safety net hospital based on the following criteria. Hospitals shall qualify for a period of only one (1) SFY and must requalify at the beginning of each SFY to continue their safety net hospital designation.

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

2. As determined from the audited base year cost report, the facility must have either –

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

B. A low income utilization rate in excess of twenty-five percent (25%).

(I) The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(a) Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges minus contractual allowances, discounts, etc.) for patient services plus the cash subsidies; and

(b) The total amount of the hospital's charges for patient services attributable to charity care (CC) less cash subsidies directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to charity care shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a state plan.
LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC – CS) / THC)

3. As determined from the audited base year cost report –

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

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

C. A public non-state governmental acute care hospital with an LIUR of at least forty percent (40%) and an MIUR greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%); or

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

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

[(12)]**(13)** Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and Medicaid provider number shall have their Medicaid reimbursement combined under the surviving hospital's (the hospital's whose Medicare and Medicaid provider number remained active) Medicaid provider number.

(A) The *per diem* rate for merged hospitals shall be calculated –

1. For the remainder of the SFY in which the merger occurred, the merged rate is calculated by multiplying each hospital's estimated Medicaid paid days by its *per diem* rate, summing the estimated *per diem* payments and estimated Medicaid paid days, and then dividing the total estimated *per diem* payments by the total estimated paid days to determine the weighted *per diem* rate. The effective date of the weighted *per diem* rate will be the date of the merger; or

2. For subsequent SFYs, the *per diem* rate will be based on the combined data from the base year cost report for each facility.

(B) The other Medicaid payments, if applicable, shall be –

1. Combined under the surviving hospital's Medicaid provider number for the remainder of the SFY in which the merger occurred; and

2. Calculated for subsequent SFYs based on the combined data from the base year cost report for each facility.

[(13)]**(14)** Payment Assurance. The state will pay each hospital, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the rules implementing the hospital reimbursement program.

[(14)]**(15)** Inappropriate Placements.

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

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

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

[(15)]**(16)** Directed Payments. Effective July 1, 2022, the Missouri Medicaid managed care organizations shall make inpatient and outpatient directed payments to in-state in-network hospitals pursuant to 42 CFR 438.6(c) as approved by the Centers for Medicare & Medicaid Services.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. ***[2022] 2023****. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb.*

13, 1969, effective Feb. 23, 1969. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Oct. 23, 2023.*

PUBLIC COST: This proposed amendment is estimated to cost the state approximately $25 million (State Share: $7.8 million FRA and $820,000 IGT for DMH) for SFY 2024. This proposed amendment is estimated to increase payments to public entities by approximately $6.2 million for SFY 2024.

PRIVATE COST: This proposed amendment is estimated to increase payments to in-state private entities by approximately $18.8 million for SFY 2024.

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.*

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FISCAL NOTE
PUBLIC COST

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

Rule Number and Name:	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) & State Hospitals enrolled in MO HealthNet - 38 **Department of Social Services, MO HealthNet Division**	**Estimated impact for SFY 2024: $6.2 million** **Estimated cost for SFY 2024: Total $25 million; State Share $7.7 million (FRA) State Share $820 thousand (IGT)**

III. WORKSHEET

Other Government (Public) & State Hospitals Impact:

Estimated Impact for SFY 2024:

	GR/FRA Fund	IGT Fund	Total
Estimated Impact to State Hospitals	$1,269,002	$2,413,197	$3,682,199
Estimated Impact to Other Government (Public) Hospitals	$2,494,205	$0	$2,494,205
Total Estimated Impact	$3,763,207	$2,413,197	$6,176,405
State Share Percentage	33.9950%	33.9950%	33.9950%
Estimated State Share	$1,279,302	$820,366	$2,099,669

Department of Social Services, MO HealthNet Division Cost:

Estimated Cost for SFY 2024:

	GR/FRA Fund	IGT Fund	Total
Estimated Cost	$22,586,803	$2,413,197	$25,000,000
State Share Percentage	33.9950%	33.9950%	33.9950%
Estimated State Share Cost	$7,678,384	$820,366	$8,498,750

IV. ASSUMPTIONS

Eighteen (18) public hospitals meet the criteria to receive the Psych Adjustment Payment for SFY 2024. The aggregate public hospital utilization percent is 9.977%. This percent times the total dollar amount of $25 million is $2.5 million in increased payments to in-state public hospitals.

Seven (7) state hospitals meet the criteria to receive the Psych Adjustment Payment for SFY 2024. The aggregate state hospital utilization percent is 14.729%. This percent times the total dollar amount of $25 million is $3.7 million in increased payments to state hospitals.

FISCAL NOTE
PRIVATE COST

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

Rule Number and Title:	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology
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:
In-State Hospitals – 66	**Private Hospitals enrolled in MO HealthNet**	**Estimated impact for SFY 2024: $18.8 million**

III. WORKSHEET

In-State Private Hospitals Impact:

Estimated Impact for SFY 2024:

	GR/FRA Fund	IGT Fund	Total
Estimated Impact to In-State Private Hospitals	$18,823,596	$0	$18,823,596
State Share Percentage	33.9950%	33.9950%	33.9950%
Estimated State Share	$6,399,081	$0	$6,399,081

IV. ASSUMPTIONS

Sixty-six (66) private hospitals meet the criteria to receive the Psych Adjustment Payment for SFY 2024. The aggregate private hospital utilization percent is 75.294%. This percent times the total dollar amount of $25 million is $18.8 million in increased payments to in-state private hospitals.

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 20 – Pharmacy Program

PROPOSED AMENDMENT

13 CSR 70-20.340 National Drug Code Requirement. The Department of Social Services is amending the purpose statement and section (1) and removing sections (2)–(5).

PURPOSE: The purpose of this amendment is to remove duplicative information that is housed in the Pharmacy Provider Manual and to simplify language for providers.

PURPOSE: This rule implements [the requirement for] the National Drug Code (NDC) ***requirement*** *for all medications administered in the clinic or outpatient hospital setting. The Deficit Reduction Act of 2005 (DRA) requires states to collect rebates for certain physician-administered drugs.*

(1) Drug charges submitted by providers on an electronic Professional or Institutional ASC X12 837 Health Care claim transaction or manually entered on a medical or outpatient claim into **the MO HealthNet Division's (**MHD*['s]***)** billing website eMOMED (www.emomed.com)*[, are to]* **must** be billed with a valid Healthcare Common Procedure Coding System (HCPCS) procedure code and a valid NDC for *[each medication, including injections, provided to the participant. Medical]* **all medications administered to MHD participants in the clinic or outpatient hospital setting. MHD must collect the eleven- (11-) digit NDC on all outpatient drug claims submitted to MHD from all providers for rebate purposes to receive federal financial participation. Providers can find the NDC on the medication's packaging, and must submit the NDC in the five (5) digit – four (4) digit – two (2) digit format. If the NDC does not appear in the five (5) digit – four (4) digit – two (2) digit format on the packaging, zero(s) (0) may be entered in front of the section that does not have the required number of digits. The MHD denies medical** or outpatient claim lines submitted with a HCPCS procedure code without the corresponding NDC *[will be denied]*. For medical or outpatient claims correctly submitted with the appropriate HCPCS procedure code and the corresponding NDC, the system *[will]* automatically generate***s*** a separate drug claim for the NDC to process as a pharmacy claim*[, and]***. It** will appear as a separate claim on your Remittance Advice. The **MHD will drop the** corresponding line with **the** HCPCS procedure code and NDC *[will be dropped]* from the medical or outpatient claim. If an NDC is not provided, the HCPCS procedure code will remain on the claim to report the denied line. **All claims must be billed with the proper NDC quantities, not the HCPCS quantities.** For drugs without a valid HCPCS procedure code, revenue code 0250**,** "General Classification: Pharmacy**,"** must be used with the appropriate NDC. Only drugs and items used during outpatient care in the hospital are covered. **MHD does not cover** *[T]***t**ake-home medications and supplies *[are not covered by MHD]* under the Hospital Program.

[(2) Effective for dates of service on or after April 1, 2016, the MO HealthNet Division (MHD) will require the National Drug Code (NDC) for all medications administered in the clinic or outpatient hospital setting, to comply with federal law. MHD must collect the eleven- (11-) digit NDC on all outpatient drug claims submitted to MHD from all providers for rebate purposes in order to receive federal financial participation. Providers are required to submit their claims with the exact NDC that appears on the product dispensed or administered to receive payment from MHD. The NDC is found on the medication's packaging and must be submitted in the five (5) digit – four (4) digit – two (2) digit format. If the NDC does not appear in the five (5) digit – four (4) digit – two (2) digit format on the packaging, zero(s) (0) may be entered in front of the section that does not have the required number of digits.

(3) All drug claims shall be routed through an automated computer system to apply edits specifically designed to ensure effective drug utilization. The Preferred Drug List (PDL) and clinical edits are designed to enhance patient care and optimize the use of program funds through therapeutically prudent use of pharmaceuticals. The edits are based on evidence-based clinical criteria and nationally recognized peer-reviewed information. This clinical information is paired with fiscal evaluation and then developed into a therapeutic class PDL recommendation. The PDL process incorporates clinical edits, including step therapies, into the MHD pharmacy program. Claims for drugs will automatically and transparently be approved for those patients who meet any of the system approval criteria. For those patients who do not meet the system approval criteria, the drugs will require a call to the MHD Drug Prior Authorization hotline at (800) 392-8030 to initiate a review and potentially authorize payment of claims. Providers may also use the CyberAccess tool to prospectively determine if a drug is a preferred agent or requires edit override, electronically initiate an edit override review, and to review a participant's MHD paid claim history.

(4) The quantity to be billed for injectables and other types of medications dispensed to MHD participants must be calculated as follows:

(A) Containers of medication in solution (for example, ampoules, bags, bottles, vials, syringes) must be billed by exact cubic centimeters or milliliters (cc or mL) dispensed, even if the quantity includes a decimal (e.g., if three (3) 0.5 mL vials are dispensed, the correct quantity to bill is 1.5 mL);

(B) Single dose syringes and single dose vials must be billed per cubic centimeters or milliliters (cc or mL), rather than per syringe or per vial;

(C) Ointments must be billed per number of grams even if the quantity includes a decimal;

(D) Eye drops must be billed per number of cubic centimeters or milliliters (cc or mL) in each bottle even if the quantity includes a decimal;

(E) Powder filled vials and syringes that require reconstitution must be billed by the number of vials;

(F) Combination products, which consist of devices and drugs, designed to be used together, are to be billed as a kit. Quantity will be the number of kits used;

(G) The product Herceptin, by Genentech, must be billed by milligram rather than by vial due to the stability of the drug; and

(H) Non-Vaccines for Children (VFC) Immunizations and vaccines must be billed by the cubic centimeters or milliliters (cc or mL) dispensed, rather than per dose.

(5) Radiopharmaceuticals used in radiologic procedures may be billed separately using the appropriate HCPCS code and/or the NDC representing the materials or agent used in the procedure. If available, MHD would prefer the NDC for reporting purposes. If the material or agent used does not have an NDC, the appropriate HCPCS code alone is acceptable. All HCPCS codes for radiopharmaceuticals are manually priced and must be billed with the manufacturer's invoice of cost attached to the claim.]

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. Emergency rule filed June 19, 2015, effective July 1, 2015, expired Dec. 28, 2015. Original rule filed July 1, 2015, effective Feb. 29, 2016. Amended: Filed Sept. 27, 2018, effective May 30, 2019. Amended: Filed Jan. 16, 2020, effective Aug. 30, 2020. Amended: Filed Oct. 20, 2023.

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

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

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

TITLE 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RESCISSION

17 CSR 10-2.010 Regulation and Licensing In General. This rule established procedures, testing requirements, and license fees for those persons required to be licensed.

PURPOSE: The board wishes to rescind this rule and adopt a new rule in its place to clarify the language in the rule and ensure compliance with the applicable law.

AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the ***Code of State Regulations****. Rescinded: Filed Oct. 20, 2023.*

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 Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RULE

17 CSR 10-2.010 Regulation and Licensing in General

PURPOSE: Under the provisions of sections 84.420 and 84.720, RSMo, the Board of Police Commissioners of Kansas City, Missouri (board) has the authority and duty to regulate and license all private security and proprietary private investigative personnel, serving or acting as such within Kansas City, Missouri (city). This rule establishes procedures, testing requirements, and license fees for those persons required to be licensed.

(1) Any corporation, partnership, or other entity that provides private security services and proprietary private investigative services is fully responsible for the acts and omissions of its employees acting in the course and scope of their duties. Training is the responsibility of the entity hiring such employees. The board is a licensing agency, not an employer, and assumes no responsibilities for the acts or omissions of any entity or individual providing such services. The board's functions are limited to licensing and regulating any entity or individual who performs such services. The board shall have the power and duty to enforce the provisions of these rules and upon complaint of any person or on its own initiative to investigate violations, or to investigate the business, business practices, or business method of any person, firm, company, partnership, corporation, or political subdivision applying for or holding a license for providing private security services and proprietary private investigative services if, in the opinion of board, the investigation is warranted. Each entity or individual applicant shall be obligated to supply the information, books, papers, or records as reasonably may be required concerning proposed business practices or methods. Those licensed must maintain the records that the board requires which include but are not limited to records of contract accounts, employment records, time records, and assignment records along with records required to be kept by federal and state law.

(2) Any license granted under section 84.720, RSMo, shall constitute a privilege to do business and shall not invest the one licensed with any contractual interest, inherent right, or property interest.

(3) Those licensed to perform private security services or proprietary private investigative services have police powers limited to the property which they have been lawfully assigned to protect. With the exception of those licensed as airport police and park rangers, whose authority is set out in 17 CSR 10-2.030(1)(A)4. and 17 CSR 10-2.030(1)(A)5., those licensed under these provisions have no authority to enforce ordinances, statutes, or rules on the public streets of the city or at any location other than on the property they have been assigned to protect.

(4) Private Officers Licensing Unit (POLU) is responsible for investigating, processing, licensing, inspecting, and the regulation of all persons working or acting as licensed private security or proprietary private investigators. The POLU is further responsible for issuing and transferring all such licenses, for reinstatements, and for periodic inspection of license holders.

(5) Private security and proprietary private investigator licenses are required for each of the following:

(A) Any individual providing private security services or proprietary private investigative services within the city whether for a licensed private security business or otherwise (collectively a security officer);

(B) Any firm, company, partnership, or corporation that provides private security services or proprietary private investigative services (collectively a security firm);

(C) Any direct supervisor of a security officer; and

(D) Any political subdivision, sole proprietorship, firm, company, partnership, or corporation that employs personnel to provide private security services or proprietary private investigative services.

(6) The board's licensing requirements do not apply to persons acting as bouncers, process servers, bondsmen, surety recovery agents (bounty hunters), or investigators for attorneys unless acting in a private security capacity as defined in these rules.

(7) No license is required for any peace officer authorized to exercise police powers in the city who holds a valid Peace Officer Standards and Training (POST) certificate.

(8) The board shall perform its functions under statute and under these regulations through the POLU of the Kansas City, Missouri Police Department (department). All private officers and proprietary private investigators are subject to inspection by employees of the board and members of the department. The purpose of such inspections is to ensure that the licensee is in compliance with the provisions of this rule.

AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the ***Code of State Regulations****. Rescinded and readopted: Filed Oct. 20, 2023.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions twelve thousand fifteen dollars ($12,015) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities six hundred sixty thousand eight hundred thirty dollars ($660,830) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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: 17
Division Title: 10
Chapter Title: 2

Rule Number and Name:	17 CSR 10-2.010 – Regulation and Licensing in General
Type of Rulemaking:	Proposed Rulemaking

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
City of Kansas City, Missouri	**$3800.00**
Jackson County, Missouri Family Court	**$640.00**
Kansas City International Airport Police	**$6505.00**
Housing Authority of Kansas City, Missouri	**$1070.00**
Total	**$12,015.00**

III. WORKSHEET

The rates for new armed licenses will be one hundred sixty-five dollars ($165.00) per year. The rate for new unarmed licenses will be one hundred ten dollars ($110.00) per year.

The yearly renewal fees for armed licenses will be one hundred ten dollars ($110.00) per year. The yearly renewal fees for unarmed licensees will be eighty-five dollars ($85.00) per year. The number of current licensees in each category was multiplied by the corresponding renewal fees charged in order to assess the fiscal impact to the current licensees.

The City of Kansas City, Missouri licenses four (4) armed security officers and thirty-six (36) unarmed security officers. The City of Kansas City, Missouri will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of armed licenses (4) for a cost of four hundred forty dollars ($440.00) yearly. The City of Kansas City, Missouri will renew thirty-six (36) unarmed licenses. Each renewal is eighty-five dollars ($85.00) per licensee for a total cost of three thousand sixty dollars ($3060.00). A company fee in the amount of three hundred dollars ($300.00) is paid by the City of Kansas City, Missouri. The total fiscal impact to the City of Kansas City, Missouri is three thousand eight hundred dollars ($3800.00) per year. A range fee is assessed to the City of Kansas City, Missouri's armed licensees in the amount of one hundred dollars ($100.00) per licensee.

This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying public (and private) fiscal notes.

Jackson County, Missouri Family Court will incur costs of eighty-five dollars ($85.00) per renewal of each of its unarmed licenses (4) for a cost of three hundred forty dollars ($340.00) yearly. A company fee in the amount of three hundred dollars ($300.00) is paid by the Jackson County, Missouri Family Court. The total fiscal impact to Jackson County, Missouri is six hundred forty dollars ($640.00) per year.

It is estimated that the Kansas City International Airport Police will license sixteen (16) new armed officers and will license (3) new unarmed officers per year. The Kansas City International Airport Police will incur costs in the amount of one hundred sixty-five dollars ($165.00) for each new armed licensee estimated to be 16 licensees for a cost of two thousand six hundred forty dollars ($2640.00) per year. The Kansas City International Airport Police will incur costs in the amount of one hundred ten dollars ($110.00) for each new unarmed licensee estimated to be 3 licensees for a cost of three hundred thirty dollars ($330.00) per year. The Kansas City International Airport Police will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of each of its armed licenses (24) for a cost of two thousand six hundred forty dollars ($2640.00) yearly. The Kansas City International Airport Police will incur costs in the amount of eighty-five dollars ($85.00) per renewal of each of its unarmed licenses (7) for a cost of five hundred ninety-five dollars ($595.00) yearly. The total fiscal impact to the Kansas City International Airport Police for renewals is six thousand two hundred five dollars ($6205.00) per year. The Kansas City International Airport Police also pay a company fee of three hundred dollars ($300.00) per year under the Proposed Rules for a total fiscal impact of six thousand five hundred five dollars ($6505.00) per year. A range fee is assessed to the Kansas City International Airport Police's armed licensees in the amount of one hundred dollars ($100.00) per armed licensee. This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying public (and private) fiscal notes.

The Housing Authority of Kansas City, Missouri will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of each of its armed licenses (7) for a cost of seven hundred seventy dollars ($770.00) yearly. The Housing Authority of Kansas City, Missouri also pays a company fee of three hundred dollars ($300.00) per year under the Proposed Rules for a total fiscal impact of one thousand seventy dollars ($1070.00) per year. A range fee is assessed to the Housing Authority of Kansas City, Missouri's armed licensees in the amount of one hundred dollars ($100.00) per licensee for a total of seven hundred dollars ($700.00). This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying public (and private) fiscal notes.

IV. ASSUMPTIONS

This rule requires that those providing security services be licensed as either armed or unarmed security officers. Other fees assessed are provided for in other sections of this chapter and the fiscal impact of those fees will be outlined in the fiscal notes prepared for those sections. These figures assume that the agencies will renew the licenses of all those currently licensed and will not switch the classifications of the persons they are licensing, i.e., from unarmed to armed or vice versa. These figures also assume that the agencies pay the license fees for those they license, rather than the individual paying the fees themselves. These cost calculations take into account only yearly renewal fees for existing licensees. If the entities license additional persons, additional costs for new

licenses will be incurred in the amounts set out above for new licenses and for the State/NCIC/FBI fingerprinting fee discussed in 17 CSR 2.040.

FISCAL NOTE
PRIVATE COST

I. Department Title: 17
Division Title: 10
Chapter Title: 2

Rule Number and Title:	17 CSR 10-2.010 – Regulation and Licensing in General
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
802	**Armed Licensees**	**$88,220.00**
508[1]	**New Armed Licenses**	**$83,820.00**
1336	**Unarmed licensees**	**$113,560.00**
2853[2]	**New Unarmed Licenses**	**$313,830.00**
170[3]	**Firms, companies, partnerships and corporations[4] Licenses**	**$51,000.00**

[1] This is Board's estimate of how many new persons wanting armed licenses will apply in the next year. This estimate will be used throughout these Fiscal Notes.
[2] This is Board's estimate of how many new persons wanting unarmed licenses will apply in the next year. This estimate will be used throughout these Fiscal Notes.
[3] This is the approximate number of companies currently licensed.
[4] Throughout these fiscal notes, the firms, companies, partnerships and corporations which hold licenses are referred to as "companies" and the licenses they hold as "company licenses." Board recognizes that the "companies" are actually organized in various forms under the law. The references to "company" and "company license" are made for ease of reference.

