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

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 If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission.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

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

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

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

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

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

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

PROPOSED AMENDMENT

5 CSR 20-400.380 Mentoring Program Standards. The State Board of Education is proposing to amend the purpose and section (1) and Appendix A.

PURPOSE: This amendment provides additional guidance to districts and charter schools around high quality mentoring program standards to improve educator retention rates.

*PURPOSE: This rule clarifies the standards for [successful] **school districts and charter schools** mentoring programs.*

(1) A successful **school district and charter school** mentoring program *[will]* **shall** include, but may not be limited to, the standards listed below:

(A) An introduction to the cultural environment of the community, school district **and charter school**, school building, and classroom that*[:]*—

1. *[Provides awareness of school and district]* **Introduces school district and charter school** policies, procedures, and mission (*[teacher]* **educator** and student handbooks, Comprehensive School Improvement Plan (CSIP), goals, etc.);

2. *[Expresses]* **Introduces** community **characteristics**/norms/local expectations (community tour, housing, medical facilities, faith community, etc.);

3. *[Complements]* **Encourages membership and participation in** professional organizations at *[district]* **school district and charter school levels** and state/national levels;

4. *[Discusses classroom equality gender/race/abilities;]* **Addresses issues of diversity and equity;**

5. *[Is]* **Provides** a systematic and ongoing **process of** introduction to data analysis, assessment practice and process, etc. (not a one-(1-)*[-]* day workshop);

6. Includes **school** district **and charter school** initiatives and parental *[concerns]* **feedback**; and

7. Defines professional**, educational,** and **school** district **and charter school** acronyms**;** *[(Adequate Yearly Progress (AYP), Missouri School Improvement Program (MSIP), Individuals with Disabilities Education Act (IDEA), Parent Teacher Organization (PTO), etc.).]*

(B) A systemic and ongoing program review/evaluation by all stakeholders*[:]*—

1. Identifies all stakeholders;

2. Identifies mentoring **characteristics,** outcomes, *[how they will be measured,]* **assessment tools,** and timelines;

3. Gathers regular *[and]* systematic**, qualitative and quantitative** feedback from mentor, *[protégé]* **mentee**, and administrators to determine if mentoring is working *[(might include pre- and post-surveys for mentors and protégés and may include information on retention rates/numbers, levels of job satisfaction, student achievement, or cost of turnover)]*;

4. Is based on a foundation of best practices;

5. Requires independent/anonymous exit interviews of staff (may be connected to beginning educators' survey at state level) so clear reasons for staff departures can be determined;

6. Is supported by central office and school board—**as evidenced by** trend data; and

7. Is included in broader Professional Development *[(PD)]* program evaluation (locally and on Missouri School Improvement Program **(MSIP)** reviews)*[.]***;**

(C) An individualized plan for beginning educators that aligns with the **school** district's **and charter school's** goals and needs that*[:]*—

1. Is aligned with *[the department's Performance Based Teacher/Educator Evaluation (PBTE) standards]* **a school district and charter school evaluation tool that is aligned with the Essential Principles of Effective Evaluation as evidenced by Screen 18a of the Core Data System**;

2. Is a systematic and *[concise]* **specific** mentoring and professional development plan that *[prioritizes the immediate and future needs of the new educator]* **identifies priority indicators for beginning educators**;

3. Aligns with *[district's]* **a school district and charter school** CSIP and certification requirements;

4. Establishes outcomes for new educators;

5. Is an extension or part of a professional development plan that may have begun during student teaching/internship or culminating project in college;

6. Establishes *[classroom or on-the-job observations that are guided by practices.]* **non-evaluative mentor observations**

that are guided by needs identified by mentor and mentee. Observations should include pre- and post- observation conferences, including reflective questions; *[and]*

7. Encourages structured experiences and expectations for all new educators*[.]* **(planning time, meeting time, time management, etc.);**

8. Establishes opportunities for mentees to observe master educators; and

9. Plans for completion of a required Beginning Teacher Assistance (BTA) Program aligned with the BTA guidelines;

(D) *[Appropriate criteria for selecting mentors that:]* **Collaborative selection of and support for mentors.**

1. Current or retired educators selected to be mentors should—

*[1.]***A.** *[Should h]***H**ave a minimum of *[three (3)]* **four (4)** years of experience;

*[2.]***B.** *[Have traits such as]* **Exhibit** enthusiasm and *[job]* commitment **to the profession, maintain confidentiality, and be respected by their colleagues**;

*[3.]***C.** *[Are]* **Be** committed to *[self-growth as well as]* **continuous learning, reflection, and** mentoring;

*[4.]***D.** Hold **or have held** a same or similar position/job or grade/subject area (in- or out-of-building/**school** district **and charter school**);

[5. May use a mechanism to end pairing if either mentor or protégé is not satisfied;]

*[6.]***E.** Understand broad educational issues as well as specific teaching/education issues; **and**

*[7.]***F.** Have a strong understanding of pedagogy*[,]* **and** instructional expertise*[, and relevant administrative issues;]* **in content area(s);**

2. School districts and charter schools shall—

*[8.]***A.** *[Are available to mentor]* **Create mentor and mentee collaboration time** (release time, **common planning time,** fewer additional assignments);

*[9.]***B.** *[Are assigned]* **Require mentor and mentee pairs to be** collaboratively **assigned** by administrator(s) and local professional development committee **member(s)** with input from grade-level or department chair; and

*[10.]***C.** *[Are supported]* **Support the mentoring process** in time/effort by administration and school board*[.]***;**

(E) Comprehensive mentor training **and support** that[:]**—**

1. Recognizes mentoring is NOT evaluation; confidentiality is required between mentor and *[protégé]* **mentee** (except in situations of child endangerment);

2. Includes cognitive coaching skills along with collaborative training;

3. Includes observation and feedback training/skills;

4. Provides an awareness of phases of first-year educators (stress, depression, etc.);

5. Provides training on mentoring standards, performance-based evaluation requirements, certification requirements, and local expectations;

6. Includes a catalogue of resources available for beginning educators;

7. Recognizes the need for knowledge and strategies on classroom management;

8. Encourages *[small]* **school** districts **and charter schools** to form mentoring consortia (may use existing structures to form consortia (e.g., conference schools));

9. Focuses on exemplary teaching and assessment practices;

10. Builds working strategies that encourage problem solving and independent thinking;

11. Provides understanding of student assessments and how educators can utilize them to guide instruction; *[and]*

12. Includes self-assessment **and reflection** that identifies whether mentoring is meeting both the mentor's and *[protégé's]* **mentee's** expectations*[.]***; and**

13. Describes and provides a template for the mentor's log – a written record of observations/meetings that includes dates and times signed by both the mentor and mentee;

(F) A complete list of responsibilities for the mentor, beginning *[teacher]* **educator,** and administrator(s) is addressed in Appendix A*[.]***;**

(G) Sufficient time for mentors to observe beginning educators, and for the beginning educators to observe master educators*[, are structured to provide multiple opportunities over time to minimize the need to require substitute teachers to facilitate observations]* by*[:]***—**

1. Aligning class schedules and planning periods to complement mentoring duties;

2. Utilizing state and local professional development funds*[, Career Ladder,]* or stipends to support mentors' additional duties;

3. Providing **a minimum of four (4) class periods each year for mentor** release time *[for coaching]* **to coach**, *[observation]* **observe**, and *[meeting (minimum of three (3) each year)]* **meet**; *[and]*

4. *[Encouraging college support of resources, on-line classes, personal visits, and/or beginning educators' assistance programs.]* **Providing a minimum of four (4) opportunities for mentees to observe master educators each year; and**

5. Providing release time to attend professional conferences, trainings, and meetings.

APPENDIX A

TOPIC	Beginning *[Teacher]* **Educator**	Mentor or Professional Development Committee **(PDC)**	*[Principal]* **Administrator**	**School** District, **Charter School,** PDC**,** and School Board	College or University	DESE, **Regional Service Centers,** Associations, and Others
MENTOR SELECTION		PDC collaboratively assists in selection and pairing	*[Principal or superintendent]* **Administrator** collaboratively assists in selection and pairing	PDC collaboratively assists in selection and pairing		**Source of content specific mentors**
MENTOR TRAINING		Mentor attends training**; PDC responsible for arranging on-going mentoring training**	Attends mentor training and supports mentor and *[protégé]* **mentee**	Provides policy and support for ongoing mentor training program	Provides awareness or expectation for graduates and may provide training for mentors	Provides **on-going** regional training for mentors with cognitive coaching *[information]* **support**
INITIAL CONTACT	Seeks contact prior to beginning of school year	Contacts *[protégé]* **mentee** and welcomes him/her to community. Confirms first meeting **(date/time)**	Contacts *[protégé]* **mentee** and welcomes him/her to community. Arranges first meeting	Provides curriculum guides, handbooks, and pertinent grade/subject level information	Instructs student teachers on expectation of mentoring **program**	
COMMUNICATION	Seeks support and assistance with mentor and colleagues	Follows through on contacts and individualizes topics for *[protégé]* **mentee**	Assures mentor and *[protégé]* **mentee** communicate regularly	May provide **school** district*[-]* wide **and charter schoolwide** opportunities for mentors and *[protégés]* **mentees**	*[Provides a]* **May provide** minimum *[of]* annual contact for 1st & 2nd year *[teachers]* **educators**	Supports communication between colleges and new *[teachers]* **educators**
CONFIDENTIALITY	Maintains confidentiality at all times and appreciates assistance	Maintains confidentiality at all times and reinforces trust	Appreciates mentor/*[protégé]* **mentee** confidentiality and does not undermine effort	Remains neutral party*[.]*		
DOCUMENTATION **OF PROFESSIONAL DEVELOPMENT**	Maintains log/list of inservice, professional workshops, reading, **collaborative development projects,** and organizational activities	Reviews documentation	Reviews formal professional *[development]* **growth** plan	Keeps required documentation for beginning educators and mentors for verification purposes	May collect data on strength or weakness of first-year *[teachers]* **educators**	May assist in data collection and review
PROFESSIONAL *[DEVELOPMENT]* **GROWTH** PLAN **(Tied to Model Teacher/Leader Standards)**	Maintains and regularly evaluates personal **growth** plan; shares with mentor	Assists in development of the *[PD]* **professional growth** plan and encourages growth and career advancement	Supports new educators' professional *[development]* **growth** plans	*[Protégé]* **Mentee** and support team complete end-of-year **school** district **and charter school** checklist or assessment	May provide on**-**going or advanced coursework/ **growth opportunities**	Provides models and workshop opportunities

MENTOR PROGRAM SUPPORT	**Network in and outside school district and charter school**	**Network in and outside school district and charter school**	Supports time for observation, collaboration, *[&]* **and** compensation **(Observation outside of school district and charter school may be needed)**	Formalizes written guidelines, mentor time, and resources	Offer support to graduates from any Missouri college	Develops rules and standards. **Develop on-going mentor training/support and networking opportunities**
EVALUATION OF MENTORING *[PROCESS]* **PROGRAM**	Participate in formal evaluation of mentoring program	Participate in formal evaluation of mentoring program	Participate in formal evaluation of mentoring program	Develops mentoring assessment/ evaluation tool that aligns with standards and assesses formal evaluation of mentoring and makes revisions	May utilize information to improve preparation programs	Provides models; evaluates for MSIP purposes

*AUTHORITY: sections 160.720[,] and 161.375, RSMo Supp. [2007] **2013, and section** 161.092, **RSMo Supp. 2014**. This rule previously filed as 5 CSR 80-850.045. Original rule filed Oct. 29, 2002, effective June 30, 2003. Rescinded and readopted: Filed Jan. 18, 2008, effective Sept. 30, 2008. Moved to 5 CSR 20-400.380, effective Aug. 16, 2011. Amended: Filed Oct. 28, 2016.*

PUBLIC COST: The proposed amendment will cost local school districts and charter schools a maximum of seven hundred thousand dollars ($700,000) per year over the life of the rule, assuming mentoring is provided through an outside vendor. The cost of implementation could be substantially reduced for school districts and charter schools reallocating the resources of existing mentoring programs.

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 Elementary and Secondary Education, attention: Paul Katnik, Assistant Commissioner, Office of Educator Quality, PO Box 480, Jefferson City, MO 65102-0480 or by email at educatorquality@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

PUBLIC COST
FISCAL NOTE

I. RULE NUMBER

Title 5 – Department of Elementary and Secondary Education

Division 20 – Division of Learning Services

Chapter 400 – Office of Educator Quality

Rule Number and Name:	5 CSR 20-400.380 Mentoring Program Standards
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
School Districts and Charter Schools	Estimated maximum cost of $700,000 per year over the life of the rule.

III. WORKSHEET

The estimated cost is based on 2,000 new teachers per year X $350 per teacher = $700,000 for mentoring services provided by an outside vendor.

IV. ASSUMPTIONS

The public cost of this rule is based on the assumption that the school district and charter school uses an outside vendor for implementation of the mentoring program. Currently, mentoring programs provided through an outside vendor cost $350 per participant. Assuming 2,000 new teachers enter Missouri school districts and charter schools each year, the total cost of mentoring programs would be $700,000 per year over the life of the rule. The cost of implementation could be substantially reduced or eliminated for school districts and charter schools reallocating the resources of existing mentoring programs. In addition, mentoring training could be included as a part of the school district's and charter school's professional development program.

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

PROPOSED RULE

5 CSR 20-400.385 Beginning Teacher Assistance Program

PURPOSE: Section 168.400, RSMo and section 168.021.1, RSMo establish the completion of a beginning teacher assistance program (BTAP) as a requirement of certification. This proposed rule establishes minimum requirements for an effective BTAP. A well-designed and implemented BTAP with on-going support can improve practice, helping new educators have the skills and knowledge to positively impact student achievement.

(1) All new teachers are required to participate in a beginning teacher assistance program (BTAP) sponsored by a Missouri teacher education program and provided by an education association, regional service center, school district, or charter school. The minimum requirements for the program shall include, but not be limited to, an overview of the topics listed below:

(A) Classroom Environment—

1. Classroom management techniques;
2. Time, space, transitions and activities management; and
3. Awareness of diverse classroom, school and community cultures;

(B) Student Engagement and Motivation—

1. Effective instruction;
2. Clear learning goals and/or objectives;
3. Student voice and choice; and
4. Teaching and learning activities with high student engagement;

(C) Professional Communication—

1. Effective communication with students, mentors, colleagues and parents;
2. Verbal and nonverbal communication techniques; and
3. Effective use of technology and social media for communication; and

(D) Education-Related Law—

1. Certification requirements;
2. Professional rights and responsibilities; and
3. Self-assessment and professional learning.

(2) An effective program includes a plan of professional growth for the first two (2) years of teaching, and provides on-going support during the initial contract year.

AUTHORITY: sections 161.092 and 168.021, RSMo Supp. 2014, and section 168.400, RSMo Supp. 2013. Original rule filed Oct. 31, 2016.

PUBLIC COST: This proposed rule will cost local school districts and charter schools a maximum of five hundred thousand dollars ($500,000) per year over the life of the rule. The cost of implementation could be substantially reduced for school districts and charter schools reallocating the resources of existing BTAPs.

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 Department of Elementary and Secondary Education, Attention: Paul Katnik, Assistant Commissioner, Office of Educator Quality, PO Box 480, Jefferson City, MO 65102-0480, or by email to educatorquality@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Title 5 – Department of Elementary and Secondary Education
Division Title: Division 20 – Division of Learning Services
Chapter Title: Chapter 400 – Office of Educator Quality

Rule Number and Title:	5 CSR 20-400.385 Beginning Teacher Assistance Program
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
School Districts/Charter Schools	Estimated maximum cost of $500,000 per year over the life of the rule.

