Title 15—ELECTED OFFICIALS
Division 60—Attorney General
Chapter 13—Rules for the Establishment of a Missouri No-Call Database

PROPOSED RULE

15 CSR 60-13.040 Effect of a Change of Telephone Number on a Residential Subscriber's Notice of Objection to Receiving Telephone Solicitations

PURPOSE: This rule describes the effect of a change of telephone number on a notice of objection to receiving telephone solicitations filed by a residential subscriber.

If a residential subscriber whose telephone number is part of the no-call database changes telephone numbers, he or she will have to submit a new notice of objection to receiving telephone solicitations pursuant to 15 CSR 60-13.020, subject to the deadlines therein, and provide the new telephone number to the Attorney General's Office.

AUTHORITY: section 407.1101, RSMo 2000. Original rule filed Sept. 28, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $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 Attorney General, Jeremiah W. "Jay" Nixon, c/o Ronald Molteni, Assistant Attorney General, P.O. Box 899, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 15—ELECTED OFFICIALS
Division 60—Attorney General
Chapter 13—Rules for the Establishment of a Missouri No-Call Database

PROPOSED RULE

15 CSR 60-13.050 Method by Which a Residential Subscriber or a Certificated Local Exchange Carrier May Revoke Notice of Objection to Receiving Telephone Solicitations

PURPOSE: This rule sets forth the method by which residential subscribers may revoke their notice of objection to receiving telephone solicitations.

A residential subscriber may revoke notice of objection to receiving telephone solicitations by completing a written form designed by the Attorney General's Office for the purpose of revoking a residential subscriber's notice of objection to receiving telephone solicitations and submitting that completed form to the Attorney General's Office. A residential subscriber may also revoke his or her notice of objection to receiving telephone solicitations by accessing the appropriate Internet site established by the Attorney General and inputting the proper data requested by the website prompts. Upon receipt of such revocation notice, the Attorney General's Office will remove the relevant telephone number from the no-call database according to the same schedule used for adding telephone numbers to the no-call database. In addition, the Attorney General's Office may remove a telephone number from the no-call database if the Missouri certificated local exchange carrier responsible for the assignment of the relevant telephone number indicates in writing or, if available, by Internet, to the Attorney General's Office that the residential subscriber who submitted the objection to receiving telephone solicitations is no longer assigned that telephone number.

AUTHORITY: section 407.1101, RSMo 2000. Original rule filed Sept. 28, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $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 Attorney General, Jeremiah W. "Jay" Nixon, c/o Ronald Molteni, Assistant Attorney General, P.O. Box 899, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 15—ELECTED OFFICIALS
Division 60—Attorney General
Chapter 13—Rules for the Establishment of a Missouri No-Call Database

PROPOSED RULE

15 CSR 60-13.060 Methods by Which a Person or Entity Desiring to Make Telephone Solicitations Will Obtain Access to the Database of Residential Subscribers' Notices of Objection to Receiving Telephone Solicitations and the Cost Assessed for Access to the Database

PURPOSE: This rule sets forth the methods by which persons or entities desiring to make telephone solicitations will obtain access to the database of residential subscribers' notices of objection to receiving telephone solicitations, and it sets forth the cost assessed for access to that database. Persons or entities obtaining copies of the no-call database are reminded that the no-call database is updated quarterly.

(1) A person or entity desiring to make telephone solicitations to residential subscribers residing or living in Missouri may obtain a copy of the no-call database by doing the following:

(A) Signing a written confidentiality agreement prepared by the Attorney General's Office that 1) restricts use of the no-call database exclusively for the purpose of compliance with sections 407.1095 to 407.1113, RSMo 2000, as amended from time-to-time, and 2) prohibits the transfer of the copy of the no-call database to any person or entity who has not submitted the signed written confidentiality agreement and payment to the Attorney General's Office for receipt of a copy of the no-call database; and

(B) Submitting the signed confidentiality agreement along with payment in the amount of $25 per quarter to the Attorney General's Office of providing the copy of the no-call database.