26[5]	**New Company Licenses**	**$10,400.00**
Total		**$660,830.00**

III. WORKSHEET

The fee for a new armed license is one hundred sixty-five dollars ($165.00) per year. The fee for new unarmed licenses is one hundred ten dollars ($110.00) per year. The yearly renewal fee for armed licenses is one hundred ten dollars ($110.00) per year. The yearly renewal fee for unarmed licensees is eighty-five dollars ($85.00).

In order to assess the fiscal impact to the individuals acquiring new armed licenses, an estimate of the number of new armed licensees, five hundred eight (508) must be multiplied by the fee amount ($165.00) for armed licenses for a total fiscal impact of $83,820.00. In order to determine the fiscal impact to individuals acquiring new unarmed licenses, an estimate of the number of new unarmed licensees, 2853, must be multiplied by the fee amount ($110.00) for unarmed licenses for a total fiscal impact of $313,830.00.

Currently approximately 802 persons hold armed licenses. With the renewal fee of one hundred ten dollars ($110.00), the fiscal impact to armed licensees is $88,220.00. Currently approximately 1336 persons hold unarmed licenses. With the renewal fee of eighty-five dollars ($85.00), the total fiscal impact to unarmed licensees is $113,560.00.

All firms, companies, partnerships and corporations licensed will pay a company renewal fee in the amount of three hundred dollars ($300.00) per year. The number of companies holding licenses (170) was multiplied by the company fee ($300.00) in order to assess the fiscal impact to the current companies holding licenses in the amount of $51,000.00. Approximately 26 new companies will obtain new licenses during the year. Each will pay the new company license fee of $400.00 for a total fiscal impact of $10,400.00.

IV. ASSUMPTIONS

These figures make assumptions about the number of new armed, unarmed and company licenses that will be issued each year. They also assume that every individual currently licensed will renew their licenses and that companies will not increase the number of security officers which they are currently licensing nor switch the classifications of the persons they are licensing, i.e., from armed to unarmed or vice versa. These figures also assume that companies pay the license fees for those they license, rather than the individual licensees paying themselves. In fact, Board is aware that some companies pay a portion of the licensing fees for their employees and the employees pay the balance. Board keeps no record of how the various companies operate and how they pay their fees. Therefore the actual cost to these companies cannot be assessed, and it must be assumed

[5] This is the number of new companies which Board anticipates will apply for a license in the next year. This estimate will be used throughout these fiscal notes.

that for purposes of this fiscal note that the companies pay the entire fee for the individuals holding licenses with the company.

For a discussion of the full fiscal impact of requiring individuals and companies to be licensed, see Private Entity Fiscal Note for 17 CSR 10-2.040.

TITLE 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RESCISSION

17 CSR 10-2.020 Application for a License. This rule, in order to promote and protect the public welfare, required the board to investigate the background, qualifications and ability of all applicants and required that applicants use application forms provided by the board.

PURPOSE: The board wishes to rescind this rule and adopt a new rule in its place to clarify the language in the rule and ensure compliance with the applicable law.

*AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the **Code of State Regulations**. Rescinded: Oct. 20, 2023.*

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 Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RULE

17 CSR 10-2.020 Application for a License

PURPOSE: In order to promote and protect the public welfare, the Board of Police Commissioners (board) shall license and regulate those persons wishing to provide private security services or proprietary private investigative services. Application forms provided by the board shall be used by all applicants. All forms may be downloaded at www.kcpd.org.

(1) All individual applicants are required to complete an "Employer's Application for Employment of Private Security/Proprietary Private Investigator 'Intent to Hire Form'" (Form 5409 P.D.). This form must be completed any time a license is applied for, renewed, transferred, or upgraded. Armed licensees may not work unarmed without submitting a new Form 5409 P.D. and obtaining an unarmed license. All firms, companies, partnerships, corporations, sole proprietorships, and political subdivisions to be licensed under the provisions of section (5) below shall complete "Application for Company License" (Form 5486 P.D.)

(2) The board shall conduct a criminal history records check of each applicant and may conduct investigations as provided by section 84.720, RSMo. The applicant must pay the fee for the criminal history records check and fingerprinting at the time of application and upon each annual renewal. All licenses granted by the board as set out herein may be temporary until the completion of the applicant's criminal history records check. Armed licenses will not be issued until the criminal history records check results are received by the Private Officers Licensing Unit (POLU).

(3) Each applicant shall submit to photographing and fingerprinting and shall provide proof of identity by submitting with the application a photo identification card, original Social Security card, proof of citizenship, permanent resident card, Military DD214/discharge papers, most recent name change documentation from a court of competent jurisdiction, or other equivalent identification. If an applicant provides proof of identity by submitting permanent resident card, the applicant must provide sufficient proof that they have established a *bona fide* residence in the United States of America. If an applicant requests a replacement license because of a name change, the applicant must supply to the POLU the appropriate name change documentation from a court of competent jurisdiction.

(4) Each applicant shall provide any additional information requested by the board to conduct its investigation and shall comply with all requests of the board in the conduct of its investigation for a license under these rules, including without limitation execution of a release allowing the board to review personnel records from prior employers.

(5) Firms, companies, partnerships, corporations, sole proprietorships, or political subdivisions engaging in the business of providing private security services or proprietary private investigative services or firms, companies, partnerships, corporations, sole proprietorships, or political subdivisions that employ other individuals to perform private security services or proprietary private investigative services shall be licensed in addition to any individual license required under these rules. An applicant wishing to obtain a company license for the sole purpose of employing proprietary private investigators must meet the guidelines outlined in 17 CSR 10-2.050(1)(C). Any license granted under this section shall be designated a "company license." All company names must be approved by POLU. All licensed companies are required to annually pay a company fee by January 31 of each year and are required to comply with the terms of this regulation and all federal, state, and local laws. Failure to pay such fee will result in the company license expiring. In the absence of the annual company license, all licenses granted to employees or agents of that company are deemed to be inactive.

(6) Before being licensed under these rules, company applicants shall file with the board a certificate of liability insurance in the amount of one (1) million dollars or the equivalent, naming the board as an additional insured and certificate holder and protecting the board from liability judgments, suits, and claims, including but not limited to suits for bodily injury, personal injury, including false arrest, libel, slander, invasion of privacy, and property damage arising out of the licensing of individuals and entities providing private security services or proprietary private investigative services. Equivalent shall mean a bond in like amount or a certificate of self-insurance by a company with audited net worth of five (5)

million dollars. The insurance must be written by a company approved by the Missouri superintendent of insurance and approved by the board with respect to its form, manner of execution, and sufficiency, provided further, however, before a license is issued to a nonresident of Missouri, the applicant must file with the Missouri Secretary of State a written consent for jurisdiction of the courts of Missouri, and any case(s) arising from any contract for performance of private security services or proprietary private investigative services made within the city are to be performed wholly or in part, in the city or in any way connected with the business within the city or occurring in connection with the business of the one licensed within the city. Any company licensed must provide the insurance specified and cover all employees; provided, however, that in the event a suit is filed or claim is made involving the board, the company shall immediately notify the board at which time the licensee may be required to furnish additional insurance. Failure of a licensee to maintain insurance is grounds for revocation of the company license. In the absence of adequate insurance, all licenses granted to employees or agents of that company will receive notice that they need to transfer their license to a company in good-standing immediately. Each certificate of insurance must stipulate coverage for armed/unarmed personnel as appropriate. The naming of the board as an additional insured in no way constitutes or should be construed as a waiver or limitation of the board's rights or defenses with regard to sovereign immunity, governmental immunity, official immunities, and/or any of the protections provided under federal and state constitutions or by law.

(7) When, in the opinion of the board, an applicant has fulfilled the requirements of these rules, the board may issue the applicant a license to provide private security services or proprietary private investigative services.

(8) All those licensed under these rules shall immediately notify the board in writing of any change of address or employment; a company shall notify the board in writing of the termination of employment of any person listed on the company application or any licensed employee and notify the board as to whether or not the individual's license has been returned to the company.

(9) Licenses, issued under these rules, are not transferable or assignable. When any person's license has been terminated, suspended, revoked, or has expired, the license shall be mailed or delivered to the POLU. If the license is lost or stolen, the license holder shall immediately notify POLU and provide a lost card affidavit signed by a company representative. An additional fee and a new Form 5409 P.D. are required. If the license has been stolen, a police report listing the license may be accepted in lieu of the additional fee. Any person licensed under these rules may hold a maximum of three (3) licenses.

(10) All those licensed will be required to furnish a photograph and description of all vehicles to be used in the course of their business, including state license numbers, vehicle identification numbers, and provide proof of adequate automobile liability insurance coverage in accordance with the requirements established by the state of Missouri. All vehicles must clearly state that the vehicle is a security vehicle and display the company name. Use of any sign, signal, or other device contrary to the ordinance of the city, or which is similar in appearance to those used by the department is prohibited and may be grounds for denial, suspension, or revocation of a license. No private security company, proprietary private investigative company, or individual is authorized to operate any emergency vehicle as that term is defined by state law or city ordinance, other than Airport Police and Park Rangers. No vehicle displaying the word "police" shall be approved for use except as set out in 17 CSR 10-2.030(1)(A)4.

(11) All licenses shall expire one (1) year from the date of initial issuance. For licenses renewed after their expiration date, the licensee will be processed as a new applicant.

AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the ***Code of State Regulations****. Rescinded and readopted: Filed Oct. 20, 2023.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions twelve thousand fifteen dollars ($12,015) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities one million six hundred forty thousand eight hundred thirty dollars ($1,640,830) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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: 17
Division Title: 10
Chapter Title: 2

Rule Number and Name:	17 CSR 10-2.020 – Application for a License
Type of Rulemaking:	Proposed Rulemaking

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
City of Kansas City, Missouri	**$3800.00**
Jackson County, Missouri Family Court	**$640.00**
Kansas City International Airport Police	**$6505.00**
Housing Authority of Kansas City, Missouri	**$1070.00**
Total	**$12,015.00**

III. WORKSHEET

The rates for new armed licenses will be one hundred sixty-five dollars ($165.00) per year. The rate for new unarmed licenses will be one hundred ten dollars ($110.00) per year.

The yearly renewal fees for armed licenses will be one hundred ten dollars ($110.00) per year. The yearly renewal fees for unarmed licensees will be eighty-five dollars ($85.00) per year. The number of current licensees in each category was multiplied by the corresponding renewal fees charged in order to assess the fiscal impact to the current licensees.

The City of Kansas City, Missouri licenses four (4) armed security officers and thirty-six (36) unarmed security officers. The City of Kansas City, Missouri will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of armed licenses (4) for a cost of four hundred forty dollars ($440.00) yearly. The City of Kansas City, Missouri will renew thirty-six (36) unarmed licenses. Each renewal is eighty-five dollars ($85.00) per licensee for a total cost of three thousand sixty dollars ($3060.00). A company fee in the amount of three hundred dollars ($300.00) is paid by the City of Kansas City, Missouri. The total fiscal impact to the City of Kansas City, Missouri is three thousand eight hundred dollars ($3800.00) per year. A range fee is assessed to the City of Kansas City, Missouri's armed licensees in the amount of one hundred dollars ($100.00) per licensee.

This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying fiscal notes.

Jackson County, Missouri Family Court will incur costs of eighty-five dollars ($85.00) per renewal of each of its unarmed licenses (4) for a cost of three hundred forty dollars ($340.00) yearly. A company fee in the amount of three hundred dollars ($300.00) is paid by the Jackson County, Missouri Family Court. The total fiscal impact to Jackson County, Missouri is six hundred forty dollars ($640.00) per year.

It is estimated that the Kansas City International Airport Police will license sixteen (16) new armed officers and will license (3) new unarmed officers per year. The Kansas City International Airport Police will incur costs in the amount of one hundred sixty-five dollars ($165.00) for each new armed licensee estimated to be 16 licensees for a cost of two thousand six hundred forty dollars ($2640.00) per year. The Kansas City International Airport Police will incur costs in the amount of one hundred ten dollars ($110.00) for each new unarmed licensee estimated to be 3 licensees for a cost of three hundred thirty dollars ($330.00) per year. The Kansas City International Airport Police will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of each of its armed licenses (24) for a cost of two thousand six hundred forty dollars ($2640.00) yearly. The Kansas City International Airport Police will incur costs in the amount of eighty-five dollars ($85.00) per renewal of each of its unarmed licenses (7) for a cost of five hundred ninety-five dollars ($595.00) yearly. The total fiscal impact to the Kansas City International Airport Police for renewals is six thousand two hundred five dollars ($6205.00) per year. The Kansas City International Airport Police also pay a company fee of three hundred dollars ($300.00) per year under the Proposed Rules for a total fiscal impact of six thousand five hundred five dollars ($6505.00) per year. A range fee is assessed to the Kansas City International Airport Police's armed licensees in the amount of one hundred dollars ($100.00) per armed licensee. This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying fiscal notes.

The Housing Authority of Kansas City, Missouri will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of each of its armed licenses (7) for a cost of seven hundred seventy dollars ($770.00) yearly. The Housing Authority of Kansas City, Missouri also pays a company fee of three hundred dollars ($300.00) per year under the Proposed Rules for a total fiscal impact of one thousand seventy dollars ($1070.00) per year. A range fee is assessed to the Housing Authority of Kansas City, Missouri's armed licensees in the amount of one hundred dollars ($100.00) per licensee for a total of seven hundred dollars ($700.00). This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying fiscal notes.

None of these public entities are required to pay any monies for liability insurance as they are self-insured governmental entities.

IV. ASSUMPTIONS

This rule requires that those providing security services be licensed as either armed or unarmed security officers. Other fees assessed are provided for in other sections of this chapter and the fiscal impact of those fees will be outlined in the fiscal notes prepared for those sections. These figures assume that the agencies will renew the licenses of all those currently licensed and will not switch the classifications of the persons they are licensing, i.e., from unarmed to armed or vice versa. These figures also assume that the agencies

pay the license fees for those they license, rather than the individual paying the fees themselves. These cost calculations take into account only yearly renewal fees for existing licensees. If the entities license additional persons, additional costs for new licenses will be incurred in the amounts set out above for new licenses and for the State/NCIC/FBI fingerprinting fee discussed in 17 CSR 2.040.

FISCAL NOTE
PRIVATE COST

I. Department Title: 17
Division Title: 10
Chapter Title: 2

Rule Number and Title:	17 CSR 10-2.020 – Application for a License
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
802	**Armed Licensees**	**$88,220.00**
508	**New Armed Licenses**	**$83,820.00**
1336	**Unarmed Licensees**	**$113,560.00**
2853	**New Unarmed Licenses**	**$313,830.00**
170[1]	**Firms, companies, partnerships and corporations[2] Licenses**	**$51,000.00**
26	**New Company Licenses**	**$10,400.00**
170	**Company Insurance cost**	**$850,000.00**

[1] This is the approximate number of companies currently licensed.
[2] Throughout these fiscal notes, the firms, companies, partnerships and corporations which hold licenses are referred to as "companies" and the licenses they hold as "company licenses." Board recognizes that the "companies" are actually organized in various forms under the law. The references to "company" and "company license" are made for ease of reference.

26	**New Company Insurance cost**	**$130,000.00**
Total		**$1,640,830.00**

III. WORKSHEET

The fee for a new armed license is one hundred sixty-five dollars ($165.00) per year. The fee for new unarmed licenses is one hundred ten dollars ($110.00) per year. The yearly renewal fee for armed licenses is one hundred ten dollars ($110.00) per year. The yearly renewal fee for unarmed licensees is eighty-five dollars ($85.00).

In order to assess the fiscal impact to the individuals acquiring new armed licenses, an estimate of the number of new armed licensees, five hundred eight (508) must be multiplied by the fee amount ($165.00) for armed licenses for a total fiscal impact of $83,820.00. In order to determine the fiscal impact to individuals acquiring new unarmed licenses, an estimate of the number of new unarmed licensees, 2853, must be multiplied by the fee amount ($110.00) for unarmed licenses for a total fiscal impact of $313,830.00.

Currently approximately 802 persons hold armed licenses. With the renewal fee of one hundred ten dollars ($110.00), the fiscal impact to armed licensees is $88,220.00. Currently approximately 1336 persons hold unarmed licenses. With the renewal fee of eighty-five dollars ($85.00), the total fiscal impact to unarmed licensees is $113,560.00.

All firms, companies, partnerships and corporations licensed will pay a company renewal fee in the amount of three hundred dollars ($300.00) per year. The number of companies holding licenses (170) was multiplied by the company fee ($300.00) in order to assess the fiscal impact to the current companies holding licenses in the amount of $51,000.00. Approximately 26 new companies will obtain new licenses during the year. Each will pay the new company license fee of $400.00 for a total fiscal impact of $10,400.00.

There are currently approximately one hundred and sixty-nine (170) companies licensed by Board. Each company is required to carry a certificate of liability insurance in the amount of one million dollars ($1,000,000.00) or the equivalent naming Board as an additional insured and certificate holder. The equivalent means a bond in like amount or a self-insurance certificate if the company has an audited net worth of five million dollars ($5,000,000.00). Using the figure of five thousand dollars ($5,000.00) per year per company, the resulting fiscal impact to the 170 companies currently holding licenses would be eight hundred fifty thousand dollars ($850,000.00). Assuming twenty-six (26) new companies apply for licenses in the next year, the resulting fiscal impact to those entities would be one hundred thirty thousand dollars ($130,000.00).

IV. ASSUMPTIONS

These figures make assumptions about the number of new armed, unarmed and company licenses that will be issued each year. They also assume that every individual currently licensed will renew their licenses and that companies will not increase the number of security officers which they are currently licensing nor switch the classifications of the

persons they are licensing, i.e., from armed to unarmed or vice versa. These figures also assume that companies pay the license fees for those they license, rather than the individual licensees paying themselves. In fact, Board is aware that some companies pay a portion of the licensing fees for their employees and the employees pay the balance. Board keeps no record of how the various companies operate and how they pay their fees. Therefore the actual cost to these companies cannot be assessed, and it must be assumed that for purposes of this fiscal note that the companies pay the entire fee for the individuals holding licenses with the company.

Board is unable to exactly calculate the fiscal impact of this insurance requirement to the companies licensed. The cost of insurance varies depending on the insurance company's loss experience with the insured, the company's payroll, whether the company employs armed or unarmed security officers, the nature and location of their business and many other factors which cannot be precisely calculated by Board. Based on information available to Board, it appears that on average the insurance cost to a company, firm or corporation is approximately five thousand dollars ($5000.00) per year. That figure was used to calculate the fiscal impact of this rule.

For a discussion of the fiscal impact of requiring private entities to purchase a company license, see Private Entity Fiscal Note for 17 CSR 10-2.010 and 17 CSR 10-2.040.

For a discussion of the fiscal impact of requiring a fingerprinting fee for new licensees to obtain a background check, see Private Entity Fiscal Note for 17 CSR 10-2.040.

TITLE 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RESCISSION

17 CSR 10-2.030 Classification of Licenses. This rule established minimum qualification standards and classification of licenses related to specific private security services provided by the board.

PURPOSE: The board wishes to rescind this rule and adopt a new rule in its place to clarify the language in the rule and ensure compliance with the applicable law.

*AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the **Code of State Regulations**. Rescinded: Filed Oct. 20, 2023.*

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 Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RULE

17 CSR 10-2.030 Classification of Licenses

PURPOSE: This rule establishes minimum standards and classification of licenses related to specific private security services or proprietary private investigative services provided.

(1) Individual licenses to provide private security services or proprietary private investigative services granted pursuant to this chapter shall be classified as either Class A licenses or Class B licenses.