III. WORKSHEET

The estimated cost is based on 2,000 new teachers per year x $250 per teacher = $500,000

IV. ASSUMPTIONS

The public cost of this rule is based on the assumption that the school district and charter school uses an outside vendor for implementation of the beginning teacher assistance program (BTAP). Currently, BTAPs provided through an outside vendor cost $250 per participant. Assuming 2,000 new teachers enter Missouri school districts and charter schools each year, the total cost of BTAPs would be $500,000 per year over the life of the rule. The cost of implementation would vary based on the number of new teachers in a school district and charter school. It could be substantially reduced or eliminated for school districts and charter schools reallocating the resources of existing BTAPs. In addition, beginning teacher assistance could be included as a part of the school district's and charter school's program of professional development.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 5—Conduct of Gaming

PROPOSED AMENDMENT

11 CSR 45-5.183 Table Game and Poker Cards—Specifications. The commission is amending section (1).

PURPOSE: This amendment allows for the use of manufacturer pre-shuffled decks of cards to be used at table games.

(1) Unless otherwise approved by the commission, all cards used for gambling games must meet the following specifications:

(G) Each deck of cards for use in table games as defined in this section shall be *[packaged]* **boxed** separately *[through the use of]* **or boxed in sets of two (2) or more manufacturer pre-shuffled decks and wrapped with** cellophane or shrink wrap or other similar material as approved by the commission and such packaging shall have a tamper resistant destructive security seal and a tear band. Each deck of poker cards shall be *[packaged]* **boxed** in sets of two (2) decks *[through the use of]* **and wrapped with** cellophane or shrink wrap or other similar material as approved by the commission and have a tamper resistant destructive security seal and a tear band;

*AUTHORITY: sections 313.004 and 313.845, RSMo 2000, and section[s] 313.805, **RSMo Supp. 2013,** and **section** 313.830, RSMo Supp. 2014. Original rule filed Dec. 17, 1996, effective Aug. 30, 1997. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 27, 2016.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 10, 2017, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 5—Conduct of Gaming

PROPOSED AMENDMENT

11 CSR 45-5.184 Table Game Cards—Receipt, Storage, Inspections, and Removal from Use. The commission is amending sections (7), (8), (11), and (12).

PURPOSE: This amendment allows decks of cards to be processed through an automated shuffler to ensure all cards are in the deck, but still requires the backs of the cards to be inspected for any deck used more than one (1) time at a table.

(7) Prior to being placed into play, all decks shall be inspected by the dealer, and the entire inspection observed by a floor supervisor or above. Card inspection at the gaming table shall require each deck to **either** be sorted into sequence and into suit **or processed through an automated shuffler capable of reading the card faces** to ensure that all cards are in the deck. *[As part of the inspection,]* **For decks that may be used more than once, the inspection shall also require** the dealer *[shall also]* **to** check the back of each card to ensure that it is not flawed, scratched, or marked in any way. Card inspection for games which use at least a six (6)-deck shoe and allow players to handle the cards may be conducted at an alternate table in the same pit. In this instance, the floor supervisor or above shall notify surveillance and surveillance shall record on the surveillance shift log both the table number where the card inspection is conducted and the table number at which the cards are to be placed into play.

(8) When cards are placed in play, the Class B licensee shall record on each deck/**multi-deck** box the table number, the date, and the time the cards were placed on the table for use.

(11) Card(s) damaged during the course of play shall be replaced by the dealer who shall request a floor supervisor or above to bring a replacement card(s) or deck/**multi-deck** from the pit stand.

(12) At the end of the gaming day or, in the alternative, at least once each gaming day at the same time each day, as designated by the licensee and approved by the commission, and at other times as may be necessary, the floor supervisor or above shall collect all used cards.

(A) These cards shall be counted down manually by the dealer or by an automated shuffler and placed in the original deck/**multi-deck** boxes. The time the decks were removed from the table shall be recorded on the deck/**multi-deck** boxes. The boxes shall be placed in a sealed envelope or container. For games in which dealing procedures require cards to be dealt only once, the sealed envelopes or containers shall be easily distinguishable from those used for all other table games. The bags will be conspicuously labeled as containing single-use cards.

*AUTHORITY: sections 313.004 and 313.845, RSMo 2000, and section[s] 313.805, **RSMo Supp. 2013,** and **section** 313.830, RSMo Supp. 2014. Original rule filed Dec. 17, 1996, effective Aug. 30, 1997. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 27, 2016.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 10, 2017, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

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

PROPOSED AMENDMENT

11 CSR 45-9.104 Minimum Internal Control Standards (MICS)—Chapter D. The commission is amending section (1).

PURPOSE: This amendment changes the minimum internal control standards for table games.

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter D—Table Games (Live Games), which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter D does not incorporate any subsequent amendments or additions as adopted by the commission on *[October 29, 2014]* **October 26, 2016**.

AUTHORITY: section 313.004, RSMo 2000, ***section*** *313.800,* ***RSMo Supp. 2016, section*** *313.805,* ***RSMo Supp. 2013,*** *and sections 313.812, 313.817, and 313.830, RSMo Supp. 2014. Emergency rule filed July 31, 2014, effective Aug. 28, 2014, expired Feb. 26, 2015. Original rule filed July 31, 2014, effective Feb. 28, 2015. Amended: Filed Oct. 27, 2016.*

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for Tuesday, January 10, 2017, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

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

PROPOSED AMENDMENT

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

PURPOSE: This proposed amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2017.

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

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

AUTHORITY: section 32.065, RSMo 2000. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 21, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 21, 2016.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate. This proposed amendment will result in an increase in the interest rate charged on delinquent taxes.

PRIVATE COST: This proposed amendment could cost private entities more than five hundred dollars ($500) in the aggregate. This proposed amendment will result in an increase in the interest rate charged on delinquent taxes. The actual number of affected taxpayers is unknown. See detailed fiscal note for further explanation.

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

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

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

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Counties	Although the 2017 interest rate imposed on delinquent taxes will be one percent higher than the rate imposed in 2016, the aggregate impact on public entities remains less than $500.
Cities	
Special Taxing Districts	

III. WORKSHEET

The proposed amendment establishes the rate of interest for 2017 at four percent (4%), an increase of one percent over the rate in 2016.

The future amount of past due taxes is unknown. Although the 2017 interest rate imposed on delinquent taxes is one percent higher than the rate imposed in 2016, this increase has no additional fiscal impact for public entities.

	Current Rule 3.00%	**Proposed Amendment 4.00%**
Past due tax amount	$100.00	$100.00
Interest Amount	+ 3.00	+ 4.00
Total Amount Due	**$103.00**	**$104.00**

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the director of revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2016 was 3.50 percent. Rounded to the nearest whole percentage results in a four percent (4%) interest rate.

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

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

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	**Classification by types of the business entities which would likely be affected:**	**Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:**
Any taxpayer with delinquent tax.	Any taxpayer with delinquent tax.	The proposed amendment could cost private entities more than $500 in the aggregate.

III. WORKSHEET

The proposed amendment establishes the rate of interest for 2017 at four percent (4%), an increase of one percent over the rate in 2016.

The future amount of past due taxes is unknown. Because the 2017 interest rate imposed on delinquent taxes is one percent higher than the rate imposed in 2016, the interest rate increases one per cent per $100 of delinquent taxes to private entities.

	Current Rule 3.00%	**Proposed Amendment 4.00%**
Past due tax amount	$100.00	$100.00
Interest Amount	+ 3.00	+ 4.00
Total Amount Due	**$103.00**	**$104.00**

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the director of revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2016 was 3.50 percent. Rounded to the nearest whole percentage results in a four percent (4%) interest rate.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects
Chapter 19—Standards for Surveyor's Real Property Report

PROPOSED AMENDMENT

20 CSR 2030-19.010 Surveyor's Real Property Report. The board is amending sections (1)–(5).

PURPOSE: This rule is being amended to add the word "professional" in front of land surveyor due to passage of HB 343.

(1) A *[registered]* **licensed professional** land surveyor in Missouri shall not provide to any party a Surveyor's Real Property Report unless they are in the possession of a work order specified elsewhere in this chapter and signed by the borrower/purchaser indicating that they have been advised of the different types of surveying services available and the scope of each of these services. The required work order is to be initiated and signed during the loan application process. The Surveyor's Real Property Report is to be used only for residential, single-family detached dwellings; duplexes; triplexes and fourplexes with not more than one (1) dwelling structure per previously surveyed and recorded parcel or tract. The Surveyor's Real Property Report is not to be used for commercial, institutional, **or** industrial buildings or multifamily dwellings which share a common entranceway or stairwell.

(2) Research and Records—The **professional land** surveyor shall perform adequate research, maintain sufficient recorded documentation**,** and provide the field crew with information necessary to locate the property in the field.

(3) Field Procedures—Detailed notes shall be taken on each Surveyor's Real Property Report and kept as a part of the **professional land** surveyor's permanent records. A diligent search for existing control shall be made by the field crew and the highest order of monumentation available shall be used. Monumentation is defined as permanent and semi-permanent monuments described in the Minimum Standards for Property Boundary Surveys and other survey control, such as stones, axles, rebars, crosses**,** and pipes. Occupation lines**,** such as fence lines, hedge rows, **and** mowing lines, are not considered monumentation unless supported by survey control. The **professional land** surveyor must obtain sufficient evidence relating to the property boundary to demonstrate general knowledge of the given area. Appropriate field instrumentation and measuring equipment needed to achieve the stated level of certainty shall be utilized. The norm would include **Electronic Distance Measuring** (EDM), theodolite, transits, and measuring tapes.

(4) Form of Report—The report is a drawing of the parcel and it shall be furnished to the borrower/purchaser and shall show the following:

(E) Easements shown on the subdivision plat shall be shown. If documentation of other easements is provided the **professional land** surveyor, they shall be shown together with their source;

(5) Certification—A Surveyor's Real Property Report shall not contain the word survey in any part of the report except as required in this standard, and must contain the following:

(A) The name, address**,** and telephone number of the **professional land** surveyor responsible for the report and the name of the party who ordered the work;

(B) A statement that the report was either conducted by the **professional** land surveyor or under his/her immediate personal supervision, the date the report was made**,** and the real property description or the public record reference of the property shown in the report;

(C) A statement that the accompanying drawing is a representation of the conditions that were found at the time of the inspection and that the report does not constitute a property boundary survey and is subject to any inaccuracies that a subsequent property boundary survey may disclose. It shall state the fact that no property corners were set*[,]* and that the information shown on the drawing should not be used to construct any fence, structure**,** or other improvements. If the property dimensions are based upon unverified recorded or deed information, this shall be so stated. Include notification that the **professional** land surveyor is not extending a warranty to the present or future owners or occupants; and

(D) The **professional** land surveyor shall sign, seal**,** and date the report.

*AUTHORITY: section 327.041, RSMo Supp. [2005] **2014, and section 327.272, RSMo Supp. 2016**. This rule originally filed as 4 CSR 30-19.010**.** Original rule filed May 3, 1994, effective Dec. 30, 1994. Amended: Filed Dec. 1, 2005, effective June 30, 2006. Moved to 20 CSR 2030-19.010, effective Aug. 28, 2006. Non-substantive change filed Oct. 21, 2015, published Dec. 31, 2015. Amended: Filed Oct. 31, 2016.*

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 Board of Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects, PO Box 184, Jefferson City, MO 65102, via facsimile at (573) 751-8046, or via email at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects
Chapter 20—Mapping Survey Standards

PROPOSED AMENDMENT

20 CSR 2030-20.030 Certification of the Map. The board is amending the purpose statement.

PURPOSE: This rule is being amended to add the words "professional land" in front of surveyor in the purpose statement due to passage of HB 343.

*PURPOSE: This rule prescribes the statement made by the **professional land** surveyor of the map.*

*AUTHORITY: section 327.041, RSMo Supp. [1993] **2014**. This rule originally filed as 4 CSR 30-20.030. Original rule filed May 3, 1994, effective Dec. 30, 1994. Moved to 20 CSR 2030-20.030, effective Aug. 28, 2006. Non-substantive change filed Oct. 21, 2015, published Dec. 31, 2015. Amended: Filed Oct. 31, 2016.*

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

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Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2085—Board of Cosmetology and Barber Examiners
Chapter 3—License Fees

PROPOSED AMENDMENT

20 CSR 2085-3.010 Fees. The board is amending the purpose and sections (1)–(3).

PURPOSE: The board is statutorily obligated to enforce and administer the provisions of sections 328.010–328.160, RSMo. Pursuant to sections 328.060.1, RSMo and 329.015, RSMo, the board shall, by rule and regulation, set the amount of fees authorized by sections 328.010–328.160, RSMo and 329.010–329.265, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the committee for administering the provisions of sections 328.010–328.160, RSMo and 329.010–329.265, RSMo. Therefore, this amendment reduces student fees and is a one- (1-) time reduction in renewal fees.

PURPOSE: This rule establishes and fixes the various fees and charges authorized by Chapters 328 and 329, RSMo[, and Truly Agreed To and Finally Passed SB 280, 2005].

(1) The following barber related fees are hereby established by the State Board of Cosmetology and Barber Examiners for those fees, activities, or licenses governed by Chapter 328, RSMo.

(A) Apprentice Barber	
1. Registration	$*[25]* **5**
(C) Barber	
1. Reciprocity	$100
2. Exam Score Endorsement Fee	$100
3. Certificate of Registration (first license)	$ 20
4. License Renewal	$ 30
A. License Renewal Effective July 1, 2017 through November 30, 2017	**$ 15**
*[A.]***B.** Reinstatement (delinquent) Fee after November 30 (not renewable after two (2) years)	$ 60
C. Reinstatement Effective December 1, 2017 through September 30, 2019	**$ 45**
*[B.]***D.** Military renewal under **section** 328.110.3, RSMo	$ 1
(D) Barber Establishment (Full Service/Chair Rental)	
1. Certificate of Registration/ License	$100
2. Change of Location	
A. Full Service Barber Establishment	$100
B. Barber Chair/Individual Space Renter	$ 50
3. Change of Ownership	$ 50
4. Adding a Co-Owner	$ 50
5. License Renewal	$ 50
A. License Renewal Effective July 1, 2017 through October 30, 2017	$ **25**
*[A.]***B.** Penalty Fee after October 30	$ 80
C. Penalty Fee Effective October 31, 2017 through September 30, 2019	**$ 55**
6. Delinquent Fee (Opening a barber establishment without registering before opening)	$100
(E) Instructor	
1. Certificate of Registration (first license)	$ 20
2. License Renewal	$ 30
A. License Renewal Effective July 1, 2017 through April 30, 2018	**$ 15**
*[A.]***B.** Reinstatement (delinquent) Fee after April 30 not renewable after two (2) years	$ 50
C. Reinstatement Effective May 1, 2018 through September 30, 2019	**$ 45**
(F) Miscellaneous Fees (Applicable to all licensees/registrants)	
1. Certification/Affidavit of Licensure	$ 10
2. Certification of Training Hours, Examination Scores	$ 10
3. Duplicate License/Registration Fee	$ 10
4. Handling/Insufficient Funds Fee (Any uncollectible check or other financial instrument)	$ 25
5. Inactive License Fee	$*[25]* **12.50**
6. Late Fee	$ 30
7. Name Search Fee	(As determined by the Missouri State Highway Patrol)
(G) School	
1. Application Fee to Open a New School/College	$500
2. Change of Location	$500
3. Change of Ownership	$300
4. Adding a Co-Owner	$ 50
5. License Renewal	$500
A. Effective July 1, 2017 through September 30, 2017	**$250**
(H) Student Barber	
1. Enrollment Application Fee	$*[25]* **5**

(2) The following cosmetology related fees are hereby established by the board for those fees, activities, or licenses governed by Chapter 329, RSMo.