(2) A person or entity who initiates any voice communication over a telephone line from a live operator, through the use of ADAD equipment or by other means for the purpose of encouraging the purchase or rental of, or investment in, property, goods or services and who claims that such communication falls under one of the exclusions to the definition of "telephone solicitation" appearing in section 407.1095(3), RSMo, as amended, shall provide notice to the Attorney General's Office of that person or entity's intention to

utilize the claimed exclusion along with an explanation of the basis for that person's claimed exclusion. If the Attorney General's Office agrees that the person or entity submitting the exclusion notice is in fact and as a matter of law entitled to utilize the claimed exclusion, the Attorney General's Office may recognize that person or entity's use of the exclusion by informing the person or entity that the Attorney General's Office recognizes the claimed exclusion. The Attorney General's Office may also investigate the claimed exclusion using the powers available under section 407.1110, RSMo, as amended. If the Attorney General's Office a) does not inform the person or entity submitting the claimed exclusion that the Attorney General's Office recognizes the exclusion or expressly informs that person that the Attorney General's Office does not recognize the claimed exclusion; or b) if a person or entity who initiates any voice communication over a telephone line from a live operator, through the use of ADAD equipment or by other means for the purpose of encouraging the purchase or rental of, or investment in, property, goods or services and who claims that such communication falls under one of the exclusions to the definition of "telephone solicitation" appearing in section 407.1095(3), RSMo, does not submit a notice of the claimed exclusion to the Attorney General's Office; then that person or entity shall not have established and implemented, with due care, reasonable practices and procedures to effectively prevent telephone solicitations.

AUTHORITY: section 407.1101, RSMo 2000. Original rule filed Sept. 28, 2000.

PUBLIC COST: This proposed rule will cost the Attorney General approximately $4,000 in the aggregate during the first year of implementation and $4,000 annually thereafter.

PRIVATE COST: This proposed rule will cost private entities approximately $7,250 in the aggregate during FY 01, and approximately $29,000 annually thereafter.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Attorney General, Jeremiah W. "Jay" Nixon, c/o Ronald Molteni, Assistant Attorney General, P.O. Box 899, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC ENTITY COST

I. RULE NUMBER

Title: 15 - Elected Officials

Division: 60 - Attorney General

Chapter: 10 - Rules for the Establishment of a Missouri No-Call Database

Type of Rulemaking: Proposed New Rule

Rule Number and Name: 15 CSR 60-10.060 - Methods by Which a Person or Entity Desiring to Make Telephone Solicitations Will Obtain Access to Database of Residential Subscribers' Notices of Objection to Receiving Telephone Solicitations and the Cost Assessed for Access to the Database.

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Attorney General's Office	$4,000 *

* This figure does not include an aggregate cost for FY 00. The costs will run annually starting in FY 01 and continue for the indefinite life of the rule on an annual basis.

The cost to the Attorney General's Office will include the cost of preparing and mailing the database on a quarterly basis.

III. WORKSHEET

II. Fund Costs by Category	FY 00	FY 01	FY 02	FY 03	FY 04
Disk Production Cost		$ 4,000	$ 4,000	S 4,000	$ 4,000

* Assumes 40 entities at $100 each

IV. ASSUMPTIONS

1. Determining the number and types of entities affected by these rules cannot be estimated with greater specificity than appears in this fiscal note because business entities' use of telephone solicitations vary greatly. In an effort to provide information to the potential affected entities, we have looked at Tennessee as we have done in regard to the number of residential consumers that have entered the database. Tennessee began taking names January 1, 2000, and required its telemarketers to receive the information beginning August 1, 2000. It currently has 290 entities that are required to obtain the database on a monthly basis.

2. The Attorney General's Office will have the capability to produce the database on CD. This cost is part of the start-up costs set out in 15 CSR 60-10.020. The cost of producing the CD is approximately $25 a piece. Using $25 and assuming the Tennessee number of 40, this results in a quarterly cost of $1,000 or $4,000 per year. The postage cost for mailing the database to be nominal at approximately $500 per year. The remaining requests, again using the Tennessee numbers, will be performed by e-mail and will include only a nominal charge, if any.

3. IT Personnel in the Attorney General's Office were consulted regarding the computer/material costs under this rule.

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 15 - Elected Officials

Division: 60 - Attorney General

Chapter: 10 - Rules for the Establishment of a Missouri No-Call Database

Type of Rulemaking: Proposed New Rule

Rule Number and Name: 15 CSR 60-10.060 - Methods by Which a Person or Entity Desiring to Make Telephone Solicitations Will Obtain Access to Database of Residential Subscribers' Notices of Objection to Receiving Telephone Solicitations and the Cost Assessed for Access to the Database.