(A) Class A licensees shall have the authority to detain or apprehend suspects either committing felonies, misdemeanors, or city ordinance violations in the presence of the licensee or during the attempt to commit the same or upon probable cause to believe an offense was committed; provided, however, the authority is limited to the private property the licensee is hired to protect during the hours s/he is hired to protect said private property and is not to extend to the public streets of the city. No vehicle pursuits are allowed except as specifically authorized in 17 CSR 10-2.030(1)(A)4. Class A licenses may be further classified pursuant to the following titles, designations, and authorities:

1. Loss prevention agent – Unarmed, nonuniformed position whose duties include but are not limited to being responsible to observe, investigate, apprehend, and prosecute shoplifters, investigate fraudulent checks, internal thefts, and the like. This individual is employed to prevent theft by unobtrusive, alert skills;

2. Patrol agent – Armed or unarmed, uniformed position delegated all the responsibility of a guard with the authority to react to illegal action by apprehension or detention. They are normally assigned to a particular designated post to protect persons and property. This individual may also be responsible for proactive policing of the persons or property they are hired to protect. These responsibilities include but are not limited to foot patrol, response to alarms, self-initiated activity such as car and pedestrian checks on designated private property, investigations, apprehension, detention, or guarding and transporting of persons, property or suspects, and assisting in prosecution;

3. Proprietary private investigator – An armed or unarmed, nonuniformed person employed exclusively and regularly by one (1) employer in connection with the affairs of that employer and where there exists an employer-employee relationship, responsible for investigations which impact that employer. The qualifications for this classification are set out in 17 CSR 10-2.050(1)(C);

4. Airport police – Armed and uniformed position responsible for patrolling the property designated as the Kansas City International Airport and the Charles B. Wheeler Downtown Airport who are granted special permission to be known as the Kansas City International Airport Police. These officers are exempt from the provisions of 17 CSR 10-2.050(6). Airport police personnel shall be required to have a Class A license. Officers with licenses pursuant to this subclassification have the following authority, in addition to those created by the Class A license. The Class A license that has the airport police designation shall have authority to enforce city ordinance and state statute violations upon the public streets of the city, but only upon the streets within the property boundaries of the Kansas City International Airport and the Charles B. Wheeler Downtown Airport. The Class A license that has the designation unarmed, uniformed "traffic control officer" shall have the authority to control traffic and issue citations for parking violations, but only upon the streets within the property boundaries of the Kansas City International Airport and the Charles B. Wheeler Downtown Airport. This section grants no authority to engage in a vehicle pursuit on streets not within the property boundaries of the Kansas City International Airport or the Charles B. Wheeler Downtown Airport; and

5. Park Rangers – Armed or unarmed uniformed position responsible for providing security for the City of Kansas City, Missouri parks and park property, which is granted special permission to be known as the park rangers. Park rangers shall be required to have a Class A license. Officers with licenses pursuant to this subclassification have the following authority, in addition to those created by the Class A license. The Class A license that has the park ranger designation shall have authority to enforce specific agreed-upon city ordinance violations exclusively upon park property. This section grants no authority to engage in a vehicle pursuit on roadways that are not park property.

(B) Class B licenses shall not grant the authority for the licensees to detain or apprehend suspects. An applicant shall designate the particular subclassification listed in this subsection when applying for a Class B license. An applicant

must make a separate application when applying for a Class B license designating more than one (1) subclassification of authority. The license identification issued by the Board of Police Commissioners of Kansas City, Missouri (the board) shall designate which subcategory of a Class B license has been granted.

1. Guard – A guard is an unarmed, uniformed position with primary responsibilities that include but are not limited to watching and reporting on/or in a specific premises or designated area, escorting or guiding, controlling crowds, giving directions, monitoring camera systems, controlling access, and offering assistance for the safety of others. The guard has no authority to detain or apprehend a person suspected of committing a crime.

2. Armed courier – An armed, uniformed position with primarily responsibilities that include but are not limited to protecting and transporting of money and other valuables from one (1) designated area to another. This licensee has the authority to conduct private security services on the public streets of the city, but this authority is limited to protecting property from activities which would impact the property protected. The courier must meet the qualifications relating to authority to carry a firearm, as set out in this chapter.

3. Proprietary private investigator – An armed or unarmed, nonuniformed person employed exclusively and regularly by one (1) employer in connection with the affairs of that employer and where there exists an employer-employee relationship, responsible for investigations which impact that employer. The qualifications for this classification are set out in 17 CSR 10-2.050(1)(C).

4. Reciprocal license – A special category Class B unarmed license may be granted for single date events. The license may be issued with only a criminal records check and certification by the applicant that he/she understands the limits of their authority.

AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5. 1979, effective March 17, 1980. For intervening history, please consult the ***Code of State Regulations****. Rescinded and readopted: Filed Oct. 20, 2023.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions twelve thousand fifteen dollars ($12,015) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities six hundred sixty thousand eight hundred thirty dollars ($660,830) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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: 17
Division Title: 10
Chapter Title: 2

Rule Number and Name:	17 CSR 10-2.030 – Classification of Licenses
Type of Rulemaking:	Proposed Rulemaking

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
City of Kansas City, Missouri	**$3800.00**
Jackson County, Missouri Family Court	**$640.00**
Kansas City International Airport Police	**$6505.00**
Housing Authority of Kansas City, Missouri	**$1070.00**
Total	**$12,015.00**

III. WORKSHEET

The rates for new armed licenses will be one hundred sixty-five dollars ($165.00) per year. The rate for new unarmed licenses will be one hundred ten dollars ($110.00) per year.

The yearly renewal fees for armed licenses will be one hundred ten dollars ($110.00) per year. The yearly renewal fees for unarmed licensees will be eighty-five dollars ($85.00) per year. The number of current licensees in each category was multiplied by the corresponding renewal fees charged in order to assess the fiscal impact to the current licensees.

The City of Kansas City, Missouri licenses four (4) armed security officers and thirty-six (36) unarmed security officers. The City of Kansas City, Missouri will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of armed licenses (4) for a cost of four hundred forty dollars ($440.00) yearly. The City of Kansas City, Missouri will renew thirty-six (36) unarmed licenses. Each renewal is eighty-five dollars ($85.00) per licensee for a total cost of three thousand sixty dollars ($3060.00). A company fee in the amount of three hundred dollars ($300.00) is paid by the City of Kansas City, Missouri. The total fiscal impact to the City of Kansas City, Missouri is three thousand eight hundred dollars ($3800.00) per year. A range fee is assessed to the City of Kansas City, Missouri's armed licensees in the amount of one hundred dollars ($100.00) per licensee. This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying public (and private) fiscal notes.

Jackson County, Missouri Family Court will incur costs of eighty-five dollars ($85.00) per renewal of each of its unarmed licenses (4) for a cost of three hundred forty dollars ($340.00) yearly. A company fee in the amount of three hundred dollars ($300.00) is paid by the Jackson County, Missouri Family Court. The total fiscal impact to Jackson County, Missouri is six hundred forty dollars ($640.00) per year.

It is estimated that the Kansas City International Airport Police will license sixteen (16) new armed officers and will license (3) new unarmed officers per year. The Kansas City International Airport Police will incur costs in the amount of one hundred sixty-five dollars ($165.00) for each new armed licensee estimated to be 16 licensees for a cost of two thousand six hundred forty dollars ($2640.00) per year. The Kansas City International Airport Police will incur costs in the amount of one hundred ten dollars ($110.00) for each new unarmed licensee estimated to be 3 licensees for a cost of three hundred thirty dollars ($330.00) per year. The Kansas City International Airport Police will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of each of its armed licenses (24) for a cost of two thousand six hundred forty dollars ($2640.00) yearly. The Kansas City International Airport Police will incur costs in the amount of eighty-five dollars ($85.00) per renewal of each of its unarmed licenses (7) for a cost of five hundred ninety-five dollars ($595.00) yearly. The total fiscal impact to the Kansas City International Airport Police for renewals is six thousand two hundred five dollars ($6205.00) per year. The Kansas City International Airport Police also pay a company fee of three hundred dollars ($300.00) per year under the Proposed Rules for a total fiscal impact of six thousand five hundred five dollars ($6505.00) per year. A range fee is assessed to the Kansas City International Airport Police's armed licensees in the amount of one hundred dollars ($100.00) per armed licensee. This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying public (and private) fiscal notes.

The Housing Authority of Kansas City, Missouri will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of each of its armed licenses (7) for a cost of seven hundred seventy dollars ($770.00) yearly. The Housing Authority of Kansas City, Missouri also pays a company fee of three hundred dollars ($300.00) per year under the Proposed Rules for a total fiscal impact of one thousand seventy dollars ($1070.00) per year. A range fee is assessed to the Housing Authority of Kansas City, Missouri's armed licensees in the amount of one hundred dollars ($100.00) per licensee for a total of seven hundred dollars ($700.00). This fee is discussed in 17 CSR 10-2.040 and 17 CSR 10-2.050 and the accompanying public (and private) fiscal notes.

IV. ASSUMPTIONS

This rule requires that those providing security services be licensed as either armed or unarmed security officers. Other fees assessed are provided for in other sections of this chapter and the fiscal impact of those fees will be outlined in the fiscal notes prepared for those sections. These figures assume that the agencies will renew the licenses of all those currently licensed and will not switch the classifications of the persons they are licensing, i.e., from unarmed to armed or vice versa. These figures also assume that the agencies pay the license fees for those they license, rather than the individual paying the fees themselves. These cost calculations take into account only yearly renewal fees for existing licensees. If the entities license additional persons, additional costs for new licenses will be incurred in the amounts set out above for new licenses and for the State/NCIC/FBI fingerprinting fee discussed in 17 CSR 2.040.

FISCAL NOTE
PRIVATE COST

I. Department Title: 17
Division Title: 10
Chapter Title: 2

Rule Number and Title:	17 CSR 10-2.030 – Classification of Licenses
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
802	**Armed Licensees**	**$88,220.00**
508[1]	**New Armed Licenses**	**$83,820.00**
1336	**Unarmed licensees**	**$113,560.00**
2853[2]	**New Unarmed Licenses**	**$313,830.00**
170[3]	**Firms, companies, partnerships and corporations**[4]	**$51,000.00**

[1] This is Board's estimate of how many new persons wanting armed licenses will apply in the next year. This estimate will be used throughout these Fiscal Notes.
[2] This is Board's estimate of how many new persons wanting unarmed licenses will apply in the next year. This estimate will be used throughout these Fiscal Notes.
[3] This is the approximate number of companies currently licensed.
[4] Throughout these fiscal notes, the firms, companies, partnerships and corporations which hold licenses are referred to as "companies" and the licenses they hold as "company licenses." Board recognizes that the "companies" are actually organized in various forms under the law. The references to "company" and "company license" are made for ease of reference.

26[5]	**New Company Licenses**	**$10,400.00**
Total		**$660,830.00**

III. WORKSHEET

The fee for a new armed license is one hundred sixty-five dollars ($165.00) per year. The fee for new unarmed licenses is one hundred ten dollars ($110.00) per year. The yearly renewal fee for armed licenses is one hundred ten dollars ($110.00) per year. The yearly renewal fee for unarmed licensees is eighty-five dollars ($85.00).

In order to assess the fiscal impact to the individuals acquiring new armed licenses, an estimate of the number of new armed licensees, five hundred eight (508) must be multiplied by the fee amount ($165.00) for armed licenses for a total fiscal impact of $83,820.00. In order to determine the fiscal impact to individuals acquiring new unarmed licenses, an estimate of the number of new unarmed licensees, 2853, must be multiplied by the fee amount ($110.00) for unarmed licenses for a total fiscal impact of $313,830.00.

Currently approximately 802 persons hold armed licenses. With the renewal fee of one hundred ten dollars ($110.00), the fiscal impact to armed licensees is $88,220.00. Currently approximately 1336 persons hold unarmed licenses. With the renewal fee of eighty-five dollars ($85.00), the total fiscal impact to unarmed licensees is $113,560.00.

All firms, companies, partnerships and corporations licensed will pay a company renewal fee in the amount of three hundred dollars ($300.00) per year. The number of companies holding licenses (170) was multiplied by the company fee ($300.00) in order to assess the fiscal impact to the current companies holding licenses in the amount of $51,000.00. Approximately 26 new companies will obtain new licenses during the year. Each will pay the new company license fee of $400.00 for a total fiscal impact of $10,400.00.

IV. ASSUMPTIONS

These figures make assumptions about the number of new armed, unarmed and company licenses that will be issued each year. They also assume that every individual currently licensed will renew their licenses and that companies will not increase the number of security officers which they are currently licensing nor switch the classifications of the persons they are licensing, i.e., from armed to unarmed or vice versa. These figures also assume that companies pay the license fees for those they license, rather than the individual licensees paying themselves. In fact, Board is aware that some companies pay a portion of the licensing fees for their employees and the employees pay the balance. Board keeps no record of how the various companies operate and how they pay their fees. Therefore the actual cost to these companies cannot be assessed, and it must be assumed

[5] This is the number of new companies which Board anticipates will apply for a license in the next year. This estimate will be used throughout these fiscal notes.

that for purposes of this fiscal note that the companies pay the entire fee for the individuals holding licenses with the company.

For a discussion of the full fiscal impact of requiring individuals and companies to be licensed, see Private Entity Fiscal Note for 17 CSR 10-2.040.

TITLE 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RESCISSION

17 CSR 10-2.040 Application Forms and Licensing Fees. This rule established a schedule of licensing fees and provided a list of approved forms used by the board to administer its responsibilities in the area of regulation and licensing of private security personnel.

PURPOSE: The board wishes to rescind this rule and adopt a new rule in its place to clarify the language in the rule and ensure compliance with the applicable law.

AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the ***Code of State Regulations****. Rescinded: Filed Oct. 20, 2023.*

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 Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RULE

17 CSR 10-2.040 Application Forms and Licensing Fees

PURPOSE: The Board of Police Commissioners of Kansas City, Missouri (board), in order to administer its responsibilities in the area of regulation and licensing of private security and proprietary private investigative personnel, shall establish a schedule of licensing fees and list of approved forms.

(1) The fees for licensing, renewing, transferring, etc., are as follows:

(A) New Company License	$400.00
(B) Company License Renewal	$300.00
(C) Class A – Armed License	$165.00
(D) Class A – Armed License Renewal	$110.00
(E) Class A – Unarmed License	$110.00
(F) Class A – Unarmed License Renewal	$85.00
(G) Class B – Armed License	$165.00
(H) Class B – Armed License Renewal	$110.00
(I) Class B – Unarmed License	$110.00
(J) Class B – Unarmed License Renewal	$85.00
(K) Replacement of Lost/Stolen License	$85.00
(L) Change of Company Name (up to and including fifteen (15) employees; over fifteen (15) employees, add an additional $10.00 per employee)	$150.00
(M) Change of License Classification	$85.00
(N) Written Test Failure	$85.00
(O) Range Failure (failure to qualify range appointment; handgun)	$100.00
(P) Failure to Attend Range Appointment (handgun)	$125.00
(Q) Weapon Change	$100.00
(R) State/NCIC/FBI Annual Fingerprinting Fee	$50.00
(S) Reinstatement Fee (following suspension/ revocation/expiration)	$85.00
(T) License Transfer	$85.00
(U) Copy Fee	$1.00 per page
(V) Annual Range Fee (Handgun Training and Qualification/ Continuing Education)	$100.00
(W) Annual Range Fee (Rifle Training and Qualification/ Continuing Education)	$200.00

(2) Only cash, credit or debit cards, money orders, cashier's checks, or checks drawn on accounts of licensed companies are accepted in payment of fees. All fees are nonrefundable.

(3) The board will provide forms for applicants to use. All forms may be located at www.kcpd.org.

(A) Form 5001 P.D., "Information for Private Security/Proprietary Investigative Personnel," provides basic information to private security and proprietary private investigative personnel which includes the source of the board's authority to license private security and proprietary private investigative personnel, information on the classifications of licenses, the duties and authority of the various license classifications, information concerning firearms qualification, and scheduling and directions to the police pistol range.

(B) Form 5297 P.D., "Instructions for Licensing a Company to Employ Private Security and Proprietary Private Investigative Personnel," provides instructions for licensing a company to employ private security and proprietary private investigative personnel which includes instructions concerning the required certificate of liability insurance, required documents, fee required, criminal history records check information, lists the private officer license classifications, procedures for monthly invoices, and information concerning the required examination and firearms qualification.

(C) Form 5409 P.D. is the "Employer's Application for Employment of Private Security/Proprietary Private Investigators 'Intent to Hire.'" This form must be presented any time a license is applied for, renewed, or transferred. This is the basic application form for individual licensees which requests the following information: name of business, address, and telephone number; the individual applicant's name, address, telephone number, date of birth; a copy of their state-issued photo ID; a copy of any valid state or city private security license if any and Social Security number; the type of license being applied for; and if armed, the make, model, caliber, and serial number of the firearm the applicant intends to carry. The form must be signed by both the individual applicant and an authorized company representative. No Form 5409 P.D. will be accepted if signed by a person other than the authorized representative designated by the company in writing and on file with the Private Officers Licensing Unit (POLU).

(D) Form 5486 P.D. is the "Application for Company License." This form is the basic application form for companies wishing to regularly work or employ persons to engage in private security or proprietary private investigative businesses in the city of Kansas City, Missouri. It requires the following information: the company's trade name; the company's legal name, its address, its mailing address, and business phone; the principal name of the company and home office address and telephone; whether the company is using a fictitious name and whether that name is registered with the Missouri secretary of state; whether the business is a corporation registered in a state other than Missouri but doing business in Missouri; a copy of the company's registration in Missouri and certificate of good standing from the Missouri secretary of state if appropriate; a description of the company; information concerning whether a license issued by any governmental entity to the company has ever been denied, suspended, or revoked; a description of the uniform along with a photograph which clearly displays the company name and the word security either on the uniform or company patch to be worn by the company's personnel (the POLU will approve in advance all uniforms to be worn by any licensee); the approximate number of persons to be licensed; a list of all company-owned firearms; a list of the names, addresses, and capacities of each of the owners, partners, officers, directors, and associates of the company; a list of the company's contact persons who are authorized to sign and do business with the board; information and proof that the persons listed in the application are U.S. citizens; and the company's federal employment identification number (E.I.N.).

(E) Form 5715 P.D. is the "Verification of Firearms Training" form. This form requires an individual and his/her instructor to certify that the applicant has been trained in the use of the firearm the applicant intends to carry on duty. Information concerning what the training must include appears on the form. The form must be signed by the training instructor and the training instructor's company must be listed. This form must be presented to the POLU prior to the applicant being scheduled for the range.

(F) Form 5636 P.D. is the "Weapons Discharge Report." This form is designed to report information whenever a licensee discharges his/her firearm. Information which must be provided on the form includes the name of the licensee and date the license expires; the licensee's weapon make, model, and serial number; the location of the incident; the time of the incident; the name of the licensee's supervisor and the time they were notified of the discharge; whether the licensee was on-duty and in uniform; whether any fatalities or injuries resulted from the discharge; whether the shooting was accidental or intentional; the case report number in connection with the incident; a narrative description of what transpired; the signature of the licensee along with the licensee's date of birth; and the signature of the company representative along with the company name and address. This form must be received by the POLU within five (5) days of the incident.

(G) Form 5707 P.D. is a "Temporary License Extension" form. It requests the date, the name of the licensee, their date of birth, and their employer's name. This form provides a temporary license to those who have not yet attended their scheduled firearms qualification date.

AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the ***Code of State Regulations****. Rescinded and readopted: Filed Oct. 20, 2023.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions eighteen thousand seven hundred fifteen dollars ($18,715) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities $1,099,588 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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: 17
Division Title: 10
Chapter Title: 2

Rule Number and Name:	17 CSR 10-2.040 – Application Forms and Licensing Fees
Type of Rulemaking:	Proposed Rulemaking

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
City of Kansas City, Missouri	**$4200.00**
Jackson County, Missouri Family Court	**$640.00**
Kansas City International Airport Police	**$12,105.00**
Housing Authority of Kansas City, Missouri	**$1770.00**
Total	**$18,715.00**

III. WORKSHEET

The fee for a new armed license is one hundred sixty-five dollars ($165.00) per year. The fee for new unarmed licenses is one hundred ten dollars ($110.00) per year. The yearly renewal fee for armed licenses is one hundred ten dollars ($110.00) per year. The yearly renewal fee for unarmed licensees is eighty-five dollars ($85.00).

The City of Kansas City, Missouri licenses four (4) armed security officers and thirty-six (36) unarmed officers. Based on past experience, the Kansas City International Airport Police will license 16 new armed officers and will renew twenty-four (24) current armed licenses. In addition, the Kansas City International Airport Police will license three (3) new unarmed officers and renew seven (7) unarmed officers. Jackson County Family Court currently licenses four (4) unarmed officers. The Housing Authority of Kansas City, Missouri currently licenses seven (7) armed officers. The number of current licensees in each category was multiplied by the corresponding renewal fees charged in order to assess the fiscal impact to the current licensees. The City of Kansas City, Missouri, the Jackson County, Missouri Family Court, the Kansas City International Airport Police and the Housing Authority of Kansas City, Missouri pay a company license renewal fee in the amount of three hundred dollars ($300.00) per year.

The City of Kansas City, Missouri licenses four (4) armed security officers and thirty-six (36) unarmed security officers. The City of Kansas City, Missouri will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of armed licenses (4) for a cost

of four hundred forty dollars ($440.00) yearly. The City of Kansas City, Missouri will renew thirty-six (36) unarmed licenses. Each renewal is eighty-five dollars ($85.00) per licensee for a total cost of three thousand sixty dollars ($3060.00). A company fee in the amount of three hundred dollars ($300.00) is paid by the City of Kansas City, Missouri. The total fiscal impact to the City of Kansas City, Missouri is three thousand eight hundred dollars ($3800.00) per year. A range fee is assessed to the City of Kansas City, Missouri's armed licensees in the amount of one hundred dollars ($100.00) per licensee for an additional four hundred dollars ($400.00).