(A) Apprentice Cosmetology	
1. Enrollment Fee	$*[25]* **5**
(C) Cosmetology Establishments (up to and including three (3) operators)	
1. Application/License Fee (Full Service & Rental Station)	$100
2. Change of Location—	
A. Full Service Cosmetology Establishment	$100
B. Rental Station/Independent Contractors	$ 50
3. Change of Ownership	$100
4. Adding Co-Owner	$ 50
5. Delinquent Fee (Opening a cosmetology establishment without registering before opening)	$100

6. Renewal Fee (Full Service & Rental Station)	$ 50
A. Renewal Fee Effective July 1, 2017 through September 30, 2017	**$ 25**
*[A.]***B.** Reinstatement (Includes Late Fee)	$ 80
C. Reinstatement Effective October 1, 2017 through September 30, 2019	**$ 55**
(D) Instructors	
1. License Fee	$ 30
2. Instructor Trainee Enrollment Fee	$*[25]* **5**
3. Reciprocity Fee	$100
4. Reinstatement Fee (Includes Late Fee)	$ 60
A. Effective October 1, 2017 through September 30, 2019	**$ 45**
5. Renewal Fee	$ 30
A. Effective July 1, 2017 through September 30, 2017	**$ 15**
(E) Miscellaneous Fees (Applicable to all licensees/registrants)	
1. Certification/Affidavit of Licensure/Registration	$ 10
2. Certification of Training Hours, Examination Scores	$ 10
3. Duplicate License Fee	$ 10
4. Handling Fee (Any uncollectible check or other financial instrument)	$ 25
5. Inactive License Fee	$*[25]* **12.50**
6. Late Fee	$ 30
(F) Operator Fees	
1. Additional Operator Fee	$ 10
2. Reciprocity Fee	$100
3. Exam Score Endorsement Fee	$100
4. Reinstatement Fee (Includes Late Fee)	$ 60
A. Effective October 1, 2017 through September 30, 2019	**$ 45**
5. Renewal Fee	$ 30
A. Effective July 1, 2017 through September 30, 2017	**$ 15**
(G) School	
1. Change of Location Fee	$500
2. School Application/License Fee	$500
3. Satellite Classroom License Fee	$300
4. Satellite Classroom Renewal Fee	$300
A. Effective July 1, 2017 through September 30, 2017	**$150**
5. School Renewal Fee	$500
A. Effective July 1, 2017 through September 30, 2017	**$250**
(H) Student	
1. Enrollment Application Fee	$*[25]* **5**

(3) The following fees are hereby established by the board for crossover licensees under Chapter 328 or Chapter 329, RSMo.

(A) Establishments:	
1. Application/License Fee	$100
2. Change of Ownership	$100
3. Adding Co-Owner	$ 50
4. Change of Location Fee (Full Service)	$100
5. Change of Location Fee (Rental)	$ 50
6. Delinquent Fee (Opening an establishment without a license)	$100
7. Reinstatement Fee (Includes Late Fee)	$130
A. Effective October 1, 2017 through September 30, 2019	**$ 80**
8. Renewal Fee (Full Service & Rental Station)	$100
A. Effective July 1, 2017 through September 30, 2017	**$ 50**
(B) Instructors	
1. Certificate of Registration	$ 20
2. Instructor Trainee Enrollment Fee (Applicants required to complete additional cosmetology instructor education or training for crossover license)	$*[25]* **5**
3. Reciprocity Fee	$100
4. Reinstatement Fee (Includes Late Fee)	$ 60
A. Effective October 1, 2017 through September 30, 2019	**$ 30**
5. Renewal Fee	$ 30
A. Effective July 1, 2017 through September 30, 2017	**$ 15**
(C) Miscellaneous Fees	
1. Certification/Affidavit of Licensure	$ 10
2. Certification of Training Hours, Examination Scores	$ 10
3. Duplicate License Fee	$ 10
4. Handling Fee (Any uncollectible check or other financial instrument)	$ 25
5. Inactive License Fee	$*[25]* **12.50**
6. Late Fee	$ 30
7. Name Search Fee (As determined by the Missouri State Highway Patrol)	
(D) Operators	
1. Initial Application/License Fee	$100
2. Reciprocity Fee	$100
3. Exam Score Endorsement Fee	$100
4. Reinstatement Fee (Includes Late Fee)	$ 90
A. Effective October 1, 2017 through September 30, 2019	**$ 60**
5. Renewal Fee	$ 60
A. Effective July 1, 2017 through September 30, 2017	**$ 30**
(E) Schools	
1. Change of Location Fee (schools)	$850
2. Delinquent Fee (Opening a school without required license)	$100
3. Initial Application/License Fee	$850
4. Reinstatement Fee (schools) (Includes Late Fee)	$880
A. Effective October 1, 2017 through September 30, 2019	**$455**
5. Renewal Fee (schools)	$850
A. Effective July 1, 2017 through September 30, 2017	**$425**

*AUTHORITY: [section 328.060.1, RSMo 2000 and] section 329.025(4), RSMo Supp. [2008] **2013**. Original rule filed June 27, 2007, effective Dec. 30, 2007. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 31, 2016.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately one million two hundred seventy-five thousand thirty dollars ($1,275,030) biennially and one hundred fifty-four thousand thirty-seven dollars and fifty cents ($154,037.50) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will save private entities approximately one million two hundred seventy-five thousand thirty dollars ($1,275,030) biennially and one hundred fifty-four thousand thirty-seven dollars and fifty cents ($154,037.50) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Cosmetology and Barber Examiners, PO Box 1062, Jefferson City, MO 65102, by facsimile at (573) 751-8176, or via email at cosbar@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions, and Professional Registration

Division 2085 - Board of Cosmetology and Barber Examiners

Chapter 3 - License Fees

PROPOSED AMENDMENT

20 CSR 2085-3.010 Fees

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Loss of Revenue	
Board of Cosmetology and Barber Examiners		
	Total Loss of Revenue Biennially for the Life of the Rule	**$1,275,030.00**
	Total Loss of Revenue Annually for the Life of the Rule	**$154,037.50**

III. WORKSHEET

See Private Entity Fiscal Note.

IV. ASSUMPTION

1. The total loss of revenue is based on the cost savings to private entities reflected in the Private Fiscal Note filed with this rule.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions, and Professional Registration

Division 2085 - Board of Cosmetology and Barber Examiners

Chapter 3 - License Fees

PROPOSED AMENDMENT

20 CSR 2085-3.010 Fees

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated annual cost savings with compliance of the amendment by affected entities:
10	Barber Apprentice Registration Fee - $20 decrease	$200.00
225	Barber Student Enrollment Fee - $20 decrease	$4,500.00
40	Cosmetology Apprentice Enrollment Fee - $20 decrease	$800.00
100	Cosmetology Instructor Trainee Enrollment Fee - $20 decrease	$2,000.00
5,300	Cosmetology Student Enrollment Application Fee - $20 decrease	$106,000.00
40	Barber Inactive License - $12.50 decrease	$500.00
3,200	Cosmetology Inactive License - $12.50 decrease	$40,000.00
0	Crossover Instructor Trainee Enrollment Fee - $20 decrease	$0.00
3	Crossover Inactive License Fee - $12.50 decrease	$37.50
	Estimated Annual Cost Savings for the Life of the Rule	**$154,037.50**
Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	**Classification by type of the business entities which would likely be affected:**	**Estimated biennial cost savings with compliance of the amendment by affected entities:**
2,700	Barber License Renewal - $15 decrease	$40,500.00
100	Barber Reinstatement - $15 decrease	$1,500.00
1,200	Barber Establishment License Renewal - $25 decrease	$30,000.00
15	Barber Establishment Reinstatement - $25 decrease	$375.00

60	Barber Instructor License Renewal - $15 decrease	$900.00
5	Barber Instructor Reinstatement - $5 decrease	$25.00
6	Barber School License Renewal - $250 decrease	$1,500.00
13,000	Cosmetology Establishment License Renewal - $25 decrease	$325,000.00
500	Cosmetology Establishment Reinstatement - $25 decrease	$12,500.00
25	Cosmetology Instructor Reinstatement - $15 decrease	$375.00
587	Cosmetology Instructor License Renewal - $15 decrease	$8,805.00
800	Cosmetology Reinstatement - $15 decrease	$12,000.00
52,500	Cosmetology License Renewal - $15 decrease	$787,500.00
1	Cosmetology School Satellite Classroom License Renewal - $150 decrease	$150.00
72	Cosmetology School License Renewal - $250 decrease	$18,000.00
85	Crossover Establishment Reinstatement - $50 decrease	$4,250.00
400	Crossover Establishment License Renewal - $50 decrease	$20,000.00
1	Crossover Instructor Reinstatement - $30 decrease	$30.00
3	Crossover Instructor License Renewal - $15 decrease	$45.00
200	Crossover Operator Reinstatement - $30 decrease	$6,000.00
30	Crossover Operator License Renewal - $30 decrease	$900.00
0	Crossover School Reinstatement - $435 decrease	$0.00
11	Crossover School License Renewal - $425 decrease	$4,675.00
	Estimated Biennial Cost Savings for the Life of the Rule	**$1,275,030.00**

III. WORKSHEET

See table above.

IV. ASSUMPTIONS

1. Number of entities based on FY16 actuals.

2. It is anticipated that the total savings may vary with inflation, and is expected to increase at the rate projected by the Legislative Oversight Committee.

3 The Missouri Board of Cosmetology and Barber Examiners is statutorily obligated to enforce and administer the provisions of sections 329.025(4), RSMo. Pursuant to section 329.025(4) RSMo, the board shall set by rule the appropriate amount of fees so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the committee for administering the provisions of Chapter 328, RSMo. Therefore, the board is reducing the fees associated with student and apprentice enrollment.

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

PROPOSED AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (29), (33), (53), and (68); removing sections (9), (21), and (52); adding new sections (30) and (37); and renumbering as necessary.

PURPOSE: This amendment revises the definitions of essential benefits, formulary, out-of-pocket maximum, and specialty medications; removes the definitions of behavior health coaching, disease management, and non-formulary; and adds definitions for excluded drug and health education quiz.

[(9) Behavior Modification Health Coaching. A program in which health coaches assist members to make or maintain positive healthy behavior and lifestyle choices to help reduce and prevent health risk(s) and chronic disease(s).]

*[(10)]***(9)** Benefits. Health care services covered by the plan.

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

*[(12)]***(11)** Cancellation of coverage. The ending of medical, dental, or vision coverage per a subscriber's voluntary request.

*[(13)]***(12)** Claims administrator. An organization or group responsible for processing claims and associated services for a health plan.

*[(14)]***(13)** Coinsurance. The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars ($100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars ($20). The health insurance or plan pays the rest of the allowed amount.

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

*[(16)]***(15)** Copayment. A fixed amount, for example, fifteen dollars ($15), the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.

*[(17)]***(16)** Date of service. Date medical services are received.

*[(18)]***(17)** Deductible. The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay. For example, if the deductible is one thousand dollars ($1,000), the member's plan will not pay anything until s/he meets his/her one thousand dollar ($1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

*[(19)]***(18)** Dependent. Spouse or child(ren) enrolled in the plan by a subscriber.

*[(20)]***(19)** Diabetes Education. A program prescribed by a provider and taught by a Certified Diabetes Educator to educate and support members with diabetes.

[(21) Disease management. A multidisciplinary program designed to educate members with chronic diseases to manage their condition(s).]

*[(22)]***(20)** Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychologist;
(G) Doctor of dental medicine, including dental surgery;
(H) Doctor of dentistry; or
(I) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

*[(23)]***(21)** Effective date. The date on which coverage takes effect.

*[(24)]***(22)** Eligible variable-hour employee. An employee of a state department or agency, whose employees are otherwise eligible for coverage, but is in a position not covered by a retirement system and the employer has notified the plan administrator that the employee has become benefit eligible due to having worked on average for thirty (30) or more hours per week during the time period measured.

*[(25)]***(23)** Eligibility date. The first day a member is qualified to enroll for coverage.

*[(26)]***(24)** Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.

*[(27)]***(25)** Emergency medical condition. The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(A) Placing a person's health in significant jeopardy;
(B) Serious impairment to a bodily function;
(C) Serious dysfunction of any bodily organ or part;
(D) Inadequately controlled pain; or
(E) With respect to a pregnant woman who is having contractions—

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

*[(28)]***(26)** Emergency services. With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

*[(29)]***(27)** Employee. A benefit-eligible person employed by the state, including present and future retirees from state employment, who meet the plan eligibility requirements.

*[(30)]***(28)** Employer. The state department or agency that employs the eligible employee.

*[(31)]***(29)** Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

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

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

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

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

(E) Mental health and substance *[ab]*use disorder services, including behavioral health treatment—inpatient and outpatient and mental health/substance *[ab]*use disorder office visits;

(F) Prescription drugs;

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

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

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

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

(30) Excluded drug. A drug the pharmacy benefit manager (PBM) does not pay for or cover unless an exception is approved by the PBM.

*[(32)]***(31)** Excluded services. Health care services that the member's health plan does not pay for or cover.

*[(33)]***(32)** Experimental/investigational/unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below and that the plan administrator determines, in the exercise of its discretion, is considered experimental/investigational/unproven and is not eligible for coverage under the plan—

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

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

(C) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

*[(34)]***(33)** Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager **(PBM)** and covered by the plan administrator. **The PBM categorizes each formulary drug and formulary supply as preferred or non-preferred.**

*[(35)]***(34)** Foster parent. Any approved specialized foster parent as defined in section 210.543, RSMo, also referred to as Elevated Needs Level B, and licensed under Chapter 210, RSMo, who provides temporary foster care for children who have a documented history of presenting behaviors or diagnoses which render the child unable to effectively function outside of a highly structured setting, not in anticipation of adoption and not for children related to such Elevated Needs Level B foster parent.

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

*[(37)]***(36)** Health assessment (HA). An online questionnaire about a member's health and lifestyle habits required for participation in the *Strive for Wellness*® Partnership Incentive.

(37) Health Education Quiz. A series of questions administered by MCHCP designed to measure understanding of MCHCP benefits and/or general health knowledge.

[(52) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.]

*[(53)]***(52)** Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

*[(54)]***(53)** Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, *[copayments,]* balance-billed charges, or health care services the plan does not cover.

*[(55)]***(54)** Participant. Shall have the same meaning as the term member defined herein (see member, section (50)).

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

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

*[(58)]***(57)** Plan year. The period of January 1 through December 31.

*[(59)]***(58)** Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

*[(60)]***(59)** Premium. The monthly amount that must be paid for health insurance.

*[(61)]***(60)** Primary care provider (PCP). An internist, family/general practitioner, pediatrician, or physician assistant or nurse practitioner in any of the practice areas listed in this definition.

*[(62)]***(61)** Preauthorization. A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. The plan may require preauthorization for certain services before the member receives them, except in an emergency. Preauthorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request preauthorization.