II. SUMMARY OF FISCAL IMPACT

Estimated number of entities which would likely be affected by the adoption of the proposed rule:	**Classification by types of the business entities which would likely be affected:**	**Annualized estimate in the aggregate as to the cost of compliance with the rule by the affected entities:**
290 *	* Home improvement, alarm companies, funeral homes/monument companies, long distance phone companies, local exchange phone companies, suppression list companies, information companies, heating and cooling, mortgage companies, insurance agents, real estate companies, stockbrokers, magazine publishing and direct marketing corporations, carpet cleaners, chiropractors, car dealers, vacation/travel related companies, resort/time share companies, roofing and remodeling, insurance-health/life, financial organizations, certified public accountants, window companies, hearing aid companies, bottled water companies, photography, Internet service providers, for-profit companies representing handicapped/disabled, credit cards, satellite TV/cable companies, credit card protection companies, fine arts/orchestra, dance clubs, appliance repairs company, gambling organizations, Tupperware/Mary Kay/special utensils, lawn care, newspapers, voice mail/beeper services.	$ 29,000 *

* The numbers set out in the summary of Fiscal Impact regard the annual cost for the life of the rule. The numbers cannot be estimated with greater specificity than contained in this fiscal note because business entities often vary their operating practices. The cost in the aggregate could exceed $500 but are unquantifiable. The fiscal note serves notice to businesses that utilize telephone solicitations that they may incur costs which will vary greatly dependent upon their use of telephone solicitations. For purposes of this rule we have referred to the State of Tennessee who has had its database operational from January 1, 2000, and its telemarketer database operational from August 1, 2000. As of the date of this rule 290 telemarketers are unlisted on the telemarketers database in the State of Tennessee.

III. WORKSHEET

Type of costs per entity	**FY 01**	**FY 02**	**FY 03**	**FY 04**
Database acquisition cost	$ 25	$ 100	$ 100	$ 100
Implementation of database by business entity	*	*	*	*
Exclusion determination process	**	**	**	**
Totals per entity	$ 25***	$ 100***	$ 100***	$ 100***
Totals for all affected entities	$7,250***	$29,000***	$29,000***	$29,000***

Businesses using telephone solicitations should expect annual costs after FY 04 for the life of the rule as set out in FY 04.

*1. As indicated in the Assumptions, this cost is impossible to determine without knowing the business set-up, but is expected to be a nominal cost.
**2. As indicated in the Assumptions, this cost is impossible to determine without knowing the business set-up, but is expected to be a nominal cost.
***3. Includes any charges in the implementation of the database and exemption determination process.

IV. ASSUMPTIONS

1. All business entities who use telephone solicitations are required to obtain and use the no-call database for their business operations. The annual cost of obtaining the database is $25/quarter or $100/year. The business entities are required to use the list effective July 1, 2001. It is assumed that the business entities may obtain the database in the last quarter of FY 01. The business entities will be assessed the yearly fee in FY 02.

2. Determining the number and types of entities affected by these rules cannot be

estimated with greater precision than appear herein because the rule could apply to any business entity that uses telephone solicitations. Additionally, the needs of specific businesses will change and so will the use of telemarketing. In an effort to provide information to all the potential entities impacted, we have looked at Tennessee as we have done in regard to the number of residential consumers who have entered the database. Tennessee, like Missouri, is a "no-fee" state. Tennessee began taking entries on January 1, 2000, and required its telemarketers to receive the information beginning August 1, 2000. It currently has 290 entities that obtain the database on a monthly basis. Two hundred fifty entities receive this by e-mail and 40 by disk.

3. The second portion of potential costs consists of the implementation of the database into its daily operations. Each business entity will exercise its own control on how to use the database. For that reason, the cost of implementation, if any, will vary and cannot be estimated with greater specificity than appears in this fiscal note. The remaining cost issue is the determination of whether a particular entity will incur costs to determine its exemption status. Again, what entities will use "telephone solicitations" will vary greatly. For this reason, though each entity's cost may be nominal, aggregate costs are not quantifiable with greater specificity than appears within this fiscal note. The database acquisition and implementation costs will be annual charges recurring in perpetuity. The exemption process should be a one time charge, assuming no change in a business entity's business practice. The annual costs will start in FY 01 and continue for the indefinite life of the rule.