The Kansas City International Airport Police will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of its armed licenses (24) for a cost of two thousand six hundred forty dollars ($2640.00) yearly. In addition, approximately sixteen (16) new armed licensees for a cost of one hundred sixty-five dollars ($165.00) each will be licensed for a total cost of two thousand six hundred forty dollars ($2640.00). Each armed applicant (40) will pay a range fee in the amount of one hundred dollars ($100.00) for an additional four thousand dollars ($4000.00). Eight (8) armed applicants will pay a rifle training fee in the amount of two hundred dollars ($200.00) each for a total of one thousand eight hundred dollars ($1600.00). The Kansas City International Airport Police will incur costs in the amount of one hundred ten dollars ($110.00) for each new unarmed licensee estimated to be 3 licensees for a cost of three hundred thirty dollars ($330.00) per year. The Kansas City International Airport Police will incur costs in the amount of eighty-five dollars ($85.00) per renewal of each of its unarmed licenses (7) for a cost of five hundred ninety-five dollars ($595.00) yearly. The Kansas City International Airport Police also pay a company license renewal fee of three hundred dollars ($300.00) per year under the Proposed Rules. The total fiscal impact for all applicants to the Kansas City International Airport Police is ten thousand five hundred five dollars ($10,505.00).

Jackson County, Missouri Family Court will incur costs of eighty-five dollars ($85.00) per renewal of each of its unarmed licenses (4) for a cost of three hundred forty dollars ($340.00) yearly. The Jackson County, Missouri Family Court will pay a company license renewal fee in the amount of three hundred dollars ($300.00) per year. The total fiscal impact for all licensees is four hundred twenty ($640.00) to the Jackson County, Missouri Family Court.

The Housing Authority of Kansas City, Missouri will incur costs in the amount of one hundred ten dollars ($110.00) per renewal of each of its armed licenses (7) for a cost of seven hundred seventy dollars ($770.00) yearly. The Housing Authority of Kansas City, Missouri also pays a company fee of three hundred dollars ($300.00) per year under the Proposed Rules for a fiscal impact of one thousand seventy dollars ($1070.00) per year. A range fee is assessed to the Housing Authority of Kansas City, Missouri's armed licensees in the amount of one hundred dollars ($100.00) per licensee for a total of seven hundred dollars ($700.00). Total fiscal impact to the Housing Authority of Kansas City, Missouri is one thousand seven hundred dollars ($1770.00).

IV. ASSUMPTIONS

This rule requires that those providing security services be licensed as either armed or unarmed security officers. Other fees assessed are provided for in other sections of this chapter and the fiscal impact of those fees will be outlined in the fiscal notes prepared for those sections. These figures assume that the agencies will renew the licenses of all those currently licensed and will not switch the classifications of the persons they are licensing, i.e., from unarmed to armed or vice versa. These figures also assume that the agencies pay

the license fees for those they license, rather than the individual paying the fees themselves. Board keeps no records of how the various entities operate and how they pay their fees. Therefore, the actual cost to these entities cannot be assessed and it must be assumed that for purposes of this fiscal note that the entities pay the entire fee. These cost calculations take into account yearly renewal fees for existing licensees. If the entities license additional persons, additional costs for new licenses will be incurred in the amounts set out above for new licenses.

This Proposed Rule also sets out the fees for license transfers, dual licenses, change of license classification fees, replacement of lost or stolen licenses, rescheduling fees for the range, weapons changes, late fees, test failure fees, range failure fees, reinstatement fees and copying fees. Because the Board is unable to estimate in advance how many persons will lose their licenses, transfer their licenses, apply for a dual license, etc., the fiscal impact cannot be estimated. Should these fees be assessed, Board would not know whether the public entities or the individual licensees would be paying these fees and therefore, the impact to the entities is uncertain. Historically these public entities have not been assessed these fees.

FISCAL NOTE
PRIVATE COST

I. Department Title: 17
Division Title: 10
Chapter Title: 2

Rule Number and Title:	17 CSR 10-2.040 – Application Forms and License Fees
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
802	**Armed Licensees**	**$88,220.00**
508	**New Armed Licensees**	**$83,820.00**
1336	**Unarmed Licensees**	**$113,560.00**
2853	**New Unarmed Licensees**	**$313,830.00**
170	**Company Licenses**	**$51,000.00**
26	**New Company Licenses**	**$10,400.00**
38	**Replacement of Lost/Stolen License**	**$3230.00**
371	**Change of License Classification**	**$31,535.00**
309	**Written Test Failure**	**$26,265.00**
199	**Range Failure**	**$19,900.00**
80	**Failure to Attend Range Appointment**	**$10,000.00**
6	**Weapon Change**	**$600.00**
3361	**State/NCIC/FBI fee**	**$168,050.00**

24	**Reinstatement Fee**	**$2040.00**
540	**License Transfer Fee**	**$45,900.00**
238	**Copy Fee**	**$238.00**
1310	**Range fee for armed licensees**	**$131,000.00**
Total		**$1,099,588.00**

III. WORKSHEET

The fee for a new armed license is one hundred sixty-five dollars ($165.00) per year. The fee for new unarmed licenses is one hundred ten dollars ($110.00) per year. The yearly renewal fee for armed licenses is one hundred ten dollars ($110.00) per year. The yearly renewal fee for unarmed licensees is eighty-five dollars ($85.00).

Currently approximately 802 persons hold armed licenses. With the renewal fee of one hundred ten dollars ($110.00), the fiscal impact to armed licensees is $88,220.00. The armed applicants will also pay a range fee of one hundred dollars ($100.00). Therefore, the fiscal impact to armed licensees is an additional $80,200.00 for a total fiscal impact of $168,420. Currently approximately 1336 persons hold unarmed licenses. With the renewal fee of eighty-five dollars ($85.00), the total fiscal impact to unarmed licensees is $113,560.00.

In order to assess the fiscal impact to the individuals acquiring new armed licenses, an estimate of the number of new armed licensees, five hundred eight (508) must be multiplied by the fee amount ($165.00) for armed licenses for a fiscal impact of $83,820.00. In addition, each new armed applicant will pay a range fee in the amount of one hundred dollars ($100.00) and an annual fingerprinting fee of fifty dollars ($50.00) for a fiscal impact of $76,200.00. The total fiscal impact to new armed licensees is $160,020.00. In order to determine the fiscal impact to individuals acquiring new unarmed licenses, an estimate of the number of new unarmed licensees, 2853, must be multiplied by the fee amount ($110.00) for unarmed licenses for a fiscal impact of $313,830.00. In addition, each new unarmed licensee will pay an annual fingerprinting fee of fifty dollars ($50.00) for a fiscal impact of $142,650.00. The total fiscal impact to new unarmed licensees is $456,480.00.

All firms, companies, partnerships and corporations licensed will pay a company fee in the amount of three hundred dollars ($300.00) per year. The approximate number of companies holding licenses (170) was multiplied by the new company fee ($300.00) in order to assess the fiscal impact to the current companies holding licenses in the amount of $51,000.00. Approximately 26 new companies will obtain new licenses during the year. Each will pay the company license fee of $400.00 for a total fiscal impact of $10,400.00.

Board has instituted a fee for those licensees who lose or have their licenses stolen in the amount of eighty-five dollars ($85.00) to cover Board's costs in reissuing a license.

Board estimates that approximately thirty-eight (38) licensees will lose or have their licenses stolen based on historical information. The total fiscal impact to companies or licensees is three thousand two hundred thirty dollars ($3230.00).

Board has instituted a fee for those licensees who wish to change their license classification (for example, from Class B to Class A or armed to unarmed) in the amount money when making changes to their existing licenses. Board estimates that approximately three hundred seventy-one (371) licensees will apply to change their license classification based on historical information at a cost of eighty-five dollars ($85.00) per change. The total fiscal impact to companies or licensees is thirty-one thousand five hundred thirty-five dollars ($31,535.00).

Board has instituted a fee for those licensees who fail to pass the written test administered to all licensees in the amount of eighty-five dollars ($85.00) to cover Board's costs in re-administering the test. Board estimates that approximately three hundred nine (309) applicants will fail the written test based on historical information. The total fiscal impact to companies or licensees is twenty-six thousand two hundred sixty-five dollars ($26,265.00).

Board has instituted a fee for those armed licensees who fail to qualify with their firearm at the range in the amount of one hundred dollars ($100.00) to cover Board's costs in re-administering the qualification test. Board estimates that approximately one hundred ninety-nine (199) armed licensees will fail to qualify at the range based on historical information. The total fiscal impact to companies or licensees is seven thousand one hundred twenty dollars ($19,900.00).

Board is instituting a fee for those armed licensees who fail to attend their scheduled range qualification in the amount of one hundred twenty-five dollars ($125.00) to cover Board's costs in re-scheduling the qualification test. Board estimates that approximately eighty (80) armed licensees will fail to attend their range qualification based on historical information. The total fiscal impact to companies or licensees is ten thousand dollars ($10,000.00).

Board has instituted a weapon change fee for armed licensees in the amount of one hundred dollars ($100.00), however historically only six (6) persons per year have changed to a different weapon so the fiscal impact is minimal and is in the amount of $600.00.

Board assesses a fee for all new applicants in order to fingerprint them for a criminal background check through the State of Missouri/National Crime Information Center/ Federal Bureau of Investigation (State/NCIC/FBI) in the amount of fifty dollars ($50.00). Board estimates there will be 508 new armed applicants who will pay the fee for a fiscal impact of twenty-five thousand four hundred dollars ($25,400.00). Board estimates there will be 2853 new unarmed applicants who will require fingerprinting for a fiscal impact of one hundred forty-two thousand six hundred fifty dollars ($142,650.00). The total fiscal impact to all new applicants due to the fingerprinting fee for the State/NCIC/FBI background check is one hundred sixty-eight thousand and fifty dollars ($168,050.00).

Board has instituted a reinstatement fee for licensees who have had their licenses suspended or revoked for a violation of Board's rules in the amount of eighty-five dollars ($85.00), however historically only approximately twenty-four (24) persons per year have been assessed this fee so the fiscal impact is minimal and is in the amount of two thousand forty dollars ($2040.00).

Board has instituted a license transfer fee for licensees who wish to transfer their licenses to another company in the amount of eighty-five dollars ($85.00). Recently approximately five hundred forty (540) persons per year have been assessed this fee. The total fiscal impact is in the amount of forty-five thousand nine hundred dollars ($45,900.00).

Board has instituted a copy fee of $1.00 per page for licensees who wish to have copies made of documents. Historically approximately two hundred thirty-eight (238) copies of documents such as range sheets and receipts for payments are made each year. The total fiscal impact is minimal and in the amount of $238.00.

Board has included in this rule a fee for shotgun and rifle training and qualification. To date, no one has ever requested or participated in rifle or shotgun training offered by Board. It is not anticipated that persons will request or participate in these types of training.

IV. ASSUMPTIONS

These figures assume that Board is correct about the number of persons who will newly apply for armed, unarmed and company licenses in the next year. These figures also assume that the companies pay the license fees for those they license, rather than the individual paying the fees themselves. In fact, Board is aware that some companies pay a portion of the licensing fees of their employees and the employees pay the balance. Board keeps no records of how the various companies operate and how they pay their fees. Therefore, the actual cost to these companies cannot be assessed and it must be assumed that for purposes of this fiscal note that the companies pay the entire fee.

This Proposed Rule also sets out various other fees for license transfers, dual licenses, change of license classification fees, replacement of lost or stolen licenses, rescheduling fees for the range, weapons changes, late fees, test failure fees, range failure fees, reinstatement fees and copying fees. Because the Board is unable to estimate in advance how many persons will lose their licenses, transfer their licenses to a new company, etc., the precise fiscal impact is an estimate. Again, Board would not know whether companies or the individual licensees would be paying these fees and therefore, the impact to businesses is uncertain.

TITLE 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RESCISSION

17 CSR 10-2.050 Testing Requirements and Qualification Standards. This rule established testing requirements for those seeking individual licensing pursuant to these provisions and established qualification standards pursuant to the duties carried out by individuals providing private security services.

PURPOSE: The board wishes to rescind this rule and adopt a new rule in its place to clarify the language in the rule and ensure compliance with the applicable law.

*AUTHORITY: section 84.720, RSMo 2000. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the **Code of State Regulations**. Rescinded: Filed Oct. 20, 2023.*

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 Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RULE

17 CSR 10-2.050 Testing Requirements and Qualification Standards

PURPOSE: In accordance with generally recognized policing standards, the Board of Police Commissioners of Kansas City, Missouri (board) has established testing requirements for those seeking individual licensing pursuant to these provisions and has established qualification standards pursuant to the duties carried out by individuals providing private security or proprietary private investigative services.

(1) All applicants for licensing shall successfully pass a written examination as presented by the department to potential licensees. A person failing to obtain a passing score as established by the board may be allowed to retake the written test three (3) times. An additional fee and a new Form 5409 P.D. is required each time the test is retaken. The test may not be taken more than one (1) time per day. An applicant shall have the right to review their test. The Private Officers Licensing Unit (POLU) may refuse to test any person if evidence exists that there is grounds for denial of the license. This excludes any person holding an active or inactive Peace Officer Standards and Training (POST) certification and all retired sworn members of the department. The board has established categories of testing that reflect the responsibilities and qualifications required for the type of license sought by the applicant. An information manual outlining the examination will be available from the POLU. It is the company's responsibility to provide training necessary to prepare the applicant to take and pass the board's written examination. In addition to obtaining the license as an armed licensee, the company must certify that the applicant or licensee has completed the required training and must present a completed Form 5715 P.D. at the time of application. The licensee must successfully qualify annually with their weapon. The qualification will be equivalent to that required for department police officers. In addition, any person holding an armed license shall requalify any time they change weapons. A licensee may only carry and qualify with one (1) handgun per company. As set out in 17 CSR 10-2.040(1)(Q), a fee will be charged any time a weapon change is made.

(A) Applicants for Class A licensing, in addition to those topics listed in subsection (1)(B) of this rule, shall also be tested on crime and criminal liability, firearms responsibility and liability, and patrol techniques. Class A licenses issued to those requesting designation as a proprietary private investigator shall also be tested on investigative techniques, illegal electronic surveillance, audio recording, and visual or video recording when permissible.

(B) Applicants for Class B licensing as provided in this chapter shall be tested on detention and seizure, how to interact with the general public and public officials, the licensing process, including rules, how to react to crisis situations, and liability issues.

(C) Applicants for proprietary private investigator must possess a high school diploma or GED and one (1) of the following: A two- (2-) year degree in Administration of Criminal Justice or a bachelor's degree; two (2) consecutive years prior investigative experience in law enforcement, military police, or military intelligence functions; or two (2) years consecutive experience with a licensed private security or proprietary private investigative company, and be certified by that company as to knowledge of the law and investigative techniques.

(D) Each armed licensee will complete four (4) hours of handgun training at the Kansas City, Missouri Police Pistol Range (range) each year and additional hours for rifle training if the applicant wishes to carry a rifle. The applicant will be required to complete both a rifle training class if they wish to carry a rifle and pay the fees associated with those training classes.

(2) As all applicants for Class A licenses are granted the authority to detain or apprehend, each applicant or his/her employer must certify annually on the Form 5409 P.D. to the satisfaction of the board that the applicant is physically and mentally capable of being able to safely detain or apprehend suspects without the necessity of resorting to the displaying or discharging of a weapon except in self-defense or in defense of another. This will require every applicant to submit at renewal annually a Form 5409 P.D. The board may investigate the certification and may reject the application if there is evidence that the certification is false or incorrect.

(3) Each applicant applying for a license under these provisions must meet these standards –

(A) Meet the qualifications in 17 CSR 10-2.020(3);

(B) Be at least twenty-one (21) years of age to hold an armed license and be at least eighteen (18) years of age to hold an unarmed license;

(C) Be able to read, write, and understand the English language;

(D) Meet physical and mental standards equivalent to those required of department police officers;

(E) Be capable of understanding and performing the duties and responsibilities of a licensee;

(F) If the applicant served in the Armed Forces of the United States within ten (10) years prior to the date of application, the final discharge of the applicant from the armed forces must be honorable or general under honorable conditions;

(G) Not have been convicted of a felony or a misdemeanor in federal or state court;

(H) Be of good moral character by having no felony convictions, misdemeanor convictions, or city ordinance convictions, which have as an essential element fraud, dishonesty, an act of violence, bribery, illegal drug use, sexual misconduct, and other similar acts constituting moral turpitude as defined by the common law of Missouri except that city ordinance convictions involving driving while intoxicated or driving under the influence of alcohol or drugs will be considered on a case-by-case basis;

(I) For armed applicants, not be the respondent named in a full order of protection currently in effect issued after a hearing by a court of competent jurisdiction;

(J) Have no prior revocation of a security license;

(K) Failing to meet the standards as set out in this division;

(L) Making any false statements or giving any false information in connection with an application for a license;

(M) Failing to provide information deemed necessary in order to establish eligibility;

(N) Holding a license which is suspended, including a suspension which is currently under review or under a stay pending the outcome of litigation in a court of competent jurisdiction;

(O) Providing other facts or actions which demonstrate that the applicant is unsuitable or ineligible for license; and

(P) Being terminated from or resigning under investigation or threat of discharge from a law enforcement agency shall make an individual ineligible for a license, but s/he may appeal to the board pursuant to the appeal process contained in this section.

(4) Applicants and their employers, in the event of license denial, will be given a written notification. Applicants may appeal in writing to the POLU within thirty (30) days of denial notification. The appeal should contain a brief statement responding to the reasons for denial. Failure to supply information to the board will result in the automatic denial of the appeal. The board will then notify the applicant in writing of its formal decision on the matter. Applicants have no right to a hearing or presentation to the board.

(5) A licensee must carry his/her license with him/her at all times while s/he is working. The license card must be worn on the outermost garment while on duty. The licensee must produce such license immediately at the request of a police officer, employee of the board, or person that the licensee has stopped or detained, if the licensee holds a license which allows him/her to stop and detain persons.

(6) The POLU will approve in advance all uniforms to be worn by any licensee. No uniform identical to or bearing resemblance to any uniform used by the department shall be approved. Additionally, no uniforms, badges, or other insignia using the word "police" shall be approved for use, except as provided in 17 CSR 10-2.030(1)(A)4. Companies licensed under this chapter shall provide the board a description, including the type and color, of the company uniform along with a photograph of the uniform. The company name must appear on the uniform or a patch and the word "security" must also appear on the uniform or patch. The word "security" must be clearly displayed on the outermost clothing to be worn by the licensee.

(7) Individuals providing private security services or proprietary private investigative services are required to file a discharge of firearms report with the board within five (5) days of the incident whenever they discharge a firearm in the course of their occupation, other than formal firearms training, or when off-duty. Failure to do so may result in action being taken by the board as outlined herein.

(8) Individuals providing private security services or proprietary private investigative services are required to notify the POLU when they are arrested or have court cases pending, within five (5) days of the incident. Failure to do so may result in action being taken by the board as outlined herein.

(9) No person licensed under these provisions shall divulge to any unauthorized person or company any information or knowledge received from the department or any source when the divulgence would be detrimental to effective law enforcement. Under no circumstances may any records received from the department, whether generated by computer or otherwise, be accessed for personal use.

AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the ***Code of State Regulations****. Rescinded and readopted: Filed Oct. 20, 2023.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions six thousand seven hundred dollars ($6700) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities one hundred thirty-two thousand eight hundred dollars ($132,800) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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: 17
Division Title: 10
Chapter Title: 2

Rule Number and Name:	17 CSR 10-2.050 – Testing Requirements and Qualification Standards
Type of Rulemaking:	Proposed Rulemaking

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
City of Kansas City, Missouri	**$400.00**
Kansas City International Airport Police	**$5600.00**
Housing Authority of Kansas City, Missouri	**$700.00**
Total	**$6700.00**

III. WORKSHEET

Each armed licensee will pay a range fee in the amount of one hundred dollars ($100.00). The City of Kansas City, Missouri licenses four (4) armed officers. The armed licensees (4) will pay one hundred dollars ($100.00) each for a total fiscal impact to the City of Kansas City, Missouri of four hundred dollars ($400.00).

The Kansas City International Airport Police has forty (40) armed licensees. The armed licensees will pay one hundred dollars ($100.00) each for a total of four thousand one hundred dollars ($4000.00). Eight (8) officers qualify with a rifle each year at a cost of two hundred dollars ($200.00) per licensee, bringing the total amount for the Kansas City International Airport Police to five thousand six hundred dollars ($5600.00).

The Housing Authority of Kansas City, Missouri licenses seven (7) armed persons. Those licensees will pay one hundred dollars ($100.00) each in range fees for a total fiscal impact to the Housing Authority of Kansas City, Missouri of seven hundred dollars ($700.00).

IV. ASSUMPTIONS

These figures assume that the number of armed licensees remains constant in the next year. These figures also assume that the agencies pay the fees for those they license, rather than the individual paying the fees themselves. In fact, Board is aware that some entities pay a portion of the licensing fees of their employees and the employees pay the balance. Board keeps no records of how the various entities operate and how they pay

their fees. Therefore, the actual cost to these agencies cannot be assessed and it must be assumed that for purposes of this fiscal note that the agencies pay the entire fee.