*[(63)]***(62)** Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(22). Other providers include, but are not limited to:

(A) Audiologist (AUD or Ph.D.);
(B) Certified Addiction Counselor for Substance Abuse (CAC);
(C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;
(D) Certified Social Worker or Masters in Social Work (MSW);
(E) Chiropractor;
(F) Licensed Clinical Social Worker (LCSW);
(G) Licensed Professional Counselor (LPC);
(H) Licensed Psychologist (LP);
(I) Nurse Practitioner (NP);
(J) Physician Assistant (PA);
(K) Occupational Therapist;
(L) Physical Therapist;
(M) Speech Therapist;
(N) Registered Nurse Anesthetist (CRNA);
(O) Registered Nurse Practitioner (ARNP); or
(P) Therapist with a Ph.D. or Master's Degree in Psychology or Counseling.

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

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

*[(66)]***(65)** Retiree. Notwithstanding any provision of law to the contrary, for the purposes of these regulations a "retiree" is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from a state-sponsored retirement system.

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

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

*[(69)]***(68)** Specialty medications. High-cost drugs *[that]***, as determined by the pharmacy benefit manager and/or third party administrator, which** treat chronic **or** complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

*[(70)]***(69)** State. Missouri.

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

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

*[(73)]***(72)** Subscriber. The person who elects coverage under the plan.

*[(74)]***(73)** Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree.

*[(75)]***(74)** Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

*[(76)]***(75)** Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

*[(77)]***(76)** Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

*[(78)]***(77)** Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

*[(79)]***(78)** Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

*[(80)]***(79)** Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

*[(81)]***(80)** Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (12) and (13).

PURPOSE: This amendment clarifies requirements for members with Medicare and clarifies requirements for members with other health coverage.

(12) *[Medicare.*

(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(B) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(C)] Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. If Medicare coverage begins before turning age sixty-five (65) years, the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.

(13) Members are required to *[annually]* disclose to the claims administrator whether **or whether not** they have other health coverage and, if so, information about the coverage. A member may submit *[other coverage]* **this** information to the claims administrator by phone, fax, mail, or online. Dependent claims will *[not]* be *[processed until the information is received]* **denied if the disclosure is not made**. Once the information is received, claims will be *[processed]* **reprocessed** subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 RULE

22 CSR 10-2.025 Rule for Participating Higher Education Entity Entry into the Missouri Consolidated Health Care Plan

PURPOSE: This rule establishes the policy of the board of trustees in regard to the procedures for Participating Higher Education Entities joining the Missouri Consolidated Health Care Plan.

(1) Terms and Conditions for Joining. Participating Higher Education Entities (PHEE) shall be a state sponsored institution of higher learning. The PHEE shall provide a letter to the board stating their intent to join the Missouri Consolidated Health Care Plan (MCHCP) no later than August 1, for coverage beginning January 1 of the following year.

(2) Eligibility Requirements. Notwithstanding any provision of rule to the contrary, eligibility of PHEE employees and retirees shall be solely determined by the PHEE. The PHEE shall be responsible for complying with all laws pertaining to employee benefits as to eligibility.

(A) The PHEE shall provide to MCHCP appropriate documentation of initial and ongoing eligibility of PHEE employees and retirees.

(B) Once provided by the PHEE, the employees and/or retirees of the PHEE submitted shall be included in the term state employee and/or state retiree used throughout this chapter.

(3) Enrollment.

(A) Initial enrollment of PHEE eligible employees and/or retirees shall take place during the plan's next open enrollment period.

(B) Ongoing enrollment shall be handled in the same manner as new employees to the state.

(4) Coverage. The MCHCP Board of Trustees shall set all benefits, plan design, rates, incentives, and contribution levels. The board shall not set different benefits, plan designs, rates, incentives, or contribution levels for a PHEE than what they choose to set for state employees.

(5) Payment. The PHEE shall be responsible for submitting payment of full premiums of their employees according to their payroll cycles and in accordance with 22 CSR 10-2.030. If at any time the PHEE falls behind in the amount of two (2) months of premiums, coverage on all PHEE employees shall be terminated due to non-payment, effective the last day of the month a full premium was received.

(6) At the end of the first year of coverage, MCHCP shall have an actuary evaluate the population being brought into the plan and compare to the current population in the state plan to determine if the population is substantial and materially different than the current population. If the population is determined to have been substantially and materially different to the plan's detriment, the actuary will determine the amount that should be charged the PHEE pursuant to section 103.079.2, RSMo.

(7) Withdrawal from Plan.

(A) Once participating, the PHEE shall remain in the state plan for a period of five (5) years.

(B) After maintaining coverage for a period of five (5) years, the PHEE may withdraw from the plan by providing official notice that the PHEE's governing board has approved the withdrawal from the MCHCP. Such notice shall be received with a minimum six- (6-) month notice prior to the end of a current plan year.

(C) All withdrawals of PHEE shall be effective January 1. No withdrawals may take place during a plan year.

(D) If a PHEE does not stay in the plan for a period of five (5) years from first entering the plan, they shall be prohibited from rejoining the plan under section 103.079.2, RSMo, without a vote from the board of trustees allowing for the PHEE to reenter the plan.

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Oct. 28, 2016.

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

aggregate.

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

22 CSR 10-2.030 Contributions. The Missouri Consolidated Health Care Plan is amending section (7).

PURPOSE: This amendment clarifies the Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree and survivor premium for members enrolled in the Medicare Prescription Drug Only Plan.

(7) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree and survivor premium for members enrolled in the Medicare Prescription Drug Only Plan is based on either of the following:

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (7)(A) is compared to *[fifty-three percent (53%)]* **fifty-eight percent (58%)** of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (7)(A) or *[fifty-three percent (53%)]* **fifty-eight percent (58%)** of the Medicare Prescription Drug Only Plan.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5) and adding a new section (15).

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) when provided at a network provider and adds requirements for members with Medicare.

(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:

(B) Nutritional counseling; *[and]*

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth*[.]*; **and**

(D) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

*AUTHORITY: section 103.059, RSMo 2000. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5) and adding a new section (15).

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) when provided at a network provider and adds requirements for members with Medicare.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth*[.]*; **and**

(D) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2000. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 adding a new section (8), amending sections (17) and (19), and renumbering as necessary.

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) after the deductible is met, clarifies that a subscriber does not qualify for the HSA Plan if they are enrolled in Medicare, unless Medicare is secondary coverage to MCHCP, and clarifies requirements for members who become ineligible for the HSA Plan during the plan year.

(8) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider and received through a network provider are covered at one hundred percent (100%) after deductible is met.

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

*[(9)]***(10)** 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 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.

*[(10)]***(11)** Each subscriber will have access to payment information of the family unit.

*[(11)]***(12)** Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

*[(12)]***(13)** Usual, customary, and reasonable fee allowed—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

*[(13)]***(14)** Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any

claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

*[(14)]***(15)** For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

*[(15)]***(16)** Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. 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.

*[(16)]***(17)** 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 *[(19)]* **(20)** of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare **(unless Medicare is secondary coverage to MCHCP)**;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-*[scope]***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.

*[(17)]***(18)** If a retiree subscriber and/or his/her dependent(s) becomes eligible for Medicare in the upcoming plan year then s/he may not enroll in the HSA Plan during open enrollment.

*[(18)]***(19)** If a 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 *[must]* **and/or his/her dependent(s) will be enrolled in the PPO 600 Plan. The subscriber may** enroll in a **different** non-HSA Plan within thirty-one (31) days of notice from MCHCP. *[If no plan selection is made, MCHCP will enroll the subscriber and his/her dependents in the PPO 600 Plan.]*

*[(19)]***(20)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

*[(20)]***(21)** Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the subscriber must be an active employee and HSA eligible as defined in the Internal Revenue Service Publication 969 on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Subscribers who enroll in the HSA Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends March 15.

(B) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP contribution will receive an applicable prorated contribution. Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.

(C) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP contribution will receive an applicable prorated contribution based on the increased level of coverage.

(D) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution, MCHCP will not request a re-payment of the contribution.

(E) If both a husband and wife are state employees covered by MCHCP and they both enroll in an HSA Plan, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars ($600) regardless of the number of HSAs or the number of children covered under the HSA Plan for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a maximum three hundred dollar ($300) contribution to each spouse to total maximum six hundred dollars ($600).

(F) The MCHCP contributions will be deposited into the subscriber's HSA as follows:

1. The January deposit will be made on the third Monday of the month, or the first working day after the third Monday if the third Monday is a holiday;

2. The April deposit will be made on the first Monday in April; and

3. Other deposits will be made on the first Monday of the month in which coverage is effective, or the first working day after the first Monday of the month coverage is effective if the first Monday is a state holiday.

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: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2013. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

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

PURPOSE: This amendment clarifies the benefits for applied behavior analysis for autism, diabetes education, eye glasses and contact lenses following cataract surgery, office visits, and preventive services.

(3) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HSA Plan.

(E) Plan benefits for the PPO 300 Plan, PPO 600 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. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy *[R]*re*[-]*testing: routine allergy re*[-]*testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism *[is covered for children younger than age nineteen (19) years]*;

4. Bariatric surgery. Bariatric surgery is covered when all of the

following requirements have been met:

A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following non-implantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

6. 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;

7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when

long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has

been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease; and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. *[Diabetic]* **Diabetes** Education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider.

15. 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;

16. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

17. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement *[immediately]* **within one (1) year** following cataract surgery;

18. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

19. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

20. 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;

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

22. 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);

23. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

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

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

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

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

24. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

25. 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;

26. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;

27. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and

requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual (DSM)*. If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;

28. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. 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, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or *[anastamosis]* **anastomosis** status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;

29. 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;

30. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the 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.

31. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

32. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

33. Office visit. Member encounter with a provider for health care, mental health, or substance *[ab]*use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

34. 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;

35. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;

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

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

36. 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 fit**ted** 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 for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

37. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations 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 *[routine lab and X-ray]* **other** services ordered as part of the exam. For benefits to be covered as preventive, including X-rays and lab services, 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—*[One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema]* **no age limit**.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

38. 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;

39. 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;

40. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

41. 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;

42. 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);

43. 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;

44. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

45. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 10-2.060 PPO 300 Plan, PPO 600 Plan, and Health Savings Account Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment removes the limitations upon gender reassignment services and associated expenses of transformation operations and self-inflicted injuries.

(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.

[(X) Gender reassignment services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.]

*[(Y)]***(X)** Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

*[(Z)]***(Y)** Health and athletic club membership—including costs of enrollment.

*[(AA)]***(Z)** Hearing aid replacement batteries.

*[(BB)]***(AA)** Home births.

*[(CC)]***(BB)** Immunizations requested by third party.

*[(DD)]***(CC)** Infertility treatment beyond the covered services to diagnose the condition.

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

*[(FF)]***(EE)** Long-term care.

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

*[(HH)]***(GG)** 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.

*[(II)]***(HH)** 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.

*[(JJ)]***(II)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

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

*[(LL)]***(KK)** Nocturnal enuresis alarm.

*[(MM)]***(LL)** 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*[d]* by the PBM.

*[(NN)]***(MM)** Non-medically necessary services.

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

*[(PP)]***(OO)** Non-reusable disposable supplies.

*[(QQ)]***(PP)** 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.

*[(RR)]***(QQ)** Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(SS)]***(RR)** Physical and recreational fitness.

*[(TT)]***(SS)** Private-duty nursing.

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

[(VV) Self-inflicted injuries—not covered unless related to a mental diagnosis.]

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

*[(XX)]***(VV)** Sex therapy.

*[(YY)]***(WW)** Surrogacy—pregnancy coverage is limited to plan member.

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

*[(AAA)]***(YY)** Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

*[(BBB)]***(ZZ)** Travel expenses.

*[(CCC)]***(AAA)** 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 2000, and section 103.080.3., RSMo Supp. 2013. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 the amount thresholds in the initial coverage stage, coverage gap stage, and catastrophic coverage stage; and clarifies terminology regarding the categories of contraception covered at one hundred percent (100%).

(1) The pharmacy benefit for Medicare primary members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non–Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and *[Medicare]* **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 *[two thousand nine hundred sixty dollars ($2,960)]* **three thousand seven hundred dollars ($3,700)**, the member will pay the following copayments:

A. **Preferred Formulary** Generic *[Formulary]* Drugs: thirty-one- (31-) day supply has an eight dollar ($8) copayment; sixty- (60-) day supply has a sixteen dollar ($16) copayment; ninety- (90-) day supply at retail has a twenty-four dollar ($24) copayment; and a ninety- (90-) day supply through home delivery has a twenty dollar ($20) copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a thirty-five dollar ($35) copayment; sixty- (60-) day supply has a seventy dollar ($70) copayment; ninety- (90-) day supply at retail has a one hundred five dollar ($105) copayment; and a ninety- (90-) day supply through home delivery has an eighty-seven dollar and fifty cent ($87.50) copayment; and

C. Non-preferred Formulary *[Brand]* Drugs **and approved excluded drugs**: thirty-one- (31-) day supply has a one hundred dollar ($100) copayment; sixty- (60-) day supply has a two hundred dollar ($200) copayment; ninety- (90-) day supply at retail has a three hundred dollar ($300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar ($250) copayment;

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[three thousand three hundred ten dollars ($3,310)]* **three thousand seven hundred dollars ($3,700)** and remain below *[four thousand eight hundred fifty dollars ($4,850)]* **four thousand nine hundred fifty dollars ($4,950)**, 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 *[four thousand eight hundred fifty dollars ($4,850)]* **four thousand nine hundred fifty dollars ($4,950)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[four thousand eight hundred fifty dollars ($4,850)]* **four thousand nine hundred fifty dollars ($4,950)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[two dollar and ninety-five cent ($2.95)]* **three dollar and thirty cent ($3.30)** 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 seven dollar and forty cent ($7.40)]* **an eight dollar and twenty-five cent ($8.25)** copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage;

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; and

6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.

(I) Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

1. Prescribed Vitamin D for all ages:

A. The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D_2 or D_3 per dose;

2. Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

3. Influenza vaccine and administration as recommend by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

4. *[Formulary]* **Preferred formulary** brand contraception and *[non-formulary]* **non-preferred** contraception when the provider determines a generic is not medically appropriate or a generic version is not available.

AUTHORITY: section 103.059, RSMo 2000. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (4).

PURPOSE: This amendment clarifies copayment and coinsurance tiers, adds a diabetic drug copayment for members enrolled in a PPO plan and coinsurance for diabetic drugs for members enrolled in the HSA Plan, clarifies coverage of specialty drugs, adds one hundred percent (100%) coverage of prescribed preferred diabetic test strips, lancets, and preferred glucometer for members in a PPO plan, and one hundred percent (100%) coverage after deductible is met for prescribed preferred diabetic test strips, lancets, and preferred glucometer for members in the HSA plan, revises claims filing instructions, and clarifies language regarding the formulary.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO 300 and PPO 600.

1. Network:

A. *[Generic]* **Preferred formulary generic drug** copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. *[Brand]* **Preferred formulary brand drug** copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug** copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

*[D.]***E.** Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum; and

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy**, unless the prescription is identified by the PBM as emergent**. The first fill of a specialty prescription **identified to be emergent,** may be filled through a retail pharmacy *[if the prescription is identified by the PBM as emergent]*;

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) *[Generic]* **Preferred formulary generic drug** copayments: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) *[Brand]* **Preferred formulary brand drug** copayments: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug** copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary;

F. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

*[E.]***G.** Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

*[F.]***H.** The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

*[G.]***I.** If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

*[H.]***J.** If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum; and

*[I.]***K.** Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and

Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; *[and]*

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer*[.]***;**

(V) Prescribed preferred diabetic test strips and lancets; and

(VI) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Individual—five thousand one hundred dollars ($5,100).