Title 15—ELECTED OFFICIALS
Division 60—Attorney General
Chapter 13—Rules for the Establishment of a Missouri No-Call Database

PROPOSED RULE

15 CSR 60-13.070 Other Matters Relating to the Database of Residential Subscribers' Notices of Objection to Receiving Telephone Solicitations

PURPOSE: This rule sets forth other matters relating to the database of residential subscribers' notice of objection to receiving telephone solicitations.

(1) No person who obtains a copy of the no-call database may use that information for purposes other than compliance with sections 407.1098 and 407.1101, RSMo 2000, as amended from time-to-time.

(2) The Attorney General's Office may use monies collected pursuant to 15 CSR 60-13.060 to carry out the functions set forth in sections 407.1095 to 407.1113, RSMo 2000, as amended from time-to-time.

AUTHORITY: section 407.1101, RSMo 2000. Original rule filed Sept. 28, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $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 Attorney General, Jeremiah W. "Jay" Nixon, c/o Ronald Molteni, Assistant Attorney General, P.O. Box 899, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH
Division 10—Office of the Director
Chapter 4—Coordinated Health Care Services

PROPOSED AMENDMENT

19 CSR 10-4.020 J-1 Visa Waiver Program. The department proposes to amend paragraphs (2)(A)13. and (7)(C)1. and sections (3), (5), (6), and (7); to add subsections (3)(A), (3)(B), (5)(A), (6)(A), (6)(B), and paragraph (7)(C)3.; and to renumber the affected sections.

PURPOSE: This proposed amendment is to add: (1) the requirement and the criteria for a facility to be predetermined as eligible to participate in the J-1 Visa Program; (2) the ability of the department to determine that emergency rooms are primary care clinical settings and may participate in the J-1 Visa Program; (3) the ability and the criteria necessary for physicians trained in other specific high need specialties besides primary care to participate in the J-1 Visa Program; and (4) a biannual reporting requirement for facilities that participate in the J-1 Visa Program.

(2) The department is committed to assisting all residents of Missouri to have access to quality, affordable health care. Therefore, under certain conditions, the department is prepared to consider recommending a waiver of the foreign residence requirement on behalf of physicians holding J-1 visas.

(A) A waiver request must come from a Missouri health care facility on behalf of a J-1 physician and not directly from a J-1 physician. All of the required information and documentation must be submitted in a single package with the documents presented in the order in paragraphs (2)(A)1.–14. Waiver requests that do not comply with these requirements will not be considered. The required documents include:

1. A letter from the head of the facility at which the physician will be employed that—

A. Requests that the department act as an interested government agency and recommend a waiver for the J-1 physician;

B. Summarizes how the health care facility has attempted to locate qualified United States physicians;

C. Describes the physician's qualifications, proposed responsibilities and how his/her employment will satisfy important unmet health care needs of a medically underserved rural community; and

D. States unequivocally that the facility is offering the physician at least three (3) years of employment in a job consistent with the department's mission;

2. A detailed description of the health care facility will be provided, including the nature and extent of the facility's medical services;

3. Valid contract of employment with the health care organization for not less than three (3) years;

4. List of HPSAs or documentation from state and local health care officials stating need for services of the physician;

5. Recruitment and retention efforts including copies of advertisements, agreements with placements services or other like documentation, and if these are not available, a detailed statement describing recruitment efforts. A statement should be submitted detailing the plans for retaining the physician during and beyond the three (3)-year obligation;

6. Effect on area of waiver denial;

7. Qualifications, including proof of Missouri medical licensure eligibility;

8. Physician's curriculum vitae and letters of recommendation;

9. Copies of all IAP-66s of physician, copies of I-94s of physician and family members, and proof of passage of examinations required by the United States Immigration and Naturalization Service;

10. Completed physician data sheet (attached as Appendix A);

11. Completed J-1 visa waiver policy affidavit and agreement (attached as Appendix B);

12. Valid offer of employment with health care organization for at least three (3) years;

13. *[A copy of the no objection letter from the home government]* **A copy of the notice from the department that the facility has been pre-determined eligible for participation in the program**; and

14. An original and one (1) unbound copy of the entire package should be included.

(3) Missouri health care facilities seeking to employ a foreign medical graduate holding a J-1 visa *[may request a packet of materials and instructions detailing the information and documentation that is required in order to submit an appropriate case file for review from the department's Center for Local Public Health Services]* **must be pre-determined by the department as eligible for participation in the J-1 Visa Waiver Program**.