FISCAL NOTE
PRIVATE COST

I. Department Title: 17
Division Title: 10
Chapter Title: 2

Rule Number and Title:	17 CSR 10-2.050 – Testing Requirements and Qualification Standards
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
802	**Armed Licensees**	**$82,000.00**
508	**New Armed Licensees**	**$50,800.00**
Total		**$132,800.00**

III. WORKSHEET

This rule allows the Board to require that individuals holding armed licenses pay a range fee for firearms qualification in the amount of one hundred dollars ($100.00). Currently approximately 802 persons hold armed licenses. The total fiscal impact to all armed licensees is $80,200.00.

In order to assess the fiscal impact to the individuals acquiring new armed licenses, an estimate of the number of new armed licensees, 508, must be multiplied by the range fee in the amount of one hundred dollars ($100.00) for a fiscal impact of $50,800.00.

In addition, nine (9) armed officers pay a fee for rifle training in the amount of two hundred dollars ($200.00), for a total of one thousand eight hundred dollars ($1800.00).

IV. ASSUMPTIONS

These figures assume that Board is correct about the number of persons who will newly apply for armed licenses in the next year and that the number of existing armed licensees will remain approximately the same. Board is aware that some companies pay a portion of the fees of their employees, and the employees pay the balance. Board keeps no

records of how the various companies operate and how they pay their fees. Therefore, the actual cost to companies versus individuals cannot be assessed.

TITLE 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RESCISSION

17 CSR 10-2.055 Weapons Regulations and Firearms Qualification. This rule established requirements for persons seeking licenses for positions authorized to carry approved firearms.

PURPOSE: The board wishes to rescind this rule and adopt a new rule in its place to clarify the language in the rule and ensure compliance with the applicable law.

AUTHORITY: section 84.720, RSMo 2016. Original rule filed May 28, 1993, effective Jan. 31, 1994. For intervening history, please consult the ***Code of State Regulations****. Rescinded: Filed Oct. 20, 2023.*

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 Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RULE

17 CSR 10-2.055 Weapons Regulations and Firearms Qualification

PURPOSE: Applicants seeking licenses for positions authorized to carry approved firearms must be certified as qualified to carry those firearms pursuant to requirements as established by the Board of Police Commissioners of Kansas City, Missouri (board) herein.

(1) A licensee is authorized to carry only handguns in a strong side hip holster approved by the board and only if the licensee has qualified with that handgun as set out herein. All licensees must have a completed Verification of Firearms Training Form (Form 5715 P.D.) before reporting to the Private Officers Licensing Unit (POLU). The handguns approved by the board are as follows: .38 caliber, double action solid frame revolvers (five (5) or six (6) shot); and semiautomatics, double action only or double/single action, which are equipped with a decocker or decocker safety. This requirement limits the semi-automatics which may be carried to .40, .45, and 9mm calibers. Striker action handguns are acceptable. The department shooting range supervisor or his/her designee may deny a licensee the opportunity to qualify if, in his/her discretion, they believe a person or a firearm does not meet the requirements set out herein or presents a danger to others.

(2) Licensees may carry patrol rifles under the following terms and conditions. The only approved rifle will be the semi-automatic AR15, 223/5.56 caliber firearm. The patrol rifle must meet the following requirements to be approved for testing at the department shooting range and use on duty:

(A) AR-15 type firearm that has forged upper and lower receivers. No cast or carbon fiber;

(B) A sixteen inch (16") overall barrel length;

(C) A factory-type trigger system. Lightweight match style triggers are not permitted on an approved personal rifle;

(D) Iron sights, with a front tritium (night) sight (mandatory). Pop-up sights are also acceptable;

(E) A minimum of two (2) 30-round magazines or three (3) 20-round magazines;

(F) A mountable light source (minimum of 80-90 lumens);

(G) A sling (1, 2, or 3 point styles are required);

(H) Armed licensees carrying a patrol rifle will only carry U.S. made factory-loaded 55 grain soft point ammunition in the weapon. (Hollow point and full metal jacket ammunition are forbidden.)

(3) All applicants seeking licensure for positions for which firearms may be possessed must qualify annually with the firearm(s) on the department pistol range and under the supervision of the department's firearms instructors. The firearms qualifications standards shall be in accordance with those established by the department for its officers.

(4) An applicant must display the ability to safely and properly handle his/her approved firearm(s).

(5) An applicant shall not be licensed armed if the applicant –

(A) Displays an inability to handle a firearm safely and properly; or

(B) Does not attain the minimum scores for qualification. The applicant shall be given a maximum of three (3) additional opportunities to qualify. An additional fee and new Forms 5409 P.D. and 5715 P.D. are required for each additional qualification, which will be scheduled by the POLU. If the applicant fails to qualify after three (3) additional attempts, the applicant will not be allowed to attempt to qualify for one (1) year from the date of the last failure; or

(C) Does not keep their scheduled range qualification appointment.

(6) If an applicant does not display the ability to safely handle a firearm, does not attain the minimum score for qualification, or does not keep their scheduled range qualification, the applicant may be licensed unarmed if they submit a new Form 5409 P.D. for unarmed licensure and pay the appropriate fee.

(7) In addition to the applicant successfully passing an approved firearms qualification test, the applicant or his/her employer must satisfy the physical certification requirements for a Class A license as established herein.

(8) Licensees holding an armed license may wear their approved firearm with their uniform, unless classified as a nonuniformed proprietary private investigator, while at work and while traveling directly to and from work.

(9) Those licensed as private security and proprietary private investigators must comply with city ordinance and state law which prohibits carrying a firearm or other weapon readily capable of lethal use into any building owned or occupied by any agency of the state government. This includes the POLU and any other office within the building or any other building occupied by the department.

(10) Each security firm shall designate a training coordinator (the training coordinator) who will be responsible for ensuring that all armed members of the security firm receive training from a qualified firearms instructor experienced in providing law enforcement/security training, as described in 17 CSR 10-2.050(1). The training coordinator will be the person responsible for signing Form 5715, verifying each individual armed security officer has received verifiable training. Form 5715 is an official document and any training coordinator knowingly providing false information to the POLU will be subject to removal as the training coordinator for a period of two (2) years and the training coordinator and the security firm will be subject to the disciplinary procedures set forth in 17 CSR 10-2.060. Training coordinators will be provided a checklist detailing the mandatory training requirements, must sign verifying that the mandatory training has been conducted, and the security firm will be subject to investigation if the individual attempting to qualify has not been properly trained.

(11) The board reserves the right to prohibit the holder of a license from carrying any firearm.

AUTHORITY: section 84.720, RSMo 2016. Original rule filed May 28, 1993, effective Jan. 31, 1994. For intervening history, please consult the ***Code of State Regulations****. Rescinded and readopted: Filed Oct. 20, 2023.*

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 cost private entities twenty-nine thousand nine hundred dollars ($29,900) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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: 17
Division Title: 10
Chapter Title: 2

Rule Number and Title:	17 CSR 10-2.055 – Firearms Regulations and Qualification
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
80	**Armed Licensees/Failed to Attend Range Qualification**	**$10,000.00**
199	**Armed Licensees/Failed to Qualify**	**$19,900.00**
Total		**$29,900.00**

III. WORKSHEET

This rule requires that individuals holding armed licenses pay a range fee to Board if a licensee fails to qualify at the Department pistol range. This fee is set out in 17 CSR 10-2.040 and is known as a Range Failure fee of one hundred dollars ($100.00). Board has determined that approximately one hundred ninety-nine (199) armed licensees will fail to qualify at the Department pistol range for a total fiscal impact of $19,900.00.

Board is imposing a fee found in 17 CSR 10-2.040 to armed licensees who fail to attend their range qualification appointment known as the Failure to Attend Range Appointment fee in the amount of one hundred twenty-five dollars ($125.00). Board estimates that in any given year, approximately 80 armed licensees will fail to attend their range qualification appointment, for a total fiscal impact of $10,000.00.

IV. ASSUMPTIONS

These figures assume that the number of persons who will fail to qualify/fail to attend will remain approximately the same as past years. These figures also assume that the companies pay the rescheduling fees for those they license, rather than the individual paying the fees themselves. In fact, Board is aware that some companies pay a portion of the fees of their employees and the employees pay the balance. Board keeps no records of how the various companies operate and how they pay their fees. Therefore, the actual cost to companies versus that to individuals cannot be assessed.

TITLE 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RESCISSION

17 CSR 10-2.060 Regulation, Suspension, and Revocation. This rule gave the board the power to suspend or revoke any license granted by it and set out an appeal process for any license so affected.

PURPOSE: The board wishes to rescind this rule and adopt a new rule in its place to clarify the language in the rule and ensure compliance with the applicable law.

*AUTHORITY: section 84.720, RSMo 2000. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the **Code of State Regulations**. Rescinded: Filed Oct. 20, 2023.*

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 Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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 17 – BOARDS OF POLICE COMMISSIONERS
Division 10 – Kansas City Board of Police Commissioners
Chapter 2 – Private Security

PROPOSED RULE

17 CSR 10-2.060 Regulation, Suspension, and Revocation

PURPOSE: Under section 84.720, RSMo, the Board of Police Commissioners of Kansas City, Missouri (board) shall regulate individuals providing private security/proprietary private investigative services. Pursuant to this authority, the board has the power to suspend, order probation, or revoke any license granted by it and is obligated to furnish an appeal process for any license so affected.

(1) The board may monitor and investigate allegations of improper conduct and the activities of individuals providing private security and proprietary private investigative services and firms, companies, partnerships, entities, or political subdivisions providing security services or proprietary private investigative services pursuant to these rules.

(2) The chief of police or his/her designee may order probation, order a suspension, or revoke a license of any company granted under section 84.720, RSMo, pursuant to the procedures set forth in section (10) of this rule, when there exists information that the licensee or, if the licensee is an organization, any of its officers, directors, partners, or associates has –

(A) Failed to meet the qualifications in 17 CSR 10-2.020(3);

(B) Failed to maintain the physical and mental standards required of department police officers;

(C) Failed to understand and perform the duties and responsibilities of a licensee;

(D) Been convicted of a felony or a misdemeanor in federal or state court;

(E) Failed to be of good moral character by having a felony conviction, misdemeanor conviction, or city ordinance conviction, an essential element of which is fraud, dishonesty, an act of violence, bribery, illegal drug use, sexual misconduct, and other similar acts constituting moral turpitude as defined by the common law of Missouri except that city ordinance convictions involving driving while intoxicated or driving under the influence of alcohol or drugs will be considered on a case-by-case basis;

(F) For armed licensees, been named as the respondent in a full order of protection currently in effect issued after a hearing by a court of competent jurisdiction;

(G) Failed to meet the standards as set out herein;

(H) Made a false statement or given any false information in connection with an investigation by the Private Officers Licensing Unit (POLU) or the department;

(I) Provided other facts or actions which demonstrate that the applicant is unsuitable or ineligible to continue to hold a license; and

(J) Being terminated from or resigning under investigation or threat of discharge from a law enforcement agency shall make an individual ineligible for a license, but s/he may appeal to the board pursuant to the appeal process contained in this section.

(3) Suspension based on a pending criminal charge which is challenged and pending before a court of competent jurisdiction will continue in effect until a final judgment by a court of competent jurisdiction.

(4) When the chief of police or his/her designee determines that a license granted pursuant to section 84.720, RSMo, shall be suspended or revoked, the following procedures shall apply:

(A) Notice that the license is under review for an action that could result in probation, suspension, or revocation of a license shall be mailed to the licensee and their company at the address maintained in the POLU;

(B) Notice of a license under review for suspension or revocation shall be signed by the chief of police or his/her designee and shall indicate –

1. The basis of the recommendation to suspend or revoke;
2. The reason(s);
3. The recommended duration of the suspension, if determinable;
4. Recommended conditions of reinstatement, if any; and
5. A description of the appeal process;

(C) Upon receipt of a notice that a license under review for suspension, or revocation, the individual or organization affected may request a review of the action of the POLU by filing a request for review, in writing, with the POLU within five (5) days of the dated written notification of suspension or revocation at 635 Woodland, Suite 2104, Kansas City, MO 64106;

(D) In the event of a request for review of a suspension or revocation of an existing license, the board may by resolution

appoint a hearing officer who shall hear the case solely on the record. There is no right to a hearing or presentation to the hearing officer or to the board. The hearing officer shall review the record which shall consist of all documentary evidence obtained by or submitted to the chief of police, the POLU and by the licensee, any agreed upon statement of the case agreed to by all the parties, and the legal briefs as might be filed by the parties or their representatives. The hearing officer shall render a decision in writing within five (5) days of receiving the record by mailing a written decision to the licensee and their company at the address maintained in the POLU. The licensee may appeal the decision of the hearing officer to the board by filing a request for an appeal within ten (10) days of the dated notification of the hearing officer's decision, in writing, by mailing a request to the POLU, 635 Woodland, Suite 2104, Kansas City, MO 64106. The board will consider the appeal solely on the record at their next regularly scheduled meeting and render a final decision;

(E) Failure to supply information to the hearing officer or the board will result in the automatic denial of the appeal;

(F) The chief of police or his/her designee may place a licensee on probation in lieu of suspension or revocation.

AUTHORITY: section 84.720, RSMo 2016. Original rule filed Dec. 5, 1979, effective March 17, 1980. For intervening history, please consult the ***Code of State Regulations****. Rescinded and readopted: Filed Oct. 20, 2023.*

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 Board of Police Commissioners of Kansas City, Missouri, 1125 Locust, Kansas City, Missouri 64106. 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 2150 – State Board of Registration for the Healing Arts
Chapter 6 – Licensure of Athletic Trainers

PROPOSED AMENDMENT

20 CSR 2150-6.060 Renewal of Licensure. The board is amending sections (3) and (4).

PURPOSE: This amendment updates the renewal deadlines.

(3) All licensees shall renew with the board on the application form furnished by the board **on or** before January ***[30]*** **31** of the year in which such license is due for renewal.

(4) Renewal application forms postmarked by the post office ***[January 31]*** **February 1** or after will be considered delinquent***[.]*****;** however, should January ***[30]*** **31** fall on a Saturday, Sunday**,** or legal holiday, renewal forms postmarked by the post office on the next business day will not be considered delinquent.

*AUTHORITY: section****[s]*** *334.125, RSMo* ***[2000] 2016,*** *and* ***sections*** *334.706 and 334.710, RSMo Supp.* ***[2004] 2023****. This rule originally filed as 4 CSR 150-6.060. Original rule filed July 25, 2000, effective Dec. 30, 2000. Amended: Filed March 1, 2005, effective Aug. 30, 2005. Moved to 20 CSR 2150-6.060, effective Aug. 28, 2006. Amended: Filed Oct. 23, 2023*

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 State Board of Registration for the Healing Arts, PO Box 4, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 751-3166, or via email at healingarts@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this rule 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 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2) and (8).

PURPOSE: This amendment clarifies eligibility for retiree coverage for Public Higher Education Entities and retirees employed with a public entity and adds that retirees can cancel dental and vision coverage when voluntarily canceling medical coverage.

(2) Eligibility Requirements.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he receives a monthly retirement benefit from either MOSERS or from Public School Retirement System (PSRS) for state employment**, or if the employee is an employee of a public higher education entity (PHEE) and the PHEE offers coverage to retirees**. The employee may elect coverage for him/herself and his/her spouse/child(ren), provided the employee and his/her spouse/child(ren) have been continuously covered for health care benefits –

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of persons covered) is required.

2. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from

MOSERS and was employed by the Missouri Department of Conservation.

3. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.

4. If the retiree's spouse is a state active employee or retiree and enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

5. If a retiree who is eligible for coverage elects not to be continuously covered for him/herself and spouse/child(ren) with MCHCP from the date first eligible, or does not apply for coverage for him/herself and spouse/child(ren) within thirty-one (31) days of his/her eligibility date, the retiree and his/her spouse/child(ren) shall not thereafter be eligible for coverage unless specified elsewhere herein.

6. An individual enrolled in another non-MCHCP Medicare Advantage (Part C) and/or Medicare Prescription Drug Plan (Part D) is not eligible for medical coverage.

7. A retiree who is employed with a participating public entity may elect to return to state coverage as a retiree as long as coverage with MCHCP is continuous and retiree coverage was elected.

(8) Voluntary Cancellation of Coverage.

(D) A subscriber may only cancel dental and/or vision coverage during the year for him/herself or his/her dependents for one (1) of the following reasons:

1. Upon retirement;
2. When beginning a leave of absence;
3. No longer eligible for coverage;
4. When new coverage is taken through other employment; *[or]*
5. When the member enrolls in Medicaid*[.]*; **or**
6. When a retiree cancels medical coverage.

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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment adds one hundred percent (100%) coverage of diagnostic breast examinations and colorectal screenings at a network provider.

(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:

(E) Sterilization procedure for men; *[and]*

(F) Virtual visits offered through the vendor's telehealth tool*[.]***;**

(G) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings; and

(H) Diagnostic colorectal screenings.

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. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 section (5).

PURPOSE: This amendment adds one hundred percent (100%) coverage of diagnostic breast examinations and colorectal screenings at a network provider.

(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:

(E) Sterilization procedure for men; *[and]*

(F) Virtual visits offered through the vendor's telehealth tool*[.]***;**

(G) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings; and

(H) Diagnostic colorectal screenings.

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. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 (7), (10), and new section (24), adding sections (11) and (12), and renumbering as necessary.

PURPOSE: This amendment makes a technical correction for nutritional counseling to nutrition counseling, revises coverage of virtual visits, adds one hundred percent (100%) coverage after deductible is met of diagnostic breast examinations and colorectal screenings at a network provider, and revises MCHCP Health Savings Account contribution amounts.

(7) Nutrition*[al]* counseling is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(10) Virtual visits offered through the vendor's telehealth tool are covered at one hundred percent (100%) *[after deductible is met]*.

(11) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings are covered at one hundred percent (100%) after deductible is met.

(12) Diagnostic colorectal screenings are covered at one hundred percent (100%) after deductible is met.

*[(11)]***(13)** Newborn's claims will be subject to deductible and coinsurance.

*[(12)]***(14)** 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.

*[(13)]***(15)** Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

*[(14)]***(16)** 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.

*[(15)]***(17)** 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.

*[(16)]***(18)** 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 time frame 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.

*[(17)]***(19)** 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.

*[(18)]***(20)** 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 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.

*[(19)]***(21)** 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 *[(20)]***(23)** 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 *[T]***t**he 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.

*[(20)]***(22)** 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.

*[(21)]***(23)** 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.

*[(22)]***(24)** 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)]* **one thousand dollars ($1,000)** 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)]* **five hundred dollar ($500)** contribution to each spouse to total a maximum of *[six hundred dollars ($600)]* **one thousand dollars ($1,000)**.

(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.

Deposit	Subscriber Only	All other coverage levels
January	$300.00	$600.00
April (delayed contribution due to health care FSA grace period)	$300.00	$600.00
All others	A proration of $300	A proration of $600

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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions one million seven hundred thousand dollars ($1,700,000) 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.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Health Care Plan
Chapter Title: State Membership

Rule Number and Name:	22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	$1,700,000

III. WORKSHEET

Estimated cost is based on current enrollment in the Health Savings Account Plan and reflects the increase in the annual amount MCHCP will contribute for individual coverage from $300 to $500 and for family coverage from $600 to $1,000. MCHCP's contribution is made annually in January. The estimated cost reflects the full annual contribution. MCHCP's actuary conducted the cost estimate for this change.

IV. ASSUMPTIONS

2024 enrollment in the Health Savings Account Plan will be similar to 2023.

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 section (3) and renumbering as necessary.

PURPOSE: This amendment adds coverage of cryopreservation cycles and infertility treatment, makes a technical correction for nutritional counseling to nutrition counseling, and revises preventive services.

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250 **Plan**, and HSA Plan.

(D) Plan benefits for the PPO 750 Plan, PPO 1250 **Plan**, 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;

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;

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;

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;

9. Chelation therapy;

10. Chiropractic services – manipulation and adjunct therapeutic procedures/modalities;

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;

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 and auditory brainstem implant;

13. Cryopreservation cycles.

A. Oocyte cryopreservation cycles including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes).

B. Sperm cryopreservation including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes);

*[13.]***14.** 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 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.]***15.** Diabetes self-management education;

*[15.]***16.** Dialysis is covered when received through a network provider;

*[16.]***17.** 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 nonfunctional 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.]***18.** 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;

*[18.]***19.** 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.]***20.** 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;

(III) Peripheral neuropathy; or

(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.]***21.** 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;

*[21.]***22.** 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.]***23.** Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

*[23.]***24.** 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.]***25.** 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. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone anchoring hearing aid (BAHA): three thousand five hundred dollars ($3,500);

*[25.]***26.** Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

*[26.]***27.** 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.]***28.** 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;

*[28.]***29.** 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; and

(V) Outpatient mental health services;

30. Infertility coverage for members with a diagnosis of infertility, including in vitro fertilization (IVF) oocyte retrievals limited to two (2) cycles as a lifetime maximum, per member;

*[29.]***31.** 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.]***32.** 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;

*[31.]***33.** 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.]***34.** 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 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.]***35.** Nutrition*[al]* 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.]***36.** Nutrition therapy;

*[35.]***37.** 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.]***38**. 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.]**39.*** 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. Tumors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical abnormality;

*[38.]***40.** 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 agoniometer 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.