D. Family—ten thousand two hundred dollars ($10,200).

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053.

1. Network:

A. *[Generic]* **Preferred formulary generic drug**: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

B. *[Brand]* **Preferred formulary brand drug**: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug**: Forty percent (40%) coinsurance after deductible has been met *[for a drug not on the formulary]*;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met;

*[D.]***E.** Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM;

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy**, unless the prescription is identified by the PBM as emergent**. The first fill of a specialty prescription **identified to be emergent,** may be filled through a retail pharmacy *[if the prescription is identified by the PBM as emergent]*;

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

*[E.]***F.** Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer.

*[F.]***H.** If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. *[Generic]* **Preferred formulary generic drug**: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. *[Brand]* **Preferred formulary brand drug**: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31) day supply for a brand drug on the formulary.

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug**: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

(3) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. A member may request a claim form from the plan or the PBM. In order to file a claim, the member must—

(A) Complete the claim form **and follow its instructions**;

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions except diabetic supplies*[. If attaching a receipt or*

*label, the receipt or label shall include:]***; and**

[1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply; and]

(4) Formulary. The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug*[. If this occurs, the generic copayment applies]*;

(C) A drug is determined to have a safety issue by the United States Food and Drug Administration (FDA). If this occurs, then the drug is no longer **covered** under the pharmacy benefit.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (10) and (14).

PURPOSE: This amendment clarifies requirements for members with Medicare and clarifies requirements for members with other health coverage.

(10) Medicare.

[(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(B) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(C) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.]

*[(D)]***(A)** Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. *[Claims will not be processed until the required information is provided.]* If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire. The member must *[submit]* **return** the completed questionnaire to MCHCP for the Medicare eligibility to be submitted to the medical *[plan]* **vendor**.

(B) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the Medicare Part D coverage gap.

(14) Members are required to *[annually]* disclose to the claims administrator whether they have other health coverage and, if so, information about the coverage. A member may submit other coverage information to the claims administrator by phone, fax, mail, or online. Dependent claims will *[not]* be *[processed]* **denied** until the information is received. Once the information is received, claims will be *[processed]* **reprocessed** subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2000, and section 103.078, RSMo Supp. 2013. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

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

PROPOSED RESCISSION

22 CSR 10-2.150 Disease Management Services Provisions and Limitations. This rule established the policy of the board of trustees in regards to the disease management services including the disease

management program and the disease management rewards; and the method and timeframes in which the requirements of the disease management rewards must be completed.

PURPOSE: This rule is being rescinded due to disease management services being discontinued.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Original rule filed Oct. 29, 2014, effective May 30, 2015. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Rescinded: Filed Oct. 28, 2016.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (28), (32), (59), and (64), removing sections (20) and (47), adding a new section (29), and renumbering as necessary.

PURPOSE: This amendment revises the definitions of essential benefits, formulary, out-of-pocket maximum, public entity, and specialty medications; removes the definitions of disease management and non-formulary; and adds the definition for excluded drug.

[(20) Disease management. A multidisciplinary program designed to educate members with chronic diseases to manage their condition(s).]

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

*[(22)]***(21)** Effective date. The date on which coverage takes effect.

*[(23)]***(22)** Eligibility date. The first day a member is qualified to enroll for coverage.

*[(24)]***(23)** Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.

*[(25)]***(24)** Emergency medical condition. The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:
(A) Placing a person's health in significant jeopardy;
(B) Serious impairment to a bodily function;
(C) Serious dysfunction of any bodily organ or part;
(D) Inadequately controlled pain; or
(E) With respect to a pregnant woman who is having contractions—
1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

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

*[(27)]***(26)** Employee. A benefit-eligible person employed by a participating public entity, including present and future retirees from the participating public entity, who meet the plan eligibility requirements.

*[(28)]***(27)** Employer. The public entity that employs the eligible employee.

*[(29)]***(28)** Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:
(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;
(B) Emergency services—ambulance services and emergency room services;
(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;
(D) Maternity and newborn care—maternity coverage and newborn screenings;
(E) Mental health and substance *[ab]*use disorder services, including behavioral health treatment—inpatient and outpatient and mental health/substance *[ab]*use disorder office visits;
(F) Prescription drugs;
(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care;
(H) Laboratory services—lab and X-ray;
(I) Preventive and wellness services and chronic disease management; and
(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive

services, and newborn screenings.

(29) Excluded drug. A drug the pharmacy benefit manager (PBM) does not pay for or cover unless an exception is approved by the PBM.

(32) Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager **(PBM)** and covered by the plan administrator. **The PBM categorizes each formulary drug and formulary supply as preferred or non-preferred.**

[(47) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.]

*[(48)]***(47)** Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

*[(49)]***(48)** Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, *[copayments,]* balance-billed charges, or health care services the plan does not cover.

*[(50)]***(49)** Participant. Shall have the same meaning as the term member defined herein (see member, section (45)).

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

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

*[(53)]***(52)** Plan year. The period of January 1 through December 31.

*[(54)]***(53)** Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

*[(55)]***(54)** Premium. The monthly amount that must be paid for health insurance.

*[(56)]***(55)** Primary care provider (PCP). An internist, family/general practitioner, pediatrician, or physician assistant or nurse practitioner in any of the practice areas listed in this definition.

*[(57)]***(56)** Preauthorization. A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. The plan may require preauthorization for certain services before the member receives them, except in an emergency. Preauthorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request preauthorization.

*[(58)]***(57)** Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010(21). Other providers include, but are not limited to:

(A) Audiologist (AUD or PhD);

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

(C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;

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

(E) Chiropractor;

(F) Licensed Clinical Social Worker (LCSW);

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

(P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

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

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

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

*[(62)]***(61)** Retiree. Notwithstanding any provision of law to the contrary, for the purposes of these regulations, a "retiree" is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from an entity-sponsored retirement system.

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

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

*[(65)]***(64)** Specialty medications. High-cost drugs *[that]***, as determined by the pharmacy benefit manager and/or third party administrator which** treat chronic **or** complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

*[(66)]***(65)** State. Missouri.

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

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

*[(69)]***(68)** Subscriber. The person who elects coverage under the plan.

*[(70)]***(69)** Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree of a public entity with a retirement system.

*[(71)]***(70)** Terminated vested subscriber. A previous active employee eligible for a future retirement benefit through a public entity's retirement system.

*[(72)]***(71)** Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

*[(73)]***(72)** Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

*[(74)]***(73)** Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

*[(75)]***(74)** Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits through a public entity's retirement system.

*[(76)]***(75)** Waiting/probationary periods. The length of time the employer requires an employee to be employed before he or she is eligible for health insurance coverage. Public entities may set different waiting/probationary periods for different employee classifications (full-time vs. part-time).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (12) and (13).

PURPOSE: This amendment clarifies requirements for members with Medicare and clarifies requirements for members with other health coverage.

(12) *[Medicare.*

(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(B) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.

(C)] Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.

(13) Members are required to *[annually]* disclose to the claims administrator whether **or whether not** they have other health coverage and, if so, information about the coverage. A member may submit *[other coverage]* **this** information to the claims administrator by phone, fax, mail, or online. Dependent claims will *[not]* be *[processed until the information is received]* **denied if the disclosure is not made**. Once the information is received, claims will be *[processed]* **reprocessed** subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending

section (5) and adding a new section (14).

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (l00%) when provided at a network provider and adds requirements for members with Medicare.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth*[.]*; **and**

(D) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider.

(14) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits, claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(D) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit(s) must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the Medicare Part D coverage gap.

AUTHORITY: section l03.059, RSMo 2000. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 l04355, Jefferson City, MO 65ll0. 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 adding a new section (8), amending section (15), and renumbering as necessary.

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) after the deductible is met and clarifies that a subscriber does not qualify for the HSA Plan if they are enrolled in Medicare, unless Medicare is secondary coverage to MCHCP.

(8) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider and received through a network provider are covered at one hundred percent (100%) after deductible is met.

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

*[(9)]***(10)** Each subscriber will have access to payment information of the family unit.

*[(10)]***(11)** 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.

*[(11)]***(12)** Usual, customary, and reasonable fee allowed—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

*[(12)]***(13)** Any claim must be initially submitted within twelve (12) months following the date of service. 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.

*[(13)]***(14)** 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.

*[(14)]***(15)** 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 *[(15)]* **(16)** 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-*[scope]***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.

*[(15)]***(16)** 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.

*[(16)]***(17)** Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2013. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5) and adding a new section (14)

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) when provided at a network provider and adds requirements for members with Medicare.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth*[.]***; and**

(D) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider.

(14) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits, claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(D) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit(s) must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the Medicare Part D coverage gap.

AUTHORITY: section 103.059, RSMo 2000. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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).

PURPOSE: This amendment clarifies the benefits for applied behavior analysis for autism, diabetes education, eye glasses and contact lenses following cataract surgery, office visits, and preventive services.

(3) Covered Charges Applicable to the PPO 600 Plan, PPO 1000, and HSA Plan.

(E) Plan benefits for the PPO 600 Plan, PPO 1000, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy *[R]*re*[-]*testing: routine allergy re*[-]*testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism *[is covered for children younger than age nineteen (19) years]*;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for

individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following non-implantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.); or

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

6. 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;

7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

10. Chiropractic services. Chiropractic manipulation and

adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that maybe relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation, or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe-to-profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

13. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury;

(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; and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequelae; and

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. *[Diabetic]* **Diabetes** Education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

15. 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;

16. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

17. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement *[immediately]* **within one (1) year** following cataract surgery;

18. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

19. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

20. 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;

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

22. 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);

23. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A comprehensive medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

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

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

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

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

24. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

25. 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;

26. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by, or under the supervision of, a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;

27. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time inpatient basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility, and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;

28. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. 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, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or *[anastamosis]* **anastomosis** status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;

29. 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;

30. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the 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;

31. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

32. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

33. Office visit. Member encounter with a provider for health care, mental health, or substance *[ab]*use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

34. 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;

35. 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 sequelae;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

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

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviations from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

36. 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 fit 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 for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissue(s);

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue(s); 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 tissue(s); or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue(s).

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;

37. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations 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 *[routine lab and X-ray]* **other** services ordered as part of the exam. For benefits to be covered as preventive, *[including X-rays and lab services,]* 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—*[One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema]* **no age limit**.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

38. 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;

39. 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 m**//L**/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;

40. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

41. 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;

42. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver-provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

43. 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 parent(s). 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;

44. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

45. Vision. One (1) routine exam and refractions is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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 10-3.060 PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment removes the limitations upon gender reassignment services and associated expenses of transformation operations and self-inflicted injuries.

(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.

[(X) Gender reassignment services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.]

[(Y)](X) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

*[(Z)]***(Y)** Health and athletic club membership—including costs of enrollment.

*[(AA)]***(Z)** Hearing aid replacement batteries.

*[(BB)]***(AA)** Home births.

*[(CC)]***(BB)** Immunizations requested by third party.

*[(DD)]***(CC)** Infertility treatment beyond the covered services to diagnose the condition.

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

*[(FF)]***(EE)** Long-term care.

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

*[(HH)]***(GG)** 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.

*[(II)]***(HH)** 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.

*[(JJ)]***(II)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(KK)]***(JJ)** Never events—a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

*[(LL)]***(KK)** Nocturnal enuresis alarm.

*[(MM)]***(LL)** 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*[d]* by the PBM.

*[(NN)]***(MM)** Non-medically necessary services.

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

*[(PP)]***(OO)** Non-reusable disposable supplies.

*[(QQ)]***(PP)** 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, filling out paperwork, or late payments.

*[(RR)]***(QQ)** Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(SS)]***(RR)** Physical and recreational fitness.

*[(TT)]***(SS)** Private-duty nursing.

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

[(VV) Self-inflicted injuries—not covered unless related to a mental diagnosis.]

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

*[(XX)]***(VV)** Sex therapy.

*[(YY)]***(WW)** Surrogacy—pregnancy coverage is limited to plan member.

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

*[(AAA)]***(YY)** Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs);

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and

that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance;

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

*[(BBB)]***(ZZ)** Travel expenses.

*[(CCC)]***(AAA)** 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 2000. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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

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

PROPOSED AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (4).

PURPOSE: This amendment clarifies copayment and coinsurance tiers, adds a diabetic drug copayment for members enrolled in a PPO plan and coinsurance for diabetic drugs for members enrolled in the HSA Plan, clarifies coverage of specialty drugs, adds one hundred percent (100%) coverage of prescribed preferred diabetic test strips, lancets, and preferred glucometer for members in a PPO plan, and one hundred percent (100%) coverage after deductible is met for prescribed preferred diabetic test strips, lancets, and preferred glucometer for members in the HSA plan, revises claims filing instructions, and clarifies language regarding the formulary.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) PPO 600 and PPO 1000 Prescription Drug Coverage.

1. Network.

A. *[Generic]* **Preferred formulary generic drug** copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. *[Brand]* **Preferred formulary brand drug** copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug** copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment.

*[D.]***E.** Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescription(s) will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy**, unless the prescription is identified by the PBM as emergent**. The first fill of a specialty prescription may be filled through a retail pharmacy *[if the prescription is identified by the PBM as emergent]*.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) *[Generic]* **Preferred formulary generic drug** copayments: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) *[Brand]* **Preferred formulary brand drug** copayments: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug** copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars

($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary.

F. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment.

*[E.]***G.** Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

*[F.]***H.** The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

*[G.]***I.** If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

*[H.]***J.** If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum.

*[I.]***K.** Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; *[and]*

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer*[.]***;**

(V) Prescribed preferred diabetic test strips and lancets; and

(VI) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Individual—five thousand one hundred dollars ($5,100).

D. Family—ten thousand two hundred dollars ($10,200).

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. *[Generic]* **Preferred formulary generic drug**: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

B. *[Brand]* **Preferred formulary brand drug**: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug**: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met.

*[D.]***E.** Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to **a** thirty-one- (31-) day*[s.]* **supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.**

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

*[E.]***F.** Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages.

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; *[and]*

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer.

*[F.]***H.** If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. *[Generic]* **Preferred formulary generic drug**: Forty percent (40%) coinsurance after deductible has been met for up to a

thirty-one- (31-) day supply for a generic drug on the formulary.

B. *[Brand]* **Preferred formulary brand drug**: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug**: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

(3) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. A member may request a claim form from the plan or the PBM. In order to file a claim, the member must—

(A) Complete the claim form **and follow its instructions**;

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions except diabetic supplies*[. If attaching a receipt or label, the receipt or label shall include:]***; and**

[1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply; and]

(4) Formulary—The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug*[. If this occurs, the generic copayment applies]*;

AUTHORITY: section 103.059, RSMo 2000. 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. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Amended: Filed Oct. 28, 2016.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

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

PROPOSED RESCISSION

22 CSR 10-3.150 Disease Management Services Provisions and Limitations. This rule is being rescinded due to disease management services being discontinued.