(A) Eligible applicants will provide the department the following information and assurances:

1. Estimated enumeration of the patient population to be served.

2. Description of demographic characteristics of the population(s) to be served, including age groups, ethnicity, poverty status, health status and insurance coverage.

3. A copy of the sliding fee scale and the applicable policy utilized by the facility.

(B) Eligible applicants may request a packet of materials and instructions detailing the information and documentation that is required in order to submit an appropriate case file for review from the department.

(5) The department's J-1 Visa Waiver Program in Missouri *[is limited]* **will give priority** to those physicians who are board-eligible or board-certified in one (1) of the following specialties: Family Practice, **General Practice,** General Pediatrics, Obstetrics/Gynecology, General Internal Medicine or Psychiatry **and providing services in a primary care clinical setting**. Physicians with other subspecialties or fellowship experience are not considered to be primary care physicians for the purpose of the J-1 Visa Waiver Program in Missouri *[and therefore are not eligible for participation]*. The credentials of the J-1 physician must be confirmed by the Missouri Board of Healing Arts. The physician must be eligible for licensure in Missouri.

(A) The department may determine emergency rooms to be primary care clinical settings where substantial amounts of primary care services are delivered in that setting. In order to qualify for participation, the sponsoring facility must provide the following:

1. The number and types of primary care encounters in the emergency room.

2. The demographic characteristics of the populations accessing primary care services in the emergency room.

3. The payor source for primary care services in the emergency room.

4. Documentation that primary care services for the identified population(s) are not available in the community.

(6) In addition to the eligible physicians set forth in section (5), waivers may be recommended for other specialties and subspecialties.

(A) Physicians trained in other specialties may be considered for placement in the J-1 Visa Program in Missouri based on the following criteria:

1. Vacant slots in the program must be available; and

2. The employer must demonstrate that the specialist services are essential to the medical needs of the underserved; and

3. The specialty physician's application must have the concurrence in writing of the primary care physicians practicing in the community that the specialty is needed in the area; and

4. The specialty physician's application must comply with all other requirements of the J-1 Visa Program.

(B) Only four (4) slots will be allocated to specialty placement in any given program year.

[(6)] **(7)** It is the responsibility of the physician and the employer to meet Missouri's licensing and credentialing requirements as delineated by the Missouri Board of Healing Arts.

[(7)] **(8)** A request for a J-1 visa waiver for a physician to enter private practice shall comply with the following:

(A) The practice must be located in a HPSA;

(B) The owner of the practice must be the employer for the J-1 physician and must submit a letter of support for the J-1 visa waiver request;

(C) The practice employer must—

1. Certify that it will provide *[primary]* **health** care **services** to all patients, including Medicare and Medicaid patients, without regard to ability to pay or the source of payment and must include a sliding fee scale for adjusting patient bills for those who are unable to pay; and

2. Conspicuously post the sliding fee scale in the practice site, in the language(s) of patients receiving services; and

3. Provide the department two (2) reports each calendar year detailing the following:

A. The number of patients covered by sliding fee scale services;

B. The number of Medicaid patients served;

C. The number of Medicare patients served;

D. The total number of patients served;

E. The demographic characteristics of patients served, including data on age, gender, and ethnicity; and

F. Evaluation of services provided and community need; and

(D) All other J-1 visa waiver requirements remain in effect.

[(8)] **(9)** A physician must work at the facility for a minimum of three (3) years. If the physician fails to fulfill the terms of the contract with the facility, the facility must notify the department. This information will be forwarded to Immigration and Naturalization Services and other agencies as necessary.

[(9)] **(10)** A physician who is practicing under a J-1 visa in another state who wishes to practice in a HPSA in Missouri and obtain a J-1 visa waiver may do so only under the following conditions:

(A) The physician must complete the J-1 visa waiver application process in Missouri and obtain a Missouri medical license prior to commencing practice;

(B) The physician should make no plans for the transfer or to move personal possessions until the department has approved the request. The physician retains sole responsibility for notifying the employer of the intent to transfer, and payment of any financial penalty caused by a breach of contract, as determined by the employer; and

(C) All other J-1 visa waiver requirements remain in effect.