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.]***41.** 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 preventive 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]* **Digital diabetes prevention** program offered through the plan's *[exclusive provider arrangement]* **claims administrator**.

H. The following services permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan:

(I) Blood pressure monitors for individuals diagnosed with hypertension;

(II) Retinopathy screenings for individuals diagnosed with diabetes;

(III) Hemoglobin A1c (HbA1c) testing for individuals diagnosed with diabetes;

(IV) Peak flow meters for individuals diagnosed with asthma; and

(V) International normalized ratio (INR) testing for individuals diagnosed with liver disease and/or bleeding disorders;

*[40.]***42.** 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.]***43.** 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.]***44.** Skilled nursing facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

*[43.]***45.** 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.]***46.** 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, postoperative vocal cord surgery);

*[45.]***47.** 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)']***(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.]***48.** Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

*[47.]***49.** 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions $2,940,000 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.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Health Care Plan
Chapter Title: State Membership

Rule Number and Name:	22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	$2,940,000

III. WORKSHEET

In total, the estimated cost reflects administrative costs and incurred claims. MCHCP's actuary conducted the cost estimate for this change.

IV. ASSUMPTIONS

Member utilization is as projected.

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) and renumbering as necessary.

PURPOSE: This amendment removes the limitation on infertility treatment.

(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.

[(AA) Infertility treatment beyond the covered services to diagnose the condition.]

*[(BB)]***(AA)** Infusions received through a non-network provider.

*[(CC)]***(BB)** Level of care*[,]* greater than is needed for the treatment of the illness or injury.

*[(DD)]***(CC)** Long-term care.

*[(EE)]***(DD)** Maxillofacial surgery.

*[(FF)]***(EE)** 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.

*[(GG)]***(FF)** 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.

*[(HH)]***(GG)** Military service-connected injury or illness – including expenses relating to Veterans Affairs or a military hospital.

*[(II)]***(HH)** Never events – never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

*[(JJ)]***(II)** 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.

*[(KK)]***(JJ)** Non-medically necessary services.

*[(LL)]***(KK)** Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

*[(MM)]***(LL)** Non-reusable disposable supplies.

*[(NN)]***(MM)** Online weight management programs.

*[(OO)]***(NN)** 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.

*[(PP)]***(OO)** 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.

*[(QQ)]***(PP)** Physical and recreational fitness.

*[(RR)]***(QQ)** Private-duty nursing.

*[(SS)]***(RR)** Routine foot care without the presence of systemic disease that affects lower extremities.

*[(TT)]***(SS)** Services obtained at a government facility if care is provided without charge.

*[(UU)]***(TT)** Sex therapy.

*[(VV)]***(UU)** Surrogacy – pregnancy coverage is limited to plan member.

*[(WW)]***(VV)** Telehealth site origination fees or costs for the provision of telehealth services are not covered.

*[(XX)]***(WW)** Travel expenses.

*[(YY)]***(XX)** 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, expired June 28, 2020. Amended: Filed Oct. 30, 2019, effective May 30, 2020. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.

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 (4).

PURPOSE: This amendment revises effect on the benefits of MCHCP when MCHCP is a secondary plan.

(4) Effect on the Benefits of MCHCP. This section applies **when**, *[which]* in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans.

(A) In the event that MCHCP is a secondary plan as to one (1) or more other plans, the benefits of MCHCP's PPO plans and

Health Savings Account Plan may be reduced under this section so as not to duplicate the benefits of the other plan. The other plan's payment is subtracted from what MCHCP or its claims administrator would have paid in absence of this COB provision using the following criteria. If there is any balance, MCHCP or its claims administrator will pay the difference not to exceed what it would have paid in absence of this COB provision.

1. In the case where Medicare is primary for physician and outpatient facility claims, Medicare's allowed amount is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

2. In the case where Medicare is primary for inpatient facility claims, the amount the facility billed is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision. Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicare paid amount. Effective April 1, 2013, Medicare's allowed amount will be used as MCHCP's allowed amount for inpatient facility claims to determine what MCHCP would have paid in absence of this COB provision and the Medicare paid amount will no longer be combined with the provider's Medicare contractual write off.

[3. In the case where another plan is primary, the lower allowed amount of either the primary plan or MCHCP is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.]

AUTHORITY: sections 103.059 and 103.089, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 section (3).

PURPOSE: This amendment updates the telephone number for Anthem expedited appeals and the mailing address and website for external review requests.

(3) Appeal Process for Medical and Pharmacy Determinations for PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(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 decided within twenty (20) business days 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 thirty (30) days. The vendor must notify the member prior to the expiration of the first 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 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) 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 will be decided within twenty (20) days 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 thirty (30) days. The vendor must notify the member prior to the expiration of the first 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 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 Anthem –

(a) First and second level pre-service, first and second level post-service, and concurrent claim appeals must be submitted in writing to –

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 105568
Atlanta, Georgia 30348-5568
or by fax to (800) 859-3046

(b) Expedited appeals may be submitted by calling *[(877) 333-7488]* **(844) 516-0248** or by submitting a written fax to (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
Federal External Review Process (FERP)
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/] **externalappeal.cms.gov**

(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 time frame 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.

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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 revises Medicare Part D coverage stage 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 hereinafter 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 *[four thousand six hundred sixty dollars ($4,660)]* **five thousand thirty dollars ($5,030)**, 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 dollar ($80) copayment; ninety- (90-) day supply at retail has a one hundred twenty dollar ($120) copayment; and a ninety- (90-) day supply through home delivery has a one hundred dollar ($100) 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 *[four thousand six hundred sixty dollars ($4,660)]* **five thousand thirty dollars ($5,030)** and remain below *[seven thousand four hundred dollars ($7,400)]* **eight thousand dollars ($8,000)**, 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 *[seven thousand four hundred dollars ($7,400)]* **eight thousand dollars ($8,000)**;

4. Catastrophic coverage stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[seven thousand four hundred dollars ($7,400)]* **eight thousand dollars ($8,000)**, the member will pay *[the greater of—*

A. Five percent (5%) coinsurance or a four dollar and fifteen cent ($4.15) 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 a ten dollar and thirty-five cent ($10.35) copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the initial coverage stage] **zero dollars ($0)**; 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 10-2.140 Strive for Wellness® Health Center Provisions, Charges, and Services. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (3).

PURPOSE: This amendment clarifies eligibility for and services available at the Strive for Wellness® Health Center.

(1) Eligibility. *[Non-Medicare primary members over]* **Members aged** eighteen (18) years *[old enrolled in an MCHCP medical plan]* **and older** shall be eligible for and able to access the services available at the health center as described in this rule.

(2) Available Services. The health center provides access to **contracted services for** treatment for uncomplicated minor illnesses and *[to]* preventive health care services**.** *[including, but not limited to, the following:*

(A) Sore throats/ears/headache;
(B) Strains/sprains/musculoskeletal problems;
(C) Non-specific abdominal pain;
(D) Non-specific chest pain;
(E) Cough;
(F) Sinus conditions;
(G) Allergies;
(H) Hormone injections;
(I) Vaccinations including influenza vaccine;
(J) Rashes;
(K) Acute urinary complaints;
(L) Personal hygiene related problems;
(M) Acute injuries/acute routine office procedures;
(N) Minor surgical procedures, such as sutures for laceration treatment;
(O) Ordinary and routine care of the nature of a visit to the health care provider's office; and
(P) Clinical Laboratory Improvement Amendments (CLIA)-waived lab services.]

(3) Limitations and *[e]***E**xclusions.

(A) The following *[employees are not eligible for]* **MCHCP eligibles are not able to utilize** the health center:

1. Active employees **and members** who are not enrolled in *[an]* MCHCP medical *[plan]* **coverage**; and

2. *[Medicare primary retirees and their Medicare primary dependents]* **Members enrolled in the Medicare Advantage plan**.

(B) Services that are beyond the scope *[of practice]* of the health center including*[,]* but not limited to*[,]* the following:

1. Emergency services;
2. Urgent care services;
3. Radiology services;
4. Specialist services;
5. Pharmacy services;
6. Occupational, speech, and physical therapy services; and
7. Chiropractic services.

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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 section (8).

PURPOSE: This amendment adds that retirees can cancel dental and vision coverage when voluntarily canceling medical coverage.

(8) Voluntary Cancellation of Coverage.

(D) A subscriber may only cancel dental and/or vision coverage during the year for him/herself or his/her dependents for one (1) of the following reasons:

1. Upon retirement;
2. When beginning a leave of absence;
3. No longer eligible for coverage;
4. When new coverage is taken through other employment; *[or]*
5. When the member enrolls in Medicaid*[.]***; or**
6. When a retiree cancels medical coverage.

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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (7) and (10), adding new sections (11) and (12), and renumbering as necessary.

PURPOSE: This amendment makes a technical correction for nutritional counseling to nutrition counseling, revises coverage of virtual visits, and adds one hundred percent (100%) coverage after deductible is met for diagnostic breast examinations and colorectal screenings at a network provider.

(7) Nutrition*[al]* counseling is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(10) Virtual visits offered through the vendor's telehealth tool are covered at one hundred percent (100%) *[after the deductible is met]*.

(11) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings are covered at one hundred percent (100%) after deductible is met.

(12) Diagnostic colorectal screenings are covered at one hundred percent (100%) after deductible is met.

*[(11)]***(13)** Newborn's claims will be subject to deductible and coinsurance.

*[(12)]***(14)** Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

*[(13)]***(15)** 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.

*[(14)]***(16)** 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.

*[(15)]***(17)** 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 time frame 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.

*[(16)]***(18)** 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.

*[(17)]***(19)** 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 *[(17)]* **(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 *[T]***t**he 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)]***(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.

*[(19)]***(21)** 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 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 section (3) and renumbering as necessary.

PURPOSE: This amendment adds coverage of cryopreservation cycles and infertility treatment, makes a technical correction for nutritional counseling to nutrition counseling, and revises preventive services.

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250 **Plan**, and HSA Plan.

(D) Plan benefits for the PPO 750 Plan, PPO 1250 **Plan**, 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;

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;

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;

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;

9. Chelation therapy;

10. Chiropractic services – manipulation and adjunct therapeutic procedures/modalities;

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;

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 and auditory brainstem implant;

13. Cryopreservation cycles.

A. Oocyte cryopreservation cycles including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes).

B. Sperm cryopreservation including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes);

*[13.]***14.** 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 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.]***15.** Diabetes self-management education;

*[15.]***16.** Dialysis is covered when received through a network provider;

*[16.]***17.** 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 nonfunctional 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.]***18.** 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;

*[18.]***19.** 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.]***20.** 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;

(III) Peripheral neuropathy; or

(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.]***21.** 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;

*[21.]***22.** 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.]***23.** Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

*[23.]***24.** 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.]***25.** 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. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone anchoring hearing aid (BAHA): three thousand five hundred dollars ($3,500);

*[25.]***26.** Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

*[26.]***27.** 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.]***28.** 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;

*[28.]***29.** 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; and

(V) Outpatient mental health services;

30. Infertility coverage for members with a diagnosis of infertility, including in vitro fertilization (IVF) oocyte retrievals limited to two (2) cycles as a lifetime maximum, per member;

*[29.]***31.** 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.]***32.** 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;

*[31.]***33.** 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.]***34.** 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 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.]***35.** Nutrition*[al]* 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.]***36.** Nutrition therapy;

*[35.]***37.** 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.]***38.** 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.]***39.** 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. Tumors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical abnormality;

*[38.]***40.** 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 agoniometer 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.

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.]***41.** 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 preventive 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]* **Digital diabetes prevention** program offered through the plan's *[exclusive provider arrangement]* **claims administrator**.

H. The following services permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan:

(I) Blood pressure monitors for individuals diagnosed with hypertension;

(II) Retinopathy screenings for individuals diagnosed with diabetes;

(III) Hemoglobin A1c (HbA1c) testing for individuals diagnosed with diabetes;

(IV) Peak flow meters for individuals diagnosed with asthma; and

(V) International normalized ratio (INR) testing for individuals diagnosed with liver disease and/or bleeding disorders;

*[40.]***42.** 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.]***43.** 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.]***44.** Skilled nursing facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

*[43.]***45.** 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.]***46.** 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, postoperative vocal cord surgery);

***[45.]*47.** 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)']*****(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.]*48.** Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

***[47.]*49.** 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions sixty thousand dollars ($60,000) 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.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Missouri Consolidated Health Care Plan
Division Title: Health Care Plan
Chapter Title: Public Entity Membership

Rule Number and Name:	22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	$60,000

III. WORKSHEET

In total, the estimated cost reflects administrative costs and incurred claims. MCHCP's actuary conducted the cost estimate for this change.

IV. ASSUMPTIONS

Member utilization is as projected.

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 section (5).

PURPOSE: This amendment adds one hundred percent (100%) coverage of diagnostic breast examinations and colorectal screenings at a network provider.

(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:

(E) Sterilization procedure for men; *[and]*

(F) Virtual visits offered through the vendor's telehealth tool*[.]***;**

(G) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings; and

(H) Diagnostic colorectal screenings.

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. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 section (5).

PURPOSE: This amendment adds one hundred percent (100%) coverage of diagnostic breast examinations and colorectal screenings at a network provider.

(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:

(E) Sterilization procedure for men; *[and]*

(F) Virtual visits offered through the vendor's telehealth tool*[.]***;**

(G) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings; and

(H) Diagnostic colorectal screenings.

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. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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) and renumbering as necessary.

PURPOSE: This amendment removes the limitation on infertility treatment.

(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.

[(AA) Infertility treatment beyond the covered services to diagnose the condition.]

*[(BB)]***(AA)** Infusions received through a non-network provider.

*[(CC)]***(BB)** Level of care*[,]* greater than is needed for the treatment of the illness or injury.

*[(DD)]***(CC)** Long-term care.

*[(EE)]***(DD)** Maxillofacial surgery.

*[(FF)]***(EE)** 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.

*[(GG)]***(FF)** 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.

*[(HH)]***(GG)** Military service-connected injury or illness – including expenses relating to Veterans Affairs or a military hospital.

*[(II)]***(HH)** Never events – never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

*[(JJ)]***(II)** 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.

*[(KK)]***(JJ)** Non-medically necessary services.

*[(LL)]***(KK)** Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

*[(MM)]***(LL)** Non-reusable disposable supplies.

*[(NN)]***(MM)** Online weight management programs.

*[(OO)]***(NN)** 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.

*[(PP)]***(OO)** 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.

*[(QQ)]***(PP)** Physical and recreational fitness.

*[(RR)]***(QQ)** Private-duty nursing.

*[(SS)]***(RR)** Routine foot care without the presence of systemic disease that affects lower extremities.

*[(TT)]***(SS)** Services obtained at a government facility if care is provided without charge.

*[(UU)]***(TT)** Sex therapy.

*[(VV)]***(UU)** Surrogacy – pregnancy coverage is limited to plan member.

*[(WW)]***(VV)** Telehealth site origination fees or costs for the provision of telehealth services are not covered.

*[(XX)]***(WW)** Travel expenses.

*[(YY)]***(XX)** 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, expired June 28, 2020. Amended: Filed Oct. 30, 2019, effective May 30, 2020. Emergency amendment filed Oct. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.

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 (4).

PURPOSE: This amendment revises effect on the benefits of MCHCP when MCHCP is a secondary plan.

(4) Effect on the benefits of MCHCP. This section applies **when**, *[which]* in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans.

(A) In the event that MCHCP is a secondary plan as to one (1) or more other plans, the benefits of MCHCP's PPO plans and Health Savings Account Plan (HSA Plan) may be reduced under this section so as not to duplicate the benefits of the other plan. The other plan's payment is subtracted from what MCHCP or its claims administrator would have paid in absence of this COB provision using the following criteria. If there is any balance, MCHCP or its claims administrator will pay the difference not to exceed what it would have paid in absence of this COB provision.

1. In the case where Medicare is primary for physician and outpatient facility claims, Medicare's allowed amount is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

2. In the case where Medicare is primary for inpatient facility claims, the amount the facility billed is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision. Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicare paid amount. Effective April 1, 2013, Medicare's allowed amount will be used as MCHCP's allowed amount for inpatient facility claims to determine what MCHCP would have paid in absence of this COB provision and the Medicare paid amount will no longer be combined with the provider's Medicare contractual write off.

[3. In the case where another plan is primary, the lower allowed amount of either the primary plan or MCHCP is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.]

AUTHORITY: sections 103.059 and 103.089, 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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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 section (3).

PURPOSE: This amendment updates the telephone number for Anthem expedited appeals and the mailing address and website for external review requests.

(3) Appeal Process for Medical and Pharmacy Determinations.

(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.

(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 decided within twenty (20) business days 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 thirty (30) days. The vendor must notify the member prior to the expiration of the first 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 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) 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 will be decided within 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 thirty (30) days. The vendor must notify the member prior to the expiration of the first 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 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 Anthem –

(a) First and second level pre-service, first and second level post-service, and concurrent claim appeals must be submitted in writing to –

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 105568
Atlanta, Georgia 30348-5568
or by fax to (888) 859-3046

(b) Expedited appeals may be submitted by calling *[(877) 333-7488]* **(844) 516-0248** or by submitting a written fax to (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
Federal External Review Process (FERP)
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/] **externalappeal.cms.gov**

(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 time frame 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.

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. 27, 2023, effective Jan. 1, 2024, expires June 28, 2024. Amended: Filed Oct. 27, 2023.*

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.*

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

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

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 100 – Office of Quality Schools

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 160.514, 160.518, 160.526, and 161.092, RSMo 2016, and sections 162.081 and 167.131, RSMo Supp. 2023, the board rescinds a rule as follows:

5 CSR 20-100.105 Missouri School Improvement Program-5 **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1364). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 100 – Office of Quality Schools

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 160.560, RSMo Supp. 2023, the board adopts a rule as follows:

5 CSR 20-100.185 Show-Me Success Diploma Program **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1364-1366). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 100 – Office of Quality Schools

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 160.514, 160.518, 160.526, 161.092, and 168.081, RSMo 2016, and section 167.131, RSMo Supp. 2023, the board rescinds a rule as follow:

5 CSR 20-100.255 Missouri School Improvement Program-5 Resource and Process Standards and Indicators **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1367). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 500 – Office of Adult Learning and Rehabilitation Services

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 178.600, 178.610, and 178.620, RSMo 2016, the board amends a rule as follows:

5 CSR 20-500.210 Services **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1367-1371). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective

thirty (30) days after publication in the *Code of State Regulations*.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 500 – Office of Adult Learning and Rehabilitation Services

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 178.600, 178.610, and 178.620, RSMo 2016, the board amends a rule as follows:

5 CSR 20-500.220 Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1372). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 500 – Office of Adult Learning and Rehabilitation Services

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 178.600, 178.610, and 178.620, RSMo 2016, the board amends a rule as follows:

5 CSR 20-500.240 Physical and Mental Restoration **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1372-1373). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 25 – Office of Childhood
Chapter 100 – Early Childhood Development

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 160.900-160.925, 161.092, and 376.1218, RSMo 2016, the board amends a rule as follows:

5 CSR 25-100.120 Individuals with Disabilities Education Act, Part C **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 3, 2023 (48 MoReg 1277-1278). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 25 – Office of Childhood
Chapter 500 – Licensing Rules for Group Child Care Homes and Child Care Centers

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.221, RSMo Supp. 2023, the board amends a rule as follows:

5 CSR 25-500.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1373-1374). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education (department) received twenty-two (22) comments on the proposed amendment.

COMMENT #1: Fifteen (15) individuals commented in support of the proposed change to revise the definition of a caregiver to include a Junior Aide.

RESPONSE: No changes have been made to the rule based on these comments.

COMMENT #2: Debbie Wren and Cathy Wagner both commented they do not feel that lowering standards by allowing for Junior Aides is the solution to the shortage of child care staff.

RESPONSE: It will be at the discretion of the child care provider as to whether or not they want to hire a Junior Aide. This is an option for staffing rather than a requirement. No changes have been made to the rule based on these comments.

COMMENT #3: Anne Jones requested that the proposed rule allow for the provider and employee's own children to be excluded from counting in the licensed capacity.

RESPONSE: This comment relates to staff/child ratios, which is outside the scope of the proposed amendment. No changes have been made to the rule based on this comment.

Due to the similarity of the following two (2) comments, one (1) response is provided after comment #5.

COMMENT #4: Jordan Aguilar commented that the department needs to stop raising child care rates.