PURPOSE: This rule established the policy of the board of trustees in regards to the disease management services including the disease management program and the disease management rewards; and the method and timeframes in which the requirements of the disease management rewards must be completed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Original rule filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expired June 28, 2016. Amended: Filed Oct. 28, 2015, effective May 30, 2016. Emergency rescission filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. Rescinded: Filed Oct. 28, 2016.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety- (90-) day period during which an agency shall file its Order of Rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the Proposed Rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 200—Office of College and Career Readiness

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo Supp. 2014, the board rescinds a rule as follows:

5 CSR 20-200.110 Standards and Operational Requirements **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2016 (41 MoReg 832–833). No changes have been made in 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: The State Board of Education (board) received no comments on the proposed rescission.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 200—Office of College and Career Readiness

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo Supp. 2014, the board rescinds a rule as follows:

5 CSR 20-200.120 Allowable Activities and Participating Student Eligibility **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2016 (41 MoReg 833). No changes have been made in 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: The State Board of Education (board) received no comments on the proposed rescission.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 200—Office of College and Career Readiness

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo Supp. 2014, the board rescinds a rule as follows:

5 CSR 20-200.130 Administration, Eligible Contributors, and Tax Credits **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2016 (41 MoReg 833). No changes have been made in 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: The State Board of Education (board) received no comments on the proposed rescission.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 200—Office of College and Career Readiness

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo Supp. 2014, the board rescinds a rule as follows:

5 CSR 20-200.140 Standards for Submission and Review of Proposals **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2016 (41 MoReg 833). No changes have been made in 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: The State Board of Education (board) received no comments on the proposed rescission.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 200—Office of College and Career Readiness

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under

section 170.061, RSMo 2000, the board rescinds a rule as follows:

5 CSR 20-200.150 Missouri Textbook Filing **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2016 (41 MoReg 833–834). No changes have been made in 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: The State Board of Education (board) received no comments on the proposed rescission.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 200—Office of College and Career Readiness

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 178.430 and 178.440, RSMo 2000, the board rescinds a rule as follows:

5 CSR 20-200.220 Determining Schools Having High Concentrations of Low-Income Children for Purposes of National Defense Education, National Direct and Federal Perkins Student Loan Cancellation **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2016 (41 MoReg 834). No changes have been made in 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: The State Board of Education (board) received no comments on the proposed rescission.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 200—Office of College and Career Readiness

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo Supp. 2014, the board rescinds a rule as follows:

5 CSR 20-200.270 Student Suicide Prevention Programs **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2016 (41 MoReg 834). No changes have been made in 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: The State Board of Education (board) received no comments on the proposed rescission.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 13—Educational Credit for Military Training or Service

ORDER OF RULEMAKING

By the authority vested in the Department of Higher Education under section 173.1158, RSMo Supp. 2013, the department adopts a rule as follows:

6 CSR 10-13.010 Educational Credit for Military Training or Service **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 15, 2016 (41 MoReg 894). No changes have been made in 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 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 9—Internal Control System

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission under section 313.805, RSMo Supp. 2013, the commission amends a rule as follows:

11 CSR 45-9.113 Minimum Internal Control Standards (MICS)—Chapter M **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2016 (41 MoReg 834–835). No changes have been made to the *Minimum Internal Control Standards* (MICS) as incorporated by reference in Chapter M. 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: A public hearing was held on this proposed amendment on August 10, 2016. No one commented on this proposed amendment at the public hearing and no written 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 MO HealthNet Division under sections 208.153 and 208.201, RSMo Supp. 2013, and section 208.152, RSMo Supp. 2015, the division amends a rule as follows:

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2016 (41 MoReg 955–956). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Social Services, MO HealthNet Division received two (2) comments from one (1) interested party on the proposed amendment.

COMMENT #1: The Missouri Hospital Association commented that the MO HealthNet Division (MHD) should update the Hospital Rate List to include projected spending associated with Children's Outlier payments.
RESPONSE: The MHD appreciates the comment, but does not plan to update the rate list to project spending associated with Children's Outlier payments. MHD notes that the costs of Children's Outlier payments were considered in the Managed Care rate development and the rates are certified as actuarially sound. A change to the proposed amendment is not warranted as a result of this comment.

COMMENT #2: The Missouri Hospital Association additionally commented that the children's hospitals recommend that MHD should continue to compile children's hospital outlier documentation for children enrolled in Managed Care and that the Managed Care Companies be required to provide paid claims and any payment or day denial detail for these children. Additionally, MHA commented that this data should be analyzed and published annually in a comparison report of the cost and health outcomes for outlier services for children enrolled in fee-for-service Medicaid or in Managed Care plans.
RESPONSE: The MHD appreciates the comments, but the MHD does not plan to continue to compile the additional documentation since this will be the responsibility of the Managed Care plans. A change to the proposed amendment is not warranted as a result of this comment.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 208.201 and 208.453, RSMo Supp. 2013, and section 208.455, RSMo 2000, the division amends a rule as follows:

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA) **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2016 (41 MoReg 957–962). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Social Services, MO HealthNet Division received no comments on the proposed amendment.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 2—Licensing of Physicians and Surgeons

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.045 and 334.046, RSMo 2000, sections 334.090 and 334.100, RSMo Supp. 2013, and section 334.125, RSMo Supp. 2014, the board rescinds a rule as follows:

20 CSR 2150-2.001 Definitions **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on August 1, 2016 (41 MoReg 963). No changes have been made in 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 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 2—Licensing of Physicians and Surgeons

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.045 and 334.046, RSMo 2000, sections 334.090 and 334.100, RSMo Supp. 2013, and sections 334.036, 334.038, and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.001 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 963–964). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received three (3) comments on the proposed rule.

COMMENT #1: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating that subsection (2)(D) indicates that an assistant physician applicant must submit proof of graduation from an "approved medical school," a term that is defined under 20 CSR 2150-2.100, as "a medical school accredited by the Liaison Committee on Medical Education of the American Medical Association, the American Osteopathic Association's Commission on Osteopathic College Accreditation, or that appears in the *World Directory of Medical Schools* or its successor." However, the statute creating the assistant physician licensure is not crafted this broadly. Section 334.036, RSMo, defines "medical school graduate," for purposes of assistant physician licensure, as "any person who has graduated from a medical college or osteopathic medical college described in section 334.031." Section 334.031, RSMo, in turn, clarifies that "Any medical college approved and accredited as reputable by the American Medical Association or the Liaison Committee on Medical Education and any osteopathic college approved and accredited as reputable by the American Osteopathic Association is deemed to have complied with the requirements of this subsection." This section makes no mention of the *World Directory*; the only accrediting bodies mentioned are the American Medical Association (AMA), Liaison Committee on Medical Education (LCME), or American Osteopathic Association (AOA). By opening assistant physician licensure to graduates from schools listed on the *World Directory*, a student from any international school of medicine could obtain licensure as an assistant physician. Given its responsibility for assuring that assistant physician licensees have some common standard or background in medical education, the Board should be aware that the *World Directory* is not an accrediting body. Its mission statement reads: "It is the mission of the *World Directory of Medical Schools (World Directory)* to list all of the medical schools in the world. …The listing of a medical school in the *World Directory of Medical Schools* does not denote recognition,

accreditation, or endorsement by the *World Directory of Medical Schools* by its partner organizations…" Being listed on the *World Directory* does not represent any measure or standard of competency by a given school. The rule should remove this reference to the *World Directory* and be consistent with the statute which states that accreditation by the AMA, AOA, or LCME meet the specified standard of medical education.
RESPONSE AND EXPLANATION OF CHANGE: The board appreciates the comments and amends the language as suggested to incorporate the standard for medical schools as outline in section 334.031.1, RSMo.

COMMENT #2: A comment was received from the Missouri Academy of Family Physicians (MAFP) suggesting section (9) be amended to change the "Accreditation Counsel (should be "Council") on Graduate Medical Education (ACGME)" is not part of the American Medical Association (since 2000, per ACGME website: http://www.acgme.org/About-Us/Overview/ACGME-History); and the "Education Committee" of the American Osteopathic Association has been changed to "Program and Trainee Review Council."
RESPONSE AND EXPLANATION OF CHANGE: The board appreciates the comments and amends the language as suggested.

COMMENT #3: A comment was received from the Missouri Academy of Family Physicians (MAFP) suggesting section (15) be amended to change "family practice medicine" to "family medicine" to reflect the specialty of integrated care for all patients in the delivery of acute, chronic, and preventive medical care services.
RESPONSE AND EXPLANATION OF CHANGE: The board appreciates the comments and amends the language as suggested.

20 CSR 2150-2.001 Definitions

(3) Approved medical school—a medical school accredited by the Liaison Commission on Medical Education of the American Medical Association or the American Osteopathic Association's Commission on Osteopathic College Accreditation, or other medical school program that enforces requirements of four (4) terms of thirty-two (32) weeks for actual instruction in each term, including, in addition to class work, such experience in operative and hospital work during the last two (2) years of instruction as is required by the American Medical Association and the American Osteopathic Association.

(9) Hospitals approved by the board—all hospitals who are part of a residency training program approved and accredited to teach graduate medical education by the Accreditation Council on Graduate Medical Education (ACGME) of the American Medical Association or the Program and Trainee Review Council of the American Osteopathic Association.

(15) Primary care—physician services in family medicine, general practice, internal medicine, pediatrics, obstetrics, or gynecology. This shall not include surgery other than minor office based procedures.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 2—Licensing of Physicians and Surgeons

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.045 Name and Address Changes **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 964–966). No changes have been made in 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 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 2—Licensing of Physicians and Surgeons

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under section 334.090.2, RSMo Supp. 2013, and section 334.125, RSMo Supp. 2014, the board withdraws a rescission as follows:

20 CSR 2150-2.080 Fees **is withdrawn**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on August 1, 2016 (41 MoReg 967). This proposed rescission is withdrawn.

SUMMARY OF COMMENTS: The board received one (1) staff comment on this proposed rescission.

COMMENT: Based on the board's five- (5-) year projections, the board filed an emergency rescission and rule and proposed rescission and rule to reduce fees established by 20 CSR 2150-2.080 in order to maintain the board's fund at a level that is authorized by section 334.090, RSMo.
RESPONSE: As a result, the board is withdrawing this proposed rescission because of the emergency rescission and rule that became effective September 11, 2016.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under section 334.090.2, RSMo Supp. 2013, and sections 334.036 and 334.125, RSMo Supp. 2014, the board withdraws a rule as follows:

20 CSR 2150-2.080 Fees **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 967–970). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: The board received one (1) staff comment on this proposed rule.

COMMENT: Based on the board's five- (5-) year projections, the board filed an emergency and proposed rule to reduce fees established by 20 CSR 2150-2.080 in order to maintain the board's fund at a level that is authorized by section 334.090, RSMo.
RESPONSE: As a result, the board is withdrawing this proposed rule because of the emergency rule that became effective September 11, 2016.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.200 is adopted.

A notice of proposed rulemaking containing the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 971–975). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received two (2) comments on the proposed rule and eleven (11) general comments regarding the licensure of assistant physicians.

COMMENT #1: A comment was received from the Missouri Academy of Family Physicians (MAFP) suggesting subsection (2)(D) - The "Accreditation Counsel (should be "Council") on Graduate Medical Education (ACGME)" is not part of the American Medical Association (since 2000, per ACGME website: http://www.acgme.org/About-Us/Overview/ACGME-History); and the "Education Committee" of the American Osteopathic Association has been changed to "Program and Trainee Review Council."
RESPONSE AND EXPLANATION OF CHANGE: The board appreciates the comments and amends the language in subsection (2)(D) of 20 CSR 2150-2.200 as suggested.

COMMENT #2: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating their comments submitted in July 2015 during the pre-filing review, encouraged the board to seek records from hospitals with which the AP applicant had previously trained, specifically faculty evaluations. We recognize that the proposed rule under subsection (4)(F) requires the applicant to disclose if, "the applicant has ever had any adverse action taken against his or her privileges at any hospital…" While this standard is weaker, and relies on self-disclosure by the candidate, we recognize it represents a step toward determining if the applicant has encountered prior difficulties in their medical training. We support the required disclosure in the proposed rule, but continue to encourage the board to go farther and request a summary of faculty evaluations from the applicant's former hospital or residency program.
RESPONSE: Paragraph (2)(E)6. of this rule requires applicants for licensure to submit proof of hospital affiliation from each hospital where the applicant has held admitting privileges in the last ten (10) years or to submit a letter from the hospital to include the dates the applicant had admitting privileges and where there was ever any adverse action taken against those privileges, including, but not limited to, revocation, suspension, or limitation of privileges or if the applicant ever resigned privileges while under investigation. Therefore, the board makes no changes.

COMMENT #3: Comments were received from Tim deVries, and Joseph Irvin supporting assistant physician licensure stating that law will be beneficial and allow Missouri to be a trend setter.
RESPONSE: No action was taken by the board.

COMMENT #4: A comment was received from Irene Scott generally summarizing the assistant physician law. No comment of support or opposition was included.
RESPONSE: No action was taken by the board.

COMMENT #5: A comment was received from Faiza Shekhani supporting the rules and stating issues of criticism of the assistant physician could be addressed by preferring United States of America (US) nationals with more experience in patient care (whether in the US or overseas) and US nationals with USMLE step 3 exam, passed within the past two (2) years.
RESPONSE: No action was taken by the board as this change would require legislative action by the Missouri General Assembly.

COMMENT #6: Comments were received from fourteen (14) individuals, Chris Strupp. Melissa Kovcas, Falin Larson, Danniell Lewis, Whitney James, Young Kim, Faisal Ishfaq, Ulziibat Person, Maimoona Arshee, Subpal Gill, Maira Beasely, Adil Iqbal, and Sabahath Shaikh requesting a change or abolishment of section 334.036 (1)(b), RSMo as it relates to successful completion of Step 1 and Step 2 of the United State Medical Licensing Examination (UMSLE) within a two- (2-) year period immediately preceding the application for licensure as a assistant physician. Commenters stated this language as written would prohibit them from being granted licensure as an assistant physician.
RESPONSE: No action was taken by the board as this change would require legislative action by the Missouri General Assembly.

COMMENT #7: Comments were received from William Blanchard and Kemberly Briggs requesting an amendment to the language as written in section 334.036 (1)(b), RSMo, or a waiver be granted as it relates to no more than three (3) years after graduation from medical college or osteopathic medical college be changed. The commenters stated that the language as written would prohibit them from being granted licensure as an assistant physician.
RESPONSE: No action was taken by the board as this change would require legislative action by the Missouri General Assembly.

COMMENT #8: A comment was received from Malkiat Singh asking the board to consider proof of proficiency of an applicant if they are disqualified by the requirements of section 334.036 (1)(b), RSMo.
RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

COMMENT #9: A comment was received from Hasfa Hassan stating that many international medical graduates have more clinical exposure than an American medical graduate because they have more clinical exposure during their medical education or have completed a post graduate training program in another country. The commenter suggested the board take into consideration the applicant's clinical exposure during medical school and the international graduate's post graduate training.
RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

COMMENT #10: Three (3) comments from Esteban Ivanoff-Tzvetcoff, Muhammed Saad, Aruna Sana were received stating they

believe it is ridiculous that physician assistants and nurse practitioners have less training and having to pass easier exams are allowed to practice medicine, while medical students who did not match because there are not enough residency programs. One (1) commenter stated that this was plainly discriminatory and not democratic. Two (2) of the comments suggested assistant physicians should have three (3) months of direct supervision by a licensed physician before starting an independent job; assistant physicians should be allowed to take the Missouri State Medical Board exam after twenty-four (24) months of work experience under the supervision of a licensed physician; and assistant physicians should be allowed to practice independently after passing the State Medical Board exam (within three (3) years).
RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

COMMENT #11: A comment was received from Tricia Degres for future rule considerations and/or additions so as not to delay the current timeline of the assistant physician being finalized this December. These considerations include rural residency credit; converting the assistant physician license to a full physician's license following a three (3) year rural residency; allowing the assistant physician to collaborate with a nurse practitioner; and expanding the area of critical shortage to include, but not be limited to, emergency rooms and veteran administration (VA) hospitals.
RESPONSE: The board encourages the commenter to contact a member of the Missouri General Assembly.