[(10)] **(11)** A physician with a J-1 visa waiver who is practicing in Missouri who wishes to transfer to another HPSA in Missouri may do so under the following conditions:

(A) At least sixty (60) days in advance of the proposed change, the physician must notify the department of the new practice site address, telephone number, site director and the effective date of the proposed change;

(B) The reason for the transfer must be explained in the written notice;

(C) A new J-1 visa waiver employer contract must be submitted to the department prior to approval of the transfer; and

(D) The physician should make no plans for the transfer or moving of personal possessions until the department has issued written approval of the transfer. The physician retains sole responsibility for notifying the employer of the intent to transfer and payment of any financial penalty caused by a breach of contract, as determined by the original employer.

[(11)] **(12)** The department is not responsible for exceptions to or interpretations of these policies which have occurred without the written approval of the director of the department or his/her designee. Applicants should be aware that hospitals or physician recruiters are not expert in the requirements of each state, and should contact the department with any questions.

[(12)] **(13)** The department is not responsible for any practice arrangements or contractual obligations entered into by the physician prior to approval of a J-1 visa waiver request.

[(13)] **(14)** In order to assist and facilitate the placement of primary care practitioners in designated HPSAs in Missouri, the department will provide, upon request, the following information:

(A) List of designated HPSAs in Missouri;

(B) List of hospitals located in HPSAs;

(C) List of community health centers in HPSAs in Missouri; and

(D) Procedure to request a J-1 visa waiver.

AUTHORITY: section 191.411.1, RSMo 1994. This rule was previously filed as 19 CSR 50-4.020. Emergency rule filed April 17, 1995, effective April 27, 1995, expired Aug. 24, 1995. Original rule filed April 17, 1995, effective Oct. 30, 1995. Changed to 19 CSR 10-4.020 July 30, 1998. Emergency amendment filed Sept. 19, 2000 effective Sept. 29, 2000 expires March 27, 2001. Amended: Filed Sept. 19, 2000.

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

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Harold Kirbey, Chief, Health Care Access and Assessment, 912 Wildwood, Jefferson City, MO 65109. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH
Division 10—Office of the Director
Chapter 5—Procedures for the Collection and Submission of Data to Monitor Health Maintenance Organizations

PROPOSED AMENDMENT

19 CSR 10-5.010 Monitoring Health Maintenance Organizations Definitions. The department proposes to amend this rule by amending section (2), subsections (2)(B), (C) and (D); amending sections (4), (5) and (6); replacing Tables A, B and D; and deleting Table C.

PURPOSE: This amendment is to clarify the requirements on submission of annual member satisfaction survey data by modifying section (2), subsections (2)(B), (C) and (D); to eliminate the submission requirements for the enrollee linkage data by deleting section (4) and renumbering sections (5) and (6); to update Table A to reflect consistency with standards of the National Quality Assurance Committee; to update Table B to reflect the data specifications for the quality indicators; to delete Table C to reflect the removal of the requirement to submit enrollee linkage data; and to revise Table D to update and expand health care access information.

(2) Starting in 1998, *[commercial]* health care plans shall submit annually to the department, member satisfaction survey data—

(B) *[The data provided to the department shall be submitted through the survey vendor in electronic form and meet the specifications of Table A. Table A is incorporated herein by reference;]* **The commercial and Medicaid member satisfaction data shall be submitted to the department in electronic form, through a certified survey vendor, and meet the specifications of Table A. Table A is incorporated herein by reference. An exception to this requirement shall be made for those Medicaid health care plans that are required to participate in a member satisfaction survey conducted by the Division of Medical Services. For these plans, the department will obtain the member satisfaction data from the Division of Medical Services;**

(C) In 1998 the data shall be submitted by September 1. In subsequent years a final **member-level** data file shall be submitted by June 15 or the date required by NCQA if other than June 15; and

(D) *[Medicaid and Medicare health care plans shall participate in a member satisfaction survey directed by the Division of Medical Services and the Health Care Financing Administration, respectively. The department will obtain the data from the agencies conducting the surveys.]* **Medicare health care plans shall participate in a member satisfaction survey conducted by the Health Care Financing Administration. The department will obtain the data from the Health Care Financing Administration.**

[(4) Starting in 1998, all commercial health care plans shall submit annually to the department enrollee data for linkage with department data to produce quality indicators—

(A) A final enrollee data file shall be submitted to the department by September 1, 1998, and by April 1 of each year thereafter, on persons enrolled in a health care plan as of December 31 of the previous year;

(B) The enrollee data shall be submitted in electronic form and shall conform to the file record contents and specifications listed in Table C of this rule. Table C is incorporated herein by reference.]