COMMENT #5: Cumilla Micks requested that the department

not make the proposed change as families will not be able to afford child care if this passes.

RESPONSE: The department does not regulate the cost of child care or how much providers charge, as each child care program establishes their own rates. No changes have been made to the rule based on these comments.

COMMENT #6: Kate Jorgensen requested no change to the infant age definition as this will restrict home daycares from being able to take children into care and increase cost of child care.

RESPONSE: The department is not proposing to change the definition of an infant. No changes have been made to the rule based on this comment.

COMMENT #7: Based on its review, the Office of Childhood recommends to change section (2) to remove the word "any" in the first and second sentences.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees and will remove the word "any" in the first and second sentences of section (2).

5 CSR 25-500.010 Definitions

(2) Caregiver is the child care provider or other child care staff member and also includes a Junior Aide for group child care homes and child care centers. A Junior Aide is an individual sixteen (16) or seventeen (17) years of age.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 25 – Office of Childhood
Chapter 500 – Licensing Rules for Group Child Care Homes and Child Care Centers

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and sections 210.221, 210.223, and 210.1080, RSMo Supp. 2023, the board amends a rule as follows:

5 CSR 25-500.102 Personnel **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1374-1375). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education (department) received twenty-six (26) comments on the proposed amendment.

COMMENT #1: Seventeen (17) individuals commented in support of the proposed change to allow Junior Aides to count in staff/child ratio with the additional requirements.

RESPONSE: No changes have been made to the rule based on these comments.

Due to the similarity in the following three (3) comments, one (1) response that addresses these comments is at the end of the three (3) comments:

COMMENT #2: Paula Dobesh requested that there be no change in the age of caregivers and that caregivers should be eighteen (18) years of age to be counted in staff/child ratio in a group child care setting.

COMMENT #3: Debbie Wren commented that lowering standards by allowing for Junior Aides is not the solution to the shortage of child care staff.

COMMENT #4: Cathy Wagner commented that much could go wrong with allowing Junior Aides to count in staff/child ratio and there needs to be hours and structure if this change is implemented.

RESPONSE: It will be at the discretion of the child care provider as to whether they want to hire a Junior Aide. This is an option for staffing rather than a requirement. If a provider hires a Junior Aide to count in staff/child ratios, the rule sets forth additional requirements for caregivers who meet the definition of a Junior Aide. No changes have been made to the rule based on these comments.

COMMENT #5: Beth Kossen requested that a Junior Aide be allowed to count in infant/toddler staffing ratios as long as an adult caregiver is with them.

RESPONSE: At this time, the department is not considering allowing a Junior Aide to count in infant/toddler staffing ratios, but may consider this in future rule changes. No change has been made to the rule based on this comment.

Due to the similarity in the following two (2) comments, one (1) response that addresses these comments is at the end of the two (2) comments:

COMMENT #6: An unidentified individual commented that they appreciate the work to lower the age of an employee, but requested Junior Aides be allowed to count in staff/child ratio for children ages three (3) and older without direct supervision by an adult caregiver.

COMMENT #7: Kim Kinnaird requests an allowance for Junior Aides to supervise children ages three (3) and older as the sole caregiver for no more than three (3) hours per day as long as there is an adult staff member in the building.

RESPONSE: The department is not considering allowing Junior Aides to count in staff/child ratios without direct supervision by an adult caregiver. No changes have been made to the rule based on these comments.

Due to the similarity in the following two (2) comments, one (1) response that addresses these comments is at the end of the two (2) comments:

COMMENT #8: Stephanie Cage inquired if Junior Aides will have to have a background check.

COMMENT #9: Caroline Thomas commented that Junior Aides will be a great addition to help manage ratios, but wants to know if Junior Aides have to follow other staffing requirements with regard to background checks and training.

RESPONSE: Junior Aides are child care staff members and will have to complete the same requirements as all staff including a comprehensive background check, medical examination, tuberculosis risk assessment or test, orientation, and training. No changes have been made to the rule as a result of these comments.

COMMENT #10: Cumilla Micks requested that the department not make the proposed change as she will not be able to afford

child care if this passes.

RESPONSE: The department does not regulate the cost of child care or how much providers charge, as each child care program establishes their own rates. No changes have been made to the rule based on this comment.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 25 – Office of Childhood
Chapter 500 – Licensing Rules for Group Child Care Homes and Child Care Centers

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and section 210.221, RSMo Supp. 2023, the board amends a rule as follows:

5 CSR 25-500.112 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1375-1378). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education (department) received thirty-four (34) comments on the proposed amendment.

COMMENT #1: Based on its review, the Office of Childhood recommends a change in the title of the rule to reflect that the requirements apply to both staff/child ratios and group size.

RESPONSE AND EXPLANATION OF CHANGE: The department has modified the title of the rule to show that the requirements apply to staff/child ratios and group size.

COMMENT #2: Elaine Rosi commented that there are no concerns with the staff/child ratios and the rule has made ratios clear.

RESPONSE: No change has been made to the rule as a result of this comment.

Due to the similarity in the following two (2) comments, one (1) response that addresses these comments is at the end of the two (2) comments:

COMMENT #3: Caroline Thomas commented that there are no issues with the proposed changes due to the addition of Junior Aides.

COMMENT #4: Cindy Alley expressed no concerns or issues with the rule and that the allowance for Junior Aides will help with staffing.

RESPONSE: No changes have been made to the rule based on these comments.

COMMENT #5: Theresa Hendrix commented that there is no issue with the rule.

RESPONSE: No changes have been made to the rule based on this comment.

COMMENT #6: Laurie McTearnen expressed no concerns with the rule. She made a recommendation for the department to provide examples of how staff/child ratio and group sizes work to ensure programs understand.

RESPONSE: Before the proposed changes become effective, the department will provide information to programs on how the department will verify compliance for this rule. No changes have been made to the rule based on this comment.

COMMENT #7: Mackenzie Miller commented that the current ratios are sufficient.

RESPONSE: The proposed amendment does not change staff/child ratios for licensed group child care homes or child care centers. No changes have been made to the rule based on this comment.

Due to the similarity in the following five (5) comments, one (1) response that addresses these comments is at the end of the five (5) comments:

COMMENT #8: Julie Malone requested that there be no change in staff/child ratios as this will increase tuition and further impact the child care crisis.

COMMENT #9: Reed Jorgensen commented that the staff/child ratio changes would increase the cost of care as facilities will have to increase staff and home daycares will have to decrease the number of children in care.

COMMENT #10: Natasa Milnovic commented that the changes in staff/child ratio would increase the cost of child care.

COMMENT #11: Anne Morris commented that the staff/child ratio changes do not make sense, especially when applied to mixed groups in home daycares. If staff/child ratios are decreased, it will force providers to raise prices.

COMMENT #12: Cumilla Micks requested that the department not make the proposed change as families will not be able to afford child care if this passes.

RESPONSE: The proposed amendment does not change staff/child ratios for licensed group child care homes and child care centers. The amendment adds group size limitations for children three (3) years of age and older and clarifies when staff/child ratios and group sizes apply throughout the day. The ratio and group size limitations were put into a table format to make the rule easier to read and understand. The rule does not apply to licensed family child care homes. No changes have been made to the rule based on these comments.

COMMENT #13: Anne Jones requested that the proposed amendment allow for the provider and employee's own children to be excluded from counting in the licensed capacity as long as staff/child ratio is not compromised.

RESPONSE: This comment relates to overall licensed capacity, which is outside the scope of the proposed amendment changes. No changes have been made to the rule based on this comment.

Due to the similarity in the following ten (10) comments, one (1) response that addresses these comments is at the end of the ten (10) comments:

COMMENT #14: Cathy Wagner expressed concern that the maximum group size limits per age group will reduce the facility capacity and negatively impact parents and providers.

COMMENT #15: Jody Hartgrove commented that the maximum group size limits for children ages three (3) and up will cause centers currently caring for more than the maximum group

size to terminate enrollments.

COMMENT #16: Ashley Ashenfelter expressed that it is already hard to keep up with staff/child ratios and there is concern that facilities will have to terminate enrollments due to the addition of maximum group size limits.

COMMENT #17: Jade Schnatz expressed concern that the group size limits will cause facilities to decrease enrollments, especially in areas in desperate need of child care.

COMMENT #18: Kayla Giger requests clarification about how to divide groups and commented that the limits on group size will limit facility capacity.

COMMENT #19: Maggie Simpson commented that the maximum group size for preschool children would cause facilities to drop enrollment and limit parents' ability to find child care. A suggestion was made to increase the maximum group size to thirty (30) for three (3) and four (4) year old children.

COMMENT #20: Ben Engle commented that the maximum group size for preschool children would eliminate preschool spots for facilities and prohibit children from getting the care they need.

COMMENT #21: Laura Franz commented that facilities have larger classrooms that accommodate more children than the maximum group size and requests the maximum group size be thirty (30) rather than twenty (20).

COMMENT #22: Pam Morff expressed concern that their school will have to disenroll children as their classrooms are designed to hold more children than the proposed maximum group sizes.

COMMENT #23: Angel Poore disagrees with the maximum group size limits, as many facilities have enrollment over the suggested group size allowance. This change will require programs to withdraw families, including families that are eligible for child care subsidy. She made a suggestion to look at how other states implemented group sizes without disrupting families. For example, some states allow the use of shelving or accordion walls to separate space within a classroom.

RESPONSE: The proposed changes to add maximum group sizes does not require a facility to reduce capacity. Group size is already defined in 5 CSR 25-500.010(12) as the maximum number of children assigned to a specific staff member or group of staff members occupying an individual classroom or well-defined physical space within a large room. A provider may rearrange existing furniture in a room to separate or define groups or may purchase shelving to define space for individual groups. No changes have been made to the rule based on these comments.

COMMENT #24: Tammy Wilkes suggested that the rule require one (1) caregiver for every four (4) children ages one (1) to two and one-half (2½) with a maximum group size of eight (8) children to be maintained at all times, including naptime and during outdoor play.

RESPONSE: Nothing in this rule prohibits facilities from maintaining lower staff/child ratios or group sizes. Facilities may require ratio and group sizes to be maintained at all times, including during naptime and outdoor play. No changes have been made to the rule based on this comment.

COMMENT #25: Kelly Raines commented that the staff/child ratios are too high, which makes it hard to provide quality care, optimize relationships with a caregiver, and promote child development.

RESPONSE: This amendment does not change staff/child ratios for group child care homes or centers. The rule does not prohibit facilities from maintaining lower ratios or group sizes. No changes have been made to the rule based on this comment.

Due to the similarity in the following two (2) comments, one (1) response that addresses these comments is at the end of the two (2) comments:

COMMENT #26: Allison Adler commented that the naptime staff/child ratio exception in subsection (1)(C) will be helpful as it will allow teachers time for professional development and lesson planning while another teacher remains in the napping area.

COMMENT #27: Shelly Gardner agrees with the rule change in subsection (1)(C) as it will be helpful to get lunch breaks for staff during this time.

RESPONSE: No changes have been made to the rule as a result of these comments.

Due to the similarity in the following two (2) comments, one (1) response that addresses these comments is at the end of the two (2) comments:

COMMENT #28: Paula Dobesh commented that the naptime ratio exception in subsection (1)(C) does not state that at least one caregiver must be present at all times in the napping area and it is not clear what ratio should be followed if not all children are asleep.

COMMENT #29: Lisa Hemsworth requested a definition for naptime to make it clear when the staff/child ratio exception applies so staff can maintain proper supervision of children.

RESPONSE: Although staff/child ratios are not required to be maintained during naptime for groups of children ages (2) and older, staff must remain available on the premise so they can return to classroom, as needed, to meet ratios. No changes have been made to the rule based on these comments.

COMMENT #30: Pam Morff commented that the group size limits would affect playground times, as there is not enough time in the day to split outdoor play.

RESPONSE: Subsection (1)(D) allows for an exception to group sizes during outdoor play for groups composed of children age two (2) and older. No changes have been made to the rule based on this comment.

COMMENT #31: Lisa Hemsworth requested that gymnasiums be added to subsection (1)(D) as a location where group sizes do not apply. Some facilities use gymnasiums for indoor gross motor activities when staff cannot take children outside and group size limits would prevent children from being able to play together.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees and has revised subsection (1)(D).

COMMENT #32: Stephanie Cage asked for clarification between subsection (1)(D) and (1)(G) with regard to outdoor play as the statements are contradicting.

RESPONSE: The exception in subsection (1)(D) states that group sizes do not have to be maintained during outdoor play for children two (2) years of age and older. Subsection (1)(G) allows for a staff/child ratio exception during outdoor play if children

two (2) years of age or younger are not present in the outdoor play space. No changes are being made to the rule based on this comment.

COMMENT #33: Jason McTheeney commented that the outdoor play ratio exception in subsection (1)(G) will be helpful.

RESPONSE: No changes have been made to the rule based on this comment.

COMMENT #34: Amy Gaffney suggested that school age programs should be exempt from group size requirements. Otherwise, group size limits would restrict the ability for children to move about space freely or limit opportunities for children to socialize.

RESPONSE: Subsection (1)(F) is an exception to group sizes for programs licensed exclusively for school-age children, meaning that the maximum group size limits do not apply and children do not need to be divided into groups. Staff/child ratios and proper supervision of children must be maintained. No change has been made to the rule based on this comment.

5 CSR 25-500.112 Staff/Child Ratios and Group Size

(1) Staff/child ratios shall be maintained at all times.

(D) Groups composed of children two (2) years old and older shall not be required to maintain group sizes during –

1. Outdoor play;

2. Indoor gross motor activities in a gymnasium or multi-purpose room;

3. Meals;

4. Field trips; and

5. Special events including but not limited to guest speakers, assemblies, and celebrations.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 25 – Office of Childhood
Chapter 500 – Licensing Rules for Group Child Care Homes and Child Care Centers

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, and sections 210.221 and 210.223, RSMo Supp. 2023, the board amends a rule as follows:

5 CSR 25-500.182 Child Care Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1379-1380). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education (department) received six (6) comments on the proposed amendment.

COMMENT #1: Elaine Rosi commented in support of the proposed requirements.

RESPONSE: No changes have been made to the rule based on this comment.

COMMENT #2: Theresa Hendrix responded that their program will not be impacted by the changes.

RESPONSE: No changes have been made to the rule based on this comment.

COMMENT #3: Cumilla Micks commented that this rule should not be changed.

RESPONSE: No changes have been made to the rule based on this comment.

COMMENT #4: Cathy Wagner commented that there should be more explanation of expectations.

RESPONSE: Before the proposed changes become effective, the department will provide information to programs on how the department will verify compliance for this rule. No changes have been made to the rule based on this comment.

COMMENT #5: Cindy Alley commented on subsection (1)(A) with a concern about the proposed change to permit preschool children to leave the napping area to engage in quiet play after the required sleep or resting period stating that teacher supervision will have to be available and nap time is when teachers can take a break or collaborate. A suggestion was made that children should be required to lay down and rest for two (2) hours.

RESPONSE: Caregivers can take a break or collaborate during naptime as long as staff/child ratios are maintained on the premise and one (1) caregiver remains in the room. The napping area and quiet play area may be within the same room, and children are permitted to move off their cot to the quiet play area if they are awake after the maximum one (1) hour rest period. Children who awaken and wish to remain on their cot to rest may be permitted, but not forced, to do so. No changes have been made to the rule based on this comment.

COMMENT #6: Kelly Raines commented on subsection (2)(C) suggesting that toddlers should be allowed to wake up slowly if they desire rather than being taken out of bed when they awaken, and that infants and toddlers should also have at least one (1) hour of outdoor time.

RESPONSE: Toddlers waking up slowly may be allowed to remain in their napping space until they indicate a desire to get up. While there is no minimum outdoor time for infants and toddlers, they can be outside as long as weather permits. No changes have been made to the rule based on this comment.

TITLE 9 – DEPARTMENT OF MENTAL HEALTH
Division 10 – Director, Department of Mental Health
Chapter 7 – Core Rules for Psychiatric and Substance Use Disorder Treatment Programs

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Mental Health under sections 630.192 and 630.193 to 630.198, RSMo 2016, the department amends a rule as follows:

9 CSR 10-7.035 Behavioral Health Healthcare Home **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1380-1382). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 9 – DEPARTMENT OF MENTAL HEALTH
Division 30 – Certification Standards
Chapter 3 – Substance Use Disorder Prevention and Treatment Programs

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Mental Health under sections 630.192 and 630.193 to 630.198, RSMo 2016, the department amends a rule as follows:

9 CSR 30-3.134 Gambling Disorder Treatment **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2023 (48 MoReg 1424). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received

TITLE 9 – DEPARTMENT OF MENTAL HEALTH
Division 30 – Certification Standards
Chapter 3 – Substance Use Disorder Prevention and Treatment Programs

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Mental Health under sections 630.192 and 630.193 to 630.198, RSMo 2016, the department amends a rule as follows:

9 CSR 30-3.201 Substance Awareness Traffic Offender Programs **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2023 (48 MoReg 1424-1425). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received..

TITLE 9 – DEPARTMENT OF MENTAL HEALTH
Division 30 – Certification Standards
Chapter 3 – Substance Use Disorder Prevention and Treatment Programs

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Mental Health under sections 630.192 and 630.193 to 630.198, RSMo 2016, the department amends a rule as follows:

9 CSR 30-3.206 SATOP Structure **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2023 (48 MoReg 1425-1426). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 9 – DEPARTMENT OF MENTAL HEALTH
Division 30 – Certification Standards
Chapter 6 – Certified Community Behavioral Health Organization

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Mental Health under sections 630.192 and 630.193 to 630.198, RSMo 2016, the department amends a rule as follows:

9 CSR 30-6.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 17, 2023 (48 MoReg 1382-1387). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: One (1) staff comment was received. Staff requested that paragraph (6)(A)7. be changed from "case management" to "community support."

RESPONSE AND EXPLANATION OF CHANGE: The department has updated the rule language as requested.

9 CSR 30-6.010 Certified Community Behavioral Health Organization

(6) Required Services. CCBHOs shall provide a comprehensive array of services to create and enhance access, stabilize people in crisis, and provide the necessary treatment for individuals with the most serious, complex mental illnesses and substance use disorders.

(A) The following core CCBHO services must be directly provided by the CCBHO in each designated service area:

1. Crisis mental health services, including a twenty-four- (24-) hour crisis line and twenty-four- (24-) hour mobile crisis response team. Crisis mental health services must be available at the CCBHO during regular business hours and be provided by a Qualified Mental Health Professional (QMHP). The crisis line and mobile crisis response team services may be directly provided by the CCBHO or by contract with a department-approved DCO.

A. If CCBHO staff determine an in-person intervention is required based on the presentation of an individual, the intervention must occur within three (3) hours.

B. CCBHO staff shall monitor and have the capacity to report the length of time from each individual's initial crisis contact to the in-person intervention and take steps to

improve performance, as necessary;

2. Screening, assessment, and diagnosis, including risk assessment;

3. Individualized treatment, including risk assessment and crisis prevention planning;

4. Outpatient mental health services;

5. Substance use disorder treatment services including –

A. Individual and group counseling;

B. Group rehabilitative support;

C. Community support;

D. Peer support;

E. Family therapy;

F. Medication services to support medication assisted treatment; and

G. American Society of Addiction Medicine (ASAM) Level 1 Outpatient and Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring as referenced in paragraph (5)(A)1. of this rule;

6. Outpatient clinic primary care screening and monitoring of key health indicators and health risks;

7. Community support;

8. Psychiatric rehabilitation services;

9. Peer support, counseling, and family support services, including peer and family support services for individuals receiving CPR and/or Comprehensive Substance Treatment and Rehabilitation (CSTAR) services, consistent with the array of services and supports specified in the job descriptions of Certified Family Support Providers and Certified Peer Specialists; and

10. Outpatient mental health services for active members of the U.S. Armed Forces and veterans.

TITLE 9 – DEPARTMENT OF MENTAL HEALTH
Division 45 – Division of Developmental Disabilities
Chapter 5 – Standards for Community-Based Services

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Mental Health under sections 630.192 and 630.193 to 630.198, RSMo 2016, the department rescinds a rule as follows:

9 CSR 45-5.060 Procedures to Obtain Certification **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on August 1, 2023 (48 MoReg 1426). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

TITLE 9 – DEPARTMENT OF MENTAL HEALTH
Division 45 – Division of Developmental Disabilities
Chapter 5 – Standards for Community-Based Services

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Mental Health under sections 630.192 and 630.193 to 630.198, RSMo 2016, the department adopts a rule as follows:

9 CSR 45-5.060 Procedures to Obtain Certification **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2023 (48 MoReg 1426-1430). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 15 – Hospital Program

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, MO HealthNet Division, under sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2023, the division amends a rule as follows:

13 CSR 70-15.160 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2023 (48 MoReg 1546-1551). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The MO HealthNet Division received one (1) comment on the proposed amendment.