COMMENT #12: A comment from Brian Sweeney was received regarding the denial of a license failure to meet any requirements of (a) Chapter 334, RSMo, or 20 CSR 2150-2.200 through 20 CSR 2150-2.270; (b) Failure to demonstrate good moral character; or (c) Any cause listed in section 334.100, RSMo. Chapter 334,040, RSMo states "The board shall not issue a permanent license as a physician and surgeon or allow the Missouri state board examination to be administered to any applicant who has failed to achieve a passing score within three (3) attempts on licensing examinations administered in one (1) or more states or territories of the United States, the District of Columbia or Canada." Many applicants who have passed the examination in more than three (3) attempts will not be qualified for an assistant physician license. The commenter requested the board remove this requirement and stated that the current licensure requirements in many states are being reviewed to reduce barriers to entry as a response to the Supreme Court ruling "North Carolina State Board of Dental Examiners v FTC."
RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

COMMENT #13: A comment was received from the American Association of Physician Assistants (AAPA) stating assistant physician-related rules must be created in its own chapter of the administrative code because assistant physicians do not meet the standard definitions of physicians and do not meet the Missouri criteria for physician licensure. Similarly, AAPA opposes adding the assistant physician regulations to the Physician Assistant chapter of the administrative code.
RESPONSE: Chapter 2 of 20 CSR 2150 contains rules and regulations of several categories of physician licensure. The board felt Chapter 2 was the appropriate chapter of the 20 CSR 2150 to place the assistant physician rules.

20 CSR 2150-2.200 Assistant Physician—Application for Licensure

(2) Applicants applying for licensure shall submit the following:

(D) Proof that the applicant has passed step 2 or level 2 of a board approved medical licensing examination within the two- (2-) year period immediately preceding application for licensure as an assistant physician, but in no event more than three (3) years after graduation from medical college or osteopathic medical college. However, if the applicant was serving as a resident physician in a residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME) of the American Medical Association or the Program and Trainee Review Council of the American Osteopathic Association in the United States within thirty (30) days of filing his or her application for an assistant physician license, the two- (2-) year time period shall not apply;

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.210 Assistant Physician License Renewal **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 976–980). No changes have been made in 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: The board received two (2) comments on the proposed rule.

COMMENT #1: A comment was received from the American Association of Physician Assistants (AAPA) stating that in keeping with the legislative intent of offering an avenue for clinical experience for medical graduates who will enter residency programs, the rules must limit renewals to not more than three (3) years.
RESPONSE: Section 334.036, RSMo does not limit the number of renewals for assistant physician licensure. It is the board's understanding that limiting the time an individual can hold an assistant physician license was removed during the final passage of Senate Bill 735 (2014) as it was the intent of the bill sponsor that this be a permanent licensure/position for those who seek it. Therefore, the board believes any changes to the licensure requirements or the length of time an individual be licensed as an assistant physician would require legislative action be taken by the Missouri General Assembly. With regard to an Attorney General's Opinion, the Board plans to implement the law passed by the Missouri General Assembly. No changes have been made to the rule as a result of this comment.

COMMENT #2: A comment was received from Coalition for Patients First (Coalition), which includes the following Coalition: American Academy of PAs, American Academy of Pediatrics, American Association of Colleges of Osteopathic Medicine, American College of Osteopathic Family Physicians, American College of Osteopathic Internists, Association of American Medical Colleges, American Medical Association, and American Osteopathic Association. The Coalition stated they would like the board to restrict licensure renewals to a finite number and strongly believe it was not the intent of the legislature to use assistant physicians as an alternative to full and unlimited physician licensure. They further believe that moving forward with allowing individuals who lack complete medical training to provide

direct patient care under limited supervision places Missouri patients at an increased risk and threatens public health, safety, and welfare. The Coalition request the board limit the number of renewals to two (2) in the final rule. Assistant physician practice should provide medical school graduates who failed to match into a postgraduate residency program with a pathway toward full medical licensure and practice. This opportunity can offer assistant physician's time to develop their skills and medical knowledge as they seek a residency position. Limiting renewals to two (2) years would also align with the law's requirement for an assistant physician to pass the final portion of the licensure examination series after the second year. Upon the successful passage of the complete licensure examination series, followed by a minimum of one (1) year of postgraduate training, assistant physicians would be eligible for full medical licensure in the State of Missouri. The Coalition believes the board does have the authority to impose this limitation when reading this in the context of the entire law, where the General Assembly did provide specific limitations on the specialty and location of assistant physician's practice and prescribing of controlled substances, it should be inferred that the General Assembly did not intend for the board to be restricted in its authority to limit licensure renewal. The Coalition suggested that the Director of the Department of Insurance, Financial Institutions and Professional Registration seek a formal opinion from the Attorney General on this issue. They believe it is imperative that the board understand its full rights and responsibilities regarding its authority to regulate assistant physicians before moving forward to finalize the proposed rule. The Coalition requests that the Attorney General review the content of section 334.036.3(1), RSMo and that the board delay finalizing the proposed rule until a formal opinion is made on the board's authority to limit licensure renewal under this section. The commenters also submitted a position statement, which is attached.

RESPONSE: Section 334.036, RSMo does not limit the number of renewals for assistant physician licensure. It is the board's understanding that limiting the time an individual can hold an assistant physician license was removed during the final passage of Senate Bill 735 (2014) as it was the intent of the bill sponsor that this be a permanent licensure/position for those who seek it. Therefore, the board believes any changes to the licensure requirements or the length of time an individual be licensed as an assistant physician would require legislative action be taken by the Missouri General Assembly. With regard to an Attorney General's opinion, the board has not requested one and plans to implement the law passed by the Missouri General Assembly. No changes have been made to the rule as a result of this comment.

Coalition for Patients First

Protecting Patient Care & Preserving Health Equity

Overview

Students, interns, residents, and fully trained physicians all have a role in caring for the nation's patient populations. Licensed health care professionals should also have a clearly defined role in patient care that is consistent with their education, training and competencies.

The evolving health care system may require new types of professionals to play a patient-oriented role in health care. "Assistant Physicians" (AP) appear to be developing from medical school graduates who have been unable to enter a graduate medical education (GME) program, and not from a patient-driven need from the health care system. While there are apparently medical school graduates unable to pursue GME training, it is our opinion that this does not create a need for a new profession of partially trained and inadequately assessed graduate physicians.

The system that trains physicians gradually and cautiously introduces new physicians to the workforce after observed and direct assessment of their abilities in a health care environment, and testing in high stakes examinations. Those medical graduates who have not succeeded in this process should not be given a scope of practice similar to fully-licensed physicians who have completed all necessary and required training.

Position Statement

Standardized Licensure Requirements: Patient Safety, Transparency and Equity

The Coalition supports team-based care, which utilizes the expertise of a fully-trained and licensed physician, and is proven in its ability to deliver high-quality care to patients in need. In addition to passing a licensing examination series, which demonstrates competency, every state requires completion of at least one year of postgraduate residency training in order to be licensed as a physician. The Coalition believes that residency training provides medical school graduates with the necessary skills needed to deliver independent patient care and care delivered through the health care team.

Health care providers within the team should be utilized to the greatest extent of their education, training and competencies. Additionally, the Coalition believes that licensure eligibility should be standardized by profession and scope of practice. This is the only way that states can assure patient protection and transparency, and create an equitable system for licensing health care professionals.

Assistant/Associate Physicians: Incomplete Training, Limited Patient Protection

In 2014, Missouri enacted a law that created a new type of health care provider, the Assistant Physician. The Missouri law allows APs to provide primary care services to individuals in rural and/or underserved areas under the supervision of a licensed physician. While the law was enacted in 2014, the Missouri Board for the Healing Arts has not yet adopted final rules for the licensure of APs, and therefore none are currently in practice. The Board sent draft rules to the Governor's Office for review and approval, and Governor Jay Nixon approved the proposal. The final rules have now been published for a 30-day open comment period, ending August 31, 2016.

During the 2015 legislative session, Kansas and Arkansas proposed similar bills. These bills were amended to limit renewals, require continuous direct supervision and ensure patient safety. During the 2016 state legislation cycle, bills were introduced in Washington State and Virginia. These bills are very similar to the Missouri law, and would create an "Associate Physician" license, allowing individuals who lack complete medical training to provide this care to patients under limited supervision. Though the terminology varies by state, the "Assistant" and "Associate" Physician positions are similar in concept.

The Coalition remains concerned with the Missouri law and similar proposals in other states. Allowing medical school graduates without complete medical training to provide independent patient care under limited supervision may jeopardize patient safety. States must also understand that this is a dangerous precedent that establishes an inappropriate standard for the delivery of health care to patients in rural and/or underserved areas.

Additionally, promoting primary care as a fallback or an alternative to a student's desired specialty is inappropriate. This devalues the important and necessary care that primary care physicians provide to patients as a first line defense in protecting patient well-being and advancing population health. Individuals who fail to match into their desired medical specialty will not necessarily make a good primary care physician, which is another example of why these proposals will prevent states from meeting their overall goal of increasing the delivery of high quality primary care to patients in rural and underserved areas.

Key Concerns and Talking Points

1. Medical school graduates are not prepared or trained to provide independent care to patients. Medical schools strive to graduate students who are prepared to enter the next phase of their professional career pathway, residency training. They require continuous direct supervision, as provided through the postgraduate residency training experience. Their role in delivering care expands, as they continue to develop the skills, knowledge and competencies required to deliver high-quality, comprehensive patient care.

a. Medical school provides exposure and fully supervised experiences, ensuring the safety of patients and that patient care is not delivered without appropriate and safety-driven oversight. The assessment of independent practice is not part of clinical clerkships in the 3rd and 4th years of training.

2. Residency training is critical and required to become a licensed physician to practice independently. These proposals, while well meaning, disregard the decades of evidence and experience behind established GME programs in the US.

a. Accredited residency programs are highly structured to provide a well-rounded and rigorous clinical and educational experience for medical school graduates.
b. Traditional residency programs are based in environments that have clinical education as a core mission, with residents providing care under the supervision of physician educators. Residents are evaluated based on standardized approaches that examine the residents' knowledge base, clinical skills and professionalism, while also identifying those in need of more training. Based on these assessments, residents are afforded progressively greater autonomy.
c. Diagnostic analytic thought patterns are developed by a physician and individual practice patterns are established during this phase of the medical education experience. This is the aspect of training that provides a professional with the competency for independent thought and practice.
d. In the midst of training, it is inappropriate to confer a title implying training is complete. Physicians are trained for independent practice and any legislative intervention that subverts the end product of medical training is harmful to both patients and to the larger health care system.

3. These proposals create a two-tiered physician system whereby some patients have access to fully-trained and licensed DOs/MDs whose abilities do not require supervision, and others would receive care from those who complete medical school, but lack patient care knowledge and skills because they have not completed residency training. Patients in rural and underserved areas, who are already at a geographic and often economic disadvantage, deserve the same quality of care as those who live in prosperous areas of the state.

a. This includes receiving care from licensed health professionals who have completed the necessary education and training.
b. Health care consumers also deserve transparency from the health professionals who are providing their care. The AP title has the potential to confuse patients, health systems, payers and other providers.

4. These attempts run counter to efforts to raise the bar for health care providers, by maintaining/increasing standards for licensure and supporting competency demonstration requirements that adequately protect patients. Lowering the bar for who can provide care to patients degrades these ongoing efforts and creates inequity in the licensing requirements for health care providers licensed to provide the same health care services. In doing so, states will erode the trust of the patient and the public, a critical factor in the successful delivery of services in the patient-centered model of care.

5. Last year, over 95% of US medical students secured a residency training position. The numbers of unmatched medical school graduates from LCME or AOA accredited colleges are too small to make noticeable progress toward addressing workforce shortages.

a. These proposals fail to take into account that certain individuals fail to match into a training program because of their specialty choice.
b. Primary care residency slots remain available for qualified medical school graduates with an interest in practicing in these specialties.

6. If the goal is to address primary care workforce shortages, while ensuring access to optimal patient care, states would be wise to take a different approach. States should instead focus on increasing residency funding to create new and expand existing primary care training programs. States should also provide support for programs that encourage medical school graduates to pursue primary care specialties, particularly in rural and underserved areas. Programs like health provider loan repayment/forgiveness and Medicaid payment parity for primary care services are examples of proven strategies. States should consider optimizing state statutes and rules to ensure that all health professionals are practicing to the top of their education and experience.

a. This is the best way to create fully-trained and licensed physicians equipped to handle the complex primary care needs of patients, and address workforce shortages across all health care provider types in rural and underserved areas.
b. New models of care delivery like telemedicine, Accountable Care Coalition and Patient Centered Medical Homes are also effective ways to maximize the impact of the existing health care workforce. States should focus on providing appropriate payment for team-based care provided in these delivery models.

Member Coalition

American Academy of PAs
American Academy of Pediatrics
American Association of Colleges of Osteopathic Medicine
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
Association of American Medical Colleges
American Medical Association American Osteopathic Association

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under section 324.039, RSMo Supp. 2013, sections 334.036 and 334.125, RSMo. Supp. 2014, and section 334.045, RSMo 2000, the board adopts a rule as follows:

20 CSR 2150-2.220 Assistant Physician Inactive Status **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 981–983). No changes have been made in 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: The board received one (1) comment on the proposed rule.

COMMENT: A comment was received from the American Association of Physician Assistants (AAPA) stating an inactive status should not be included in the rule.
RESPONSE: Section 334.002, RSMo, authorizes any person licensed by Chapter 334, RSMo to apply to the board for an inactive status. Therefore, no change was made to the rule based on this comment.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.230 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 984–986). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received two (2) comments on the proposed rule.

COMMENT #1: A comment was received from the Missouri Academy of Family Physicians (MAFP) stating section (2) - The "Accreditation Counsel (should be "Council") on Graduate Medical Education (ACGME)" is not part of the American Medical Association (since 2000, per ACGME website: http://www.acgme.org/About-Us/Overview/ACGME-History); and the "Education Committee" of the American Osteopathic Association has been changed to "Program and Trainee Review Council".
RESPONSE AND EXPLANATION OF CHANGE: The board appreciates the comments and amends the language as suggested.

COMMENT #2: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating the proposed rule requires the applicant attest to completing at least one hundred (100) hours of continuing medical education (CME) over a two (2) year timeframe. We believe this is an appropriate CME standard and support its inclusion in the rule. However, CME should not be confused with or substituted for training or direct experience in treating patients. WUSTL is concerned that the board has not required a sufficient amount of hands-on training for assistant physicians before they are allowed to practice without direct supervision.
DRAFT RESPONSE: The board appreciates the comment. However, requiring hands-on training exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly. No changes have been made to the rule as a result of this comment.

20 CSR 2150-2.230 Assistant Physician—Continuing Education

(2) In order to count toward the required one hundred (100) hours, the continuing education shall be accredited by the American Medical Association (AMA) as Category 1; or by the American Academy of Family Physicians (AAFP) or the American Osteopathic Association (AOA) as Category 1-A or 2-A; or offered by a residency program or hospital-approved by Accreditation Council on Graduate Medical Education (ACGME) of the American Medical Association or the Program and Trainee Review Council of the American Osteopathic Association.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, and section 334.037, RSMo Supp. 2015, the board adopts a rule as follows:

20 CSR 2150-2.240 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 987–990). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received four (4) comments on the proposed rule and seven (7) general comments.

COMMENT #1: A comment was received from the Missouri Academy of Family Physicians (MAFP) suggesting subsection (2)(D) be amended to state - The methods of treatment, including any authority to administer, dispense, or prescribe drugs, delegated in a collaborative practice arrangement between a collaborating physician and a collaborating assistant physician, shall be delivered only pursuant to a written agreement, jointly agreed-upon protocols, or standing orders that are specific to the clinical conditions treated by the collaborating physician and collaborating assistant physician.
RESPONSE AND EXPLANATION OF CHANGE: The board appreciates the comments and amends the language as suggested.

COMMENT #2: A comment was received from Employee Retirement Income Security Act (ERISA) Industry Committee

(ERIC) supporting rules that recognize the potential benefits of telehealth as they relate to assistant physician collaborative practice agreements. ERIC represents large employers and welcomes the opportunity to share our support for leveraging telehealth to increase access to health care. ERIC thanks the board for thoughtfully developing regulations to maximize the benefits of telehealth and to express large employer's interest on the issues. ERIC encourages the board, to the extent permitted by law to—

• Adopt technology-neutral requirements, permitting use of different types of technology platforms that are designed for telehealth;

• Adopt licensing policies that facilitate interstate practice so providers, located in or out of the state, who deliver high-quality care, can serve patients located in Missouri;

• Avoid restrictions that require patients to visit specific location (e.g., "originating sites") in order to access telehealth services;

• Avoid imposing additional requirements on providers that offer telehealth service that are not imposed on in-person visits; and

• Consider the needs of patients to have better access to care that can be provided via telehealth, either through a telehealth visit or remote monitoring of health conditions.

RESPONSE: The board appreciates the comments and makes no changes to the rule.

COMMENT #3: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating the model of the assistant physicians relies exclusively on the collaborating physician taking responsibility for the supervision and training of the assistant physician. WUSTL is deeply concerned that the proposed rule does not provide adequate standards for supervision and training, especially for the recent medical graduate. The proposed rule under subsection (1)(B) allows an assistant physician to practice at a location fifty (50) miles away from the collaborating physician if not utilizing telehealth; if utilizing telehealth, there is no mileage restriction. Thus, an assistant physician could conceivably be providing health care services in Sikeston while the collaborating physician is in St. Joseph. Whereas these mileage standards might be appropriate for a well-trained medical professional, the only training required in the proposed rule, before the assistant physician can practice away from the collaborating physician, is a one- (1-) month period where the collaborating physician is continuously present. Aside from the above-mentioned biennial continuing medical education (CME) requirement, there is no other mention in the proposed rule regarding actual training for an assistant physician beyond this one- (1-) month apprenticeship. An earlier draft of the proposed rule, which was the basis of their July 14, 2015, comment letter, would have required the first six (6) months of licensure to involve one hundred percent (100%) supervision by the collaborating physician, followed by another six (6) months of at least two (2) half-days of supervision per week. This standard was recommended by a group of medical school representatives who determined this was an appropriate, albeit minimal, amount of supervision and training for individuals who will be given the ability to prescribe medical treatment. These requirements are essential to ensure both the development of the assistant physician's ability to diagnose disease and recommend treatment, but also to ensure the safety of the patients they see. Moreover, the statute under 334.037(3) states that any patient being seen by an assistant physician retains the "right to see the collaborating physician." A reasonable interpretation of this section could lead one to conclude this right is to see the physician "in person," and not via telehealth or via phone. It is unclear how the patient being seen by the assistant physician in Sikeston can exercise her or his right if the collaborating physician is in St. Joseph. WUSTL strongly urges the board to include more rigorous training and supervision standards in the final rule. At a minimum, the first six (6) months of collaborative practice should involve one hundred percent (100%) supervision of the assistant physician, followed by a graduated process of independence.

RESPONSE: Mileage restrictions and the use of telehealth are established by rule to be consistent with other collaborative practice agreements. The board acted cautiously not to place greater restrictions than what is required by statute. The board believes this change would require legislative action by the Missouri General Assembly. No changes have been made to the rule as a result of this comment.

COMMENT #4: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating there are several components in the sections dealing with the prescription of controlled substances that are confusing. Paragraph (2)(E)8. provides for the ability of the collaborating physician to delegate to an assistant physician the ability to prescribe controlled substances listed in Schedules II (hydrocodone), III, IV, and V. Paragraph (2)(E)8. further specifies that Schedule III substances are limited to a one hundred twenty- (120-) hour supply. If Schedule III drugs are limited to a one hundred twenty- (120-) hour supply, WUSTL believes this limit should apply to Schedule II controlled substance prescriptions as well. Moreover, paragraph (2)(E)10. goes on to state that an assistant physician may only dispense "starter doses of medication to cover a period of time for seventy-two (72) hours." Given the high potential for abuse of scheduled drugs, WUSTL recommends the seventy-two- (72-) hour standard be applied to drugs both dispensed and prescribed that are on the Schedule. A consistent standard would be clearer for the assistant physician, the collaborating physician, and the patient.

RESPONSE: The board appreciates the comment. The board makes no change as this change would require legislative action by the Missouri General Assembly.

COMMENT #5: One (1) comment was received from the American Association of Physician Assistants (AAPA) suggesting another way to expand access to care would be to optimize Missouri's physician assistant (PAs) statutes and rules to ensure that PAs are practicing to the top of their education and experience. PAs could be optimized by allowing chart review to determine the practice level. PAs are healthcare providers who are nationally certified and state licensed to practice medicine and prescribe medication in every medical and surgical specialty and setting. PAs practice and prescribe in all fifty (50) states, the District of Columbia, and all U.S. territories with the exception of Puerto Rico. PAs are educated at the graduate level, with most PAs receiving a Master's degree. In order to maintain national certification, PAs are required to recertify as medical generalists every ten (10) years and complete one hundred (100) hours of continuing medical education every two (2) years.

RESPONSE: No action was taken by the board as this change would require legislative action by the Missouri General Assembly.

COMMENT #6: A comment was received from the American Association of Physician Assistants (AAPA) stating the rules should specify that assistant physicians may only serve in certain federal or state designated healthcare shortage area.

RESPONSE: Section 334.038, RSMo, defines the assistant physician's practice location; therefore, the rules do not need to restate statute. The board made no changes to the rule based on this comment.

COMMENT #7: Three (3) comments were received from Esteban Ivanoff-Tzvetcoff, Muhammad Saad, and Aruna Sana stating they believe it is ridiculous that physician assistants and nurse practitioners have less training and having to pass easier exams are allowed to practice medicine, while medical students who did not match because there are not enough residency programs. One (1) commenter stated that this was plainly discriminatory and not democratic. Two (2) of the comments suggested assistant physicians should have three (3) months of direct supervision by a licensed physician before starting an independent job; assistant physicians should be allowed to take Missouri State Medical Board exam after twenty-four (24) months of work experience under the supervision of a licensed physician; and assistant physicians should be allowed to practice

independently after passing the State Medical Board exam (within three (3) years).
RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

COMMENT #8: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating many organizations such as the American Association of Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Medical Association, have raised concerns about the assistant physician concept. WUSTL shares these concerns. Central to those objections is the fear of putting untrained individuals into situations where they are dealing with vulnerable patients in underserved areas without an adequate support system in place. Just because patients live in an underserved area does not mean they should be subject to a different standard of care than other individuals. The board must take care to ensure that assistant physicians are providing evidence-based medical care. It is important for the board to think about ways it can track the experience of assistant physicians and their patients to understand better what is working well and what may need further refinement or improvement in the future. WUSTL stated they would be willing to assist the board in thinking through how to track such outcomes.
RESPONSE: The board appreciates the comment.

COMMENT #9: A comment was received from Washington University in St. Louis School of Medicine (WUSTL). The comment builds upon and reinforces comments provided by Dr. Rebecca McAlister, the school's Associate Dean for Graduate Medical Education, on May 12, 2015, and by Dr. Larry Shapiro, former Executive Vice Chancellor for Medical Affairs and Dean, dated July 10, 2015. WUSTL states that unfortunately, the regulations as proposed, in many ways, represent a step backwards compared to earlier drafts of the rule shared last year. WUSTL, as an organization dedicated to preparing medical professionals for the rigors of practicing medicine, state they are deeply concerned that the proposed rules do not provide adequate supervision of, or training for, assistant physicians before they are allowed to prescribe medical treatments. A medical degree itself is not sufficient to ensure an individual can appropriately diagnose and treat a patient presenting with disease. The national model currently used to ensure physicians are capable of competently delivering health care involves completion of the Board of Registration for the M.D. degree followed by a period of residency training which can range from three (3) years to seven (7) years, depending on the physician's specialty. Some specialists will seek even further subspecialty training through fellowships. Any licensed physician will tell you how critical these training experiences are in becoming an experienced and proficient doctor. The assistant physician pathway, by design, lacks a credible period of training. This absence is why it is essential that the board uphold its obligation to protect public health and safety by ensuring that assistant physicians are adequately supervised and exposed to meaningful training opportunities.
RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

20 CSR 2150-2.240 Assistant Physician Collaborative Practice Agreements

(2) Methods of treatment.

(D) The methods of treatment, including any authority to administer, dispense, or prescribe drugs, delegated in a collaborative practice arrangement between a collaborating physician and a collaborating assistant physician, shall be delivered only pursuant to a written agreement, jointly agreed-upon protocols, or standing orders that are specific to the clinical conditions treated by the collaborating physician and collaborating assistant physician.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 2—Licensing of Physicians and Surgeons

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.250 Assistant Physician Supervision Change Requirements **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 991–993). No changes have been made in 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 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 2—Licensing of Physicians and Surgeons

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, and section 334.037, RSMo Supp. 2015, the board adopts a rule as follows:

20 CSR 2150-2.260 Assistant Physician Certificate of Prescriptive Authority **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 994–996). No changes have been made in 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.

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 7—DEPARTMENT OF TRANSPORTATION
Division 10—Missouri Highways and Transportation Commission
Chapter 25—Motor Carrier Operations

IN ADDITION

7 CSR 10-25.010 Skill Performance Evaluation Certificates for Commercial Drivers

PUBLIC NOTICE

Public Notice and Request for Comments on Applications for Issuance of Skill Performance Evaluation Certificates to Intrastate Commercial Drivers with Diabetes Mellitus or Impaired Vision

SUMMARY: This notice publishes MoDOT's receipt of applications for the issuance of Skill Performance Evaluation (SPE) Certificates from individuals who do not meet the physical qualification requirements in the Federal Motor Carrier Safety Regulations for drivers of commercial motor vehicles in Missouri intrastate commerce because of impaired vision or an established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control. If granted, the SPE Certificates will authorize these individuals to qualify as drivers of commercial motor vehicles (CMVs), in intrastate commerce only, without meeting the vision standard prescribed in 49 CFR 391.41(b)(10), if applicable, or the diabetes standard prescribed in 49 CFR 391.41(b)(3).

DATES: Comments must be received at the address stated below, on or before, January 3, 2017.

ADDRESSES: You may submit comments concerning an applicant, identified by the Application Number stated below, by any of the following methods:
• *Email:* Pamela.lueckenotto@modot.mo.gov
• *Mail:* PO Box 270, Jefferson City, MO 65102
• *Hand Delivery:* 830 MoDOT Drive, Jefferson City, MO 65102
• *Instructions:* All comments submitted must include the agency name and Application Number for this public notice. For detailed instructions on submitting comments, see the Public Participation heading of the Supplementary Information section of this notice. All comments received will be open and available for public inspection and MoDOT may publish those comments by any available means.

COMMENTS RECEIVED BECOME MoDOT PUBLIC RECORD

• By submitting any comments to MoDOT, the person authorizes MoDOT to publish those comments by any available means.
• *Docket:* For access to the department's file, to read background documents or comments received, 830 MoDOT Drive, Jefferson City, MO 65102, between 7:30 a.m. and 4:00 p.m., CT, Monday through Friday, except state holidays.

FOR FURTHER INFORMATION CONTACT: Pam Lueckenotto, Motor Carrier Investigations Specialist, 636-288-6082, MoDOT Motor Carrier Services Division, PO Box 270, Jefferson City, MO 65102. Office hours are from 7:30 a.m. to 4:00 p.m., CT, Monday through Friday, except state holidays.

SUPPLEMENTARY INFORMATION:

Public Participation
If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard.

Background
The individuals listed in this notice have recently filed applications requesting MoDOT to issue SPE Certificates to exempt them from the physical qualification requirements relating to vision in 49 CFR 391.41(b)(10), or to diabetes in 49 CFR 391.41(b)(3), which otherwise apply to drivers of CMVs in Missouri intrastate commerce.

Under section 622.555, RSMo, MoDOT may issue an SPE Certificate, for not more than a two- (2-) year period, if it finds that the applicant has the ability, while operating CMVs, to maintain a level of safety that is equivalent to or greater than the driver qualification standards of 49 CFR 391.41. Upon application, MoDOT may renew an exemption upon expiration.

Accordingly, the agency will evaluate the qualifications of each applicant to determine whether issuing an SPE Certificate will comply with the statutory requirements and will achieve the required level of safety. If granted, the SPE Certificate is only applicable to intrastate transportation wholly within Missouri.

Qualifications of Applicants

Application #100

Renewal Applicant's Name & Age: Steven B. Tornow, 34

Relevant Physical Condition: Insulin-treated diabetes mellitus (ITDM). Mr. Tornow's best uncorrected visual acuity in his right eye is 20/25 Snellen. His left eye best uncorrected visual acuity is 20/25 Snellen. Mr. Tornow has been an insulin-treated diabetic since October 10, 2004.

Relevant Driving Experience: Mr. Tornow has approximately four (4) years of commercial motor vehicle experience. Mr. Tornow currently has a Class A license. In addition, he has experience driving personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in October 2016, a board-certified endocrinologist certified his condition would not adversely affect his ability to operate a commercial motor vehicle safely.

Traffic Accidents and Violations: Mr. Tornow has had no tickets or accidents on record for the previous three (3) years.

Request for Comments
The Missouri Department of Transportation, Motor Carrier Services Division, pursuant to section 622.555, RSMo, and rule 7 CSR 10-25.010, requests public comment from all interested persons on the applications for issuance of Skill Performance Evaluation Certificates described in this notice. We will consider all comments received before the close of business on the closing date indicated earlier in this notice.

Issued on: October 28, 2016

Scott Marion, Motor Carrier Services Director, Missouri Department of Transportation.

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 22, 2016. These applications are available for public inspection at the address shown below.

Date Filed

Project Number: Project Name
City (County)
Cost, Description

11/4/16

#5382 NT: Putnam County Care Center
Unionville (Putnam County)
$984,004, Renovate and Modernize 60-bed SNF

11/10/16

#5396 HT: Barnes-Jewish Hospital
St. Louis (St. Louis City)
$8,385,301, Replace Linear Accelerator

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, 2016. All written requests and comments should be sent to—

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
PO Box 570
Jefferson City, MO 65102
For additional information contact Karla Houchins at (573) 751-6700.