COMMENT #1: Jamie Purnell, Clinical Program and Policy Unit Manager, MHD, commented that the 2022 *National Dental Advisory Service* (NDAS), which is incorporated by reference in paragraph (1)(D)3., needs to be updated to the 2023 *National Dental Advisory Service* (NDAS).

RESPONSE AND EXPLANATION OF CHANGE: The MHD updated the 2022 *National Dental Advisory Service* (NDAS) to the 2023 *National Dental Advisory Service* (NDAS) in paragraph (1)(D)3.

13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology

(1) Outpatient *Simplified Fee Schedule* (OSFS) Payment Methodology.

(D) Fee schedule methodology. Fees for outpatient hospital services covered by the MO HealthNet program are determined by the HCPCS procedure code at the line level and the following hierarchy:

1. The APC relative weight or payment rate assigned to the procedure in the Medicare OPPS *Addendum B* is used to calculate the fee for the service, with the exception of the hospital observation per hour fee which is calculated based on the method described in subparagraph (1)(D)1.B. Fees derived from APC weights and payment rates are established using the Medicare OPPS *Addendum B* effective as of January 1 of each year as published by the CMS for Medicare OPPS. The Medicare OPPS *Addendum B* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/

addendum-and-addendum-b-updates/january-2023, January 20, 2023. This rule does not incorporate any subsequent amendments or additions.

A. The fee is calculated using the APC relative weight times the Missouri conversion factor. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee.

B. The hourly fee for observation is calculated based on the relative weight for the Medicare APC (using the Medicare OPPS *Addendum A* effective as of January 1 of each year as published by the CMS for Medicare OPPS), which corresponds with comprehensive observation services multiplied by the Missouri conversion factor divided by forty (40), the maximum payable hours by Medicare. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee. The Medicare OPPS *Addendum A* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/january-2023-0, January 20, 2023. This rule does not incorporate any subsequent amendments or additions.

C. For those APCs with no assigned relative weight, ninety percent (90%) of the Medicare APC payment rate is used as the fee;

2. If there is no APC relative weight or APC payment rate established for a particular service in the Medicare OPPS *Addendum B*, then the MHD approved fee will be ninety percent (90%) of the rate listed on other Medicare fee schedules, effective as of January 1 of each year: Clinical Laboratory Fee Schedule; Physician Fee Schedule; and Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule, applicable to the outpatient hospital service.

A. The Medicare *Clinical Laboratory Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://www.cms.gov/medicare/medicare-fee-service-payment/clinicallabfeesched/clinical-laboratory-fee-schedule-files/23clabq1, January 12, 2023. This rule does not incorporate any subsequent amendments or additions.

B. The Medicare *Physician Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-carrier-specific-files/all-states-2, January 5, 2023. This rule does not incorporate any subsequent amendments or additions.

C. The Medicare *Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://www.cms.gov/medicaremedicare-fee-service-paymentdmeposfeescheddmepos-fee-schedule/dme23, December 19, 2022. This rule does not incorporate any subsequent amendments or additions;

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on thirty-eight and one half percent (38.5%) of the fiftieth percentile fee for Missouri reflected in the 2023 *National Dental Advisory Service* (NDAS). The 2023 NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental at its website at https://wasserman-medical.com/product-category/dental/ndas/, January 10, 2023. This rule does not incorporate any subsequent amendments or additions;

4. If there is no APC relative weight, APC payment rate, other Medicare fee schedule rate, or NDAS rate established for a covered outpatient hospital service, then a MO HealthNet fee will be determined using the MHD *Dental, Medical, Other Medical or Independent Lab–Technical Component* fee schedules.

A. The MHD *Dental Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, March 8, 2023. This rule does not incorporate any subsequent amendments or additions.

B. The MHD *Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, March 8, 2023. This rule does not incorporate any subsequent amendments or additions.

C. The MHD *Other Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, March 8, 2023. This rule does not incorporate any subsequent amendments or additions.

D. The MHD *Independent Lab–Technical Component Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, March 8, 2023. This rule does not incorporate any subsequent amendments or additions;

5. In-state federally deemed critical access hospitals will receive an additional forty percent (40%) of the rate as determined in paragraph (1)(B)2. for each billed procedure code; and

6. Nominal charge providers will receive an additional twenty-five percent (25%) of the rate as determined in paragraph (1)(B)2. for each billed procedure code.

TITLE 15 – ELECTED OFFICIALS
Division 50 – Treasurer
Chapter 3 – Unclaimed Property

ORDER OF RULEMAKING

By the authority vested in the treasurer under sections 447.565 and 447.579, RSMo 2016, the treasurer amends a rule as follows:

15 CSR 50-3.095 Charitable Donation of Allowed Claims **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2023 (48 MoReg 1449). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60 – Missouri Health Facilities Review Committee
Chapter 50 – Certificate of Need Program

NOTIFICATION OF REVIEW: APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the CON applications listed below. A decision is tentatively scheduled for December 27, 2023. These applications are available for public inspection at the address shown below.

Date Filed

Project Number: Project Name
City (County)
Cost, Description

11/6/23

#6065 HT: Bothwell Regional Health Center
Sedalia (Pettis County)
$1,297,073, Replace MRI unit

11/13/23

#6070 DT: The King's Daughters Home
Mexico (Audrain County)
$1,465,868, Renovate/Modernize RCF and ICF (Therapy Center Addition)

#6068 HT: Barnes-Jewish Hospital
St. Louis (St. Louis City)
$1,147,941, Replace electrophysiology lab

#6069 HT: Christian Hospital
St. Louis (St. Louis County)
$1,885,927, Replace MRI unit

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by December 14, 2023. All written requests and comments should be sent to:

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
920 Wildwood Dr.
PO Box 570
Jefferson City, MO 65102

For additional information, contact Alison Dorge at alison.dorge@health.mo.gov.

The Secretary of State is required by sections 347.141 and 359.481, RSMo, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to adrules.dissolutions@sos.mo.gov.

NOTICE OF CORPORATE DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST FORMATION STRATEGIES, P.C.

Articles of Dissolution for Formation Strategies, P.C. have been filed with the Missouri Secretary of State. All claims against Formation Strategies, P.C. must be submitted in writing to:

Stanley B. Gillespie
8330 Ward Parkway, Suite 300
Kansas City, MO 64114.

Claims must include the name, address and phone number of the claimant, amount claimed, date claim arose and the basis for such claim. All claims will be barred unless a proceeding to enforce the claim is commenced within two years of publication of this notice.

NOTICE OF WINDING UP FOR LIMITED LIABILITY COMPANY TO ALL CREDITORS AND CLAIMANTS AGAINST STILL DITCHING SERVICES, LLC

On October 23, 2023, Still Ditching Services, LLC, a Missouri limited liability company (hereinafter the "Company"), filed its notice with the Missouri Secretary of State. Any claims against the Corporation must be sent to:

Brock A. Patton
114 Westwoods Dr.
Liberty, MO 64068

Each claim must include the following information: the name, address and phone number of the claimant; the amount claimed; the date on which the claim arose; the basis for the claim; and any documentation to support the claim. All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

NOTICE OF DISSOLUTION OF CORPORATION TO ALL CREDITORS OF AND CLAIMANTS AGAINST TEE-2-GREEN, INC

On October 16, 2023, Tee-2-Green, Inc., a Missouri Corporation (hereinafter the "Corporation"), filed its Articles of Dissolution with the Missouri Secretary of State. Any claims against the Corporation must be sent to

Gary K. Patton
Patton Wagner & Associates, P.C.
114 Westwoods Dr., Liberty, MO 64068

Each claim must include the following information: the name, address and phone number of the claimant; the amount claimed; the date on which the claim arose; the basis for the claim; and any documentation for the claim. All claims against the Corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication of this notice.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST BIG SOLUTIONS, LLC

On October 9, 2023, Big Solutions, LLC filed its Notice of Winding Up with the Missouri Secretary of State. Big Solutions, LLC requests that all persons and organizations who have claims against it present them immediately by letter to:

Allison Bischoff
777 E. Stella Lane, Apt. 135
Phoenix, AZ 85014.

All claims must include the following information: (a) name and address of the claimant, (b) the amount claimed, (c) date on which the claim arose, (d) basis for the claim and documentation thereof, and (e) whether or not the claim was secured and, if so, the collateral used as security. All claims against Big Solutions, LLC will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the date of publication of this notice.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST MANCHESTER PROPERTIES AT MARSHALL AVENUE, LLC

On October 24, 2023, Manchester Properties at Marshall Avenue, LLC, a Missouri limited liability company (the "Company"), filed a Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. You are hereby notified that if you believe you have a claim against the Company you must submit the claim in writing to:

David S. Spewak
8000 Maryland Avenue, Suite 1500
St. Louis, MO 63105.

The claim must include:

1. The name, address and telephone number of the claimant.
2. The amount of the claim.
3. The date on which the event occurred on which the claim is based.
4. A brief description of the nature of or the basis for the claim.

All claims against the Company will be barred unless the proceeding to enforce the claim is commenced within three years after the publication of this notice.

NOTICE OF DISSOLUTION TO ALL CREDITORS AND CLAIMANTS AGAINST CREST HOME IMPROVEMENT, LLC

On October 19, 2023, Crest Home Improvement, LLC, being a Missouri limited liability company, filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. The effective date of this Company's dissolution and commencement of winding up of its business was that date. Crest Home Improvement, LLC, requests that all persons who have claims against the Company present them immediately by letter addressed to:

645 Leffingwell Avenue
St. Louis, Missouri 63122.

All claims must include the following: the name and address of the claimant; the amount claimed; the basis of the claim; and documentation of the claim. Pursuant to Section 347.141 of the Revised Statutes of Missouri, as amended, any claim against Crest Home Improvement, LLC, will be barred unless a proceeding to enforce the claim is commenced within three years after the last publication of this notice.

NOTICE OF CORPORATE DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST FUTURE LADY LANCERS

On October 30, 2023, Future Lady Lancers, a Missouri nonprofit corporation, filed its Articles of Dissolution with the Missouri Secretary of State. Dissolution plan executed and effective October 19, 2023. Said nonprofit corporation requests that all persons and organizations who have claims against it present them immediately by letter to the corporation at:

Future Lady Lancers Attn: Stuart W. Duncan 17809 Keystone Trail Ct Wildwood, MO 63005	and/or	Attn: Kelly Rock c/o Sandberg Phoenix & von Gontard P.C 120 S Central Ave. Suite 1600 St. Louis, MO 63105

All claims must include the name and address of the claimant; the amount claimed; the basis for the claim; and the date(s) on which the event(s) on which the claim is based occurred. NOTICE: Because of the dissolution of Future Lady Lancers, any claims against it will be barred unless a proceeding to enforce the claim is commenced within two years after the publication date of the notices authorized by statute, whichever is published last.

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*. Citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year – 47 (2022) and 48 (2023). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				47 MoReg 1457
1 CSR 10-3.010	Commissioner of Administration		48 MoReg 1757		
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-1.010	Animal Health		48 MoReg 1596		
2 CSR 30-2.004	Animal Health		48 MoReg 987	48 MoReg 2073	
2 CSR 30-2.010	Animal Health		48 MoReg 989	48 MoReg 2075	
2 CSR 30-2.020	Animal Health		48 MoReg 995	48 MoReg 2078	
2 CSR 30-2.040	Animal Health		48 MoReg 1000	48 MoReg 2080	
2 CSR 30-9.100	Animal Health		48 MoReg 1180R	48 MoReg 1978R	
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2 CSR 90-20.040	Weights, Measures and Consumer Protection		48 MoReg 1009	48 MoReg 1847	
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2 CSR 90-25.010	Weights, Measures and Consumer Protection		48 MoReg 1010	48 MoReg 1847	
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3 CSR 10-5.250	Conservation Commission		48 MoReg 1183	48 MoReg 1849	
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3 CSR 10-5.425	Conservation Commission		48 MoReg 1211	48 MoReg 1859	
3 CSR 10-5.430	Conservation Commission		48 MoReg 1213	48 MoReg 1859W	
3 CSR 10-5.435	Conservation Commission		48 MoReg 1215	48 MoReg 1860	
3 CSR 10-5.436	Conservation Commission		48 MoReg 1217	48 MoReg 1860	
3 CSR 10-5.440	Conservation Commission		48 MoReg 1219	48 MoReg 1861W	
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3 CSR 10-6.535	Conservation Commission		48 MoReg 1250	48 MoReg 1870	
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3 CSR 10-9.350	Conservation Commission		48 MoReg 1250	48 MoReg 1870	
3 CSR 10-9.351	Conservation Commission		48 MoReg 1252	48 MoReg 1870	
3 CSR 10-9.352	Conservation Commission		48 MoReg 1252	48 MoReg 1871	
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3 CSR 10-10.707	Conservation Commission		48 MoReg 1265	48 MoReg 1873W	
3 CSR 10-10.708	Conservation Commission		48 MoReg 1267	48 MoReg 1873W	
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3 CSR 10-11.130	Conservation Commission		48 MoReg 1815		
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3 CSR 10-12.110	Conservation Commission		48 MoReg 1815		
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4 CSR 85-5.040	Division of Business and Community Solutions		48 MoReg 1602		
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5 CSR 20-500.210	Division of Learning Services		48 MoReg 1367	This Issue	
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11 CSR 30-9.010	Office of the Director		48 MoReg 203R		
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20 CSR 2220-2.900	State Board of Pharmacy		48 MoReg 1834		
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1 CSR 10-11.010	State of Missouri Travel Regulations	48 MoReg 789	April 3, 2023	Jan. 10, 2024
Department of Public Safety				
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11 CSR 90-2.010	Definitions	48 MoReg 1535	Aug. 28, 2023	Feb. 22, 2024
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12 CSR 10-41.010	Annual Adjusted Rate of Interest	Next Issue	Jan. 1, 2024	June 28, 2024
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13 CSR 35-60.010	Family Homes Offering Foster Care	48 MoReg 1673	Aug. 28, 2023	Feb. 23, 2024
13 CSR 35-60.040	Physical and Environmental Standards	48 MoReg 1673	Aug. 28, 2023	Feb. 23, 2024
13 CSR 35-60.050	Care of Children	48 MoReg 1674	Aug. 28, 2023	Feb. 23, 2024
13 CSR 35-71.015	Background Checks for Personnel of Residential Care Facilities and Child Placing Agencies	48 MoReg 1149	June 13, 2023	Dec. 9, 2023
13 CSR 35-71.020	Basic Residential Treatment for Children and Youth Core Requirements (Applicable To All Agencies) – Basis for Licensure and Licensing Procedures	48 MoReg 1675	Aug. 28, 2023	Feb. 23, 2024
13 CSR 35-71.045	Personnel	48 MoReg 1676	Aug. 28, 2023	Feb. 23, 2024
13 CSR 35-71.070	Protection and Care of the Child	48 MoReg 1677	Aug. 28, 2023	Feb. 23, 2024
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13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	48 MoReg 1349	June 30, 2023	Dec. 26, 2023
13 CSR 70-15.160	Outpatient Hospital Services Reimbursement Methodology	48 MoReg 1357	June 30, 2023	Dec. 26, 2023
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19 CSR 10-3.050	Graduate Medical Education Grant Program	48 MoReg 1747	Sept. 18, 2023	March 15, 2024
19 CSR 10-3.060	Health Professional Loan Repayment Program	48 MoReg 2053	Oct. 27, 2023	April 23, 2024
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19 CSR 30-1.002	Schedules of Controlled Substances	48 MoReg 1906	Oct. 10, 2023	April 6, 2024
19 CSR 30-20.125	Unlicensed Assistive Personnel Training Program	48 MoReg 1177	June 6, 2023	Dec. 2, 2023
Department of Commerce and Insurance				
State Board of Registration for the Healing Arts				
20 CSR 2150-5.025	Administration of Vaccines	48 MoReg 1678	Aug. 28, 2023	Feb. 23, 2024
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20 CSR 2220-2.410	Class B Hospital Pharmacy Compounding for Drug Shortages	48 MoReg 1421	July 6, 2023	Term. Oct.3, 2023
20 CSR 2220-2.410	Class B Hospital Pharmacy Compounding for Drug Shortages ***Termination***	48 MoReg 2058	July 6, 2023	Term. Oct.3, 2023
20 CSR 2220-6.050	Administration of Vaccines	48 MoReg 1680	Aug. 28, 2023	Feb. 23, 2024
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22 CSR 10-2.020	General Membership Provisions	This Issue	Jan. 1, 2024	June 28, 2024
22 CSR 10-2.046	PPO 750 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2024	June 28, 2024
22 CSR 10-2.047	PPO 1250 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2024	June 28, 2024
22 CSR 10-2.053	Health Savings Account Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2024	June 28, 2024
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22 CSR 10-2.089	Pharmacy Employer Group Waiver Plan for Medicare Primary Members	This Issue	Jan. 1, 2024	June 28, 2024
22 CSR 10-2.140	Strive for Wellness® Health Center Provisions, Charges, and Services	This Issue	Jan. 1, 2024	June 28, 2024
22 CSR 10-3.020	General Membership Provisions	This Issue	Jan. 1, 2024	June 28, 2024
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22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2024	June 28, 2024
22 CSR 10-3.058	PPO 750 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2024	June 28, 2024
22 CSR 10-3.059	PPO 1250 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2024	June 28, 2024
22 CSR 10-3.061	Plan Limitations	This Issue	Jan. 1, 2024	June 28, 2024
22 CSR 10-3.070	Coordination of Benefits	This Issue	Jan. 1, 2024	June 28, 2024
22 CSR 10-3.075	Review and Appeals Procedure	This Issue	Jan. 1, 2024	June 28, 2024

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

ORDER	SUBJECT MATTER	FILED DATE	PUBLICATION
	2023		
23-09	Orders state offices to be closed on Friday, November 24, 2023	November 9, 2023	This Issue
23-08	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to forecasted severe storm systems	August 5, 2023	48 MoReg 1684
23-07	Designates members of his staff to have supervisory authority over departments, divisions and agencies of state government	July 28, 2023	48 MoReg 1595
23-06	Rescinds Executive Order 17-20	June 29, 2023	48 MoReg 1423
23-05	Declares drought alerts for 60 Missouri counties in accordance with the Missouri Drought Mitigation and Response Plan	May 31, 2023	48 MoReg 1179
23-04	Designates members of the governor's staff as having supervisory authority over each department, division, or agency of state government	April 14, 2023	48 MoReg 911
23-03	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to severe storm systems	March 31, 2023	48 MoReg 795
23-02	Extends Executive Order 22-08, the State of Emergency, and waivers until February 28, 2023	January 24, 2023	48 MoReg 433
23-01	Orders the commencement of the Missourians Aging with Dignity Initiative, with directives to support all citizens as they age	January 19, 2023	48 MoReg 431
	2022		
22-11	Extends Executive Order 22-08, the State of Emergency, and waivers until January 31, 2023	December 29, 2022	48 MoReg 193
22-10	Declares that the current State of Emergency shall permit certain vehicles be temporarily exempt from some hours of service requirements	December 21, 2022	48 MoReg 191
22-09	Declares a call and order into active service of the organized militia and directs the Missouri State Emergency Operations Plan be activated due to forecasted severe winter storm systems	December 20, 2022	48 MoReg 189
22-08	Declares a State of Emergency and waives certain regulations to allow other registered entities to fill liquefied petroleum gas containers owned by Gygr-Gas	December 15, 2022	48 MoReg 117
22-07	Extends Executive Order 22-04 to address drought-response efforts until March 1, 2023	November 28, 2022	48 MoReg 39
22-06	Closes executive branch state offices for Friday, November 25, 2022	November 7, 2022	47 MoReg 1708
Proclamation	Convenes the One Hundred First General Assembly in the First Extraordinary Session of the Second Regular Session regarding extension of agricultural tax credits and to enact legislation amending Missouri income tax	August 22, 2022	47 MoReg 1420
22-05	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to severe storm systems	July 26, 2022	47 MoReg 1279
22-04	Declares a drought alert for 53 Missouri counties and orders the director of the Department of Natural Resources to activate and designate a chairperson for the Drought Assessment Committee	July 21, 2022	47 MoReg 1277
Proclamation	In accordance with *Dobbs*, Section 188.017, RSMo, is hereby effective as of the date of this order	June 24, 2022	47 MoReg 1075
22-03	Terminates the State of Emergency declared in Executive Order 22-02	February 7, 2022	47 MoReg 411

ORDER	SUBJECT MATTER	FILED DATE	PUBLICATION
22-02	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to forecasted severe winter storm systems	February 1, 2022	47 MoReg 304
22-01	Establishes and Designates the Missouri Early Childhood State Advisory Council	January 7, 2022	47 MoReg 222

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TOP

Rulemaking Classes

Are you new to rulemaking or in need of a refresher course to assist you in filing rules or understanding the rulemaking process?

The Administrative Rules Division offers group and individual classes for rule drafting and preparation of rule packets. Please call Curtis at (573) 751-2022 or email curtis.treat@sos.mo.gov to schedule a class.

We offer both in-person and virtual classes.

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