[(5)] **(4)** In 1998 access to care data shall be submitted by September 1. In subsequent years the data shall be submitted by June 15. Access to care data shall include the data elements and conform to the specifications listed in Table D. Table D is incorporated herein by reference.

[(6)] **(5)** A health care plan demonstrates continual or substantial failure to comply with the provisions of this rule when the health care plan has been notified by the department that it fails to comply with the provisions of section 192.068, RSMo and this rule and the health care plan—

(A) Fails to provide required data;

(B) Fails to submit data that meet the data standards detailed in this rule; or

(C) Fails to submit data within the time frames established in this rule.

AUTHORITY: section 192.068, RSMo Supp. 1999. Emergency rule filed Jan. 16, 1998, effective Jan. 26, 1998, terminated April 15, 1998. Original rule filed Jan. 16, 1998, effective Aug. 30, 1998. Amended: Filed Oct. 30, 1998, effective May 30, 1999. Amended: Filed Dec. 20, 1999, effective May 30, 2000. Amended: Filed Sept. 15, 2000.

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

PRIVATE COST: This proposed amendment will cost private entities $160,000 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Health, Center for Health Information Management and Epidemiology, Garland Land, Director, P.O. Box 570, Jefferson City, MO 65102, (573) 751-6272. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: Department of Health

Division: Office of the Director

Chapter: Procedures for the Collection and Submission of Data to Monitor Health Maintenance Organizations

Type of Rule Making: Proposed Rule Amendment

Rule Number and Name: 19 CSR 10 - 5.010 Monitoring Health Maintenance Organizations

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities.
8	Health Plans and products	$160,000 annually

III. WORKSHEET

The estimate in the aggregate was calculated as follows. There are eight (8) MC+ plan products that are independently effected by this rule during the reporting year 2001. The cost is estimated at $20,000 per product. The total annual cost to the health care plans is estimated at a $160,000.

IV. ASSUMPTIONS

Costs to the MC+ health care plans that are affected by this rule change are estimated at $20,000 per product per plan per year. The number of affected products is calculated by determining the number of Medicaid health plan products that will be required to conduct independent, member satisfactions surveys for their enrollee populations, in accordance with the technical specifications in the rule. For the remaining plans, no new costs or additional costs are incurred. There are eight (8) products that are independently effected by this rule. For these products the total cost to the health care plans, including external data collection expenses, is estimated at a $160,000 annually.

Table A

Member Satisfaction Survey Data File Specifications

File Content

Member satisfaction survey data shall be based on the version of the NCQA-required Consumer Assessment of Health Plans Study (CAHPS) Questionnaire, applicable for the reporting year. The data reported to the Department shall include the adult core set of questions, plus any NCQA-mandated or -recommended items for the adult segment of the questionnaire. The data shall also include any HEDIS measures specified in Table B, for a given product line and reporting year, that are collected via the CAHPS survey tool.

File format and media

The member-level satisfaction survey data shall be submitted electronically, using the data submission tool (DST) specified by the Department. Other file specifications shall conform to those required by NCQA for submission of the CAHPS Questionnaire results by the certified vendors.

File consistency

Plans that elect to submit separate files for sub-groups of their enrollment population must consistently do so for all data submission categories required by this rule.

Table B

Quality Indicator Data Specifications
Reporting Period: CY 2000

Data reported for each of the indicators listed below shall conform to the NCQA HEDIS Data Submission Tool and all other HEDIS technical specifications for indicator descriptions and calculations. An "X" in the table below indicates data are to be reported for this quality indicator if the health care plan offers this product line to Missouri residents.

	Applicable to:		
Indicator*	**Commercial**	**Medicaid**	**Medicare**
Childhood Immunization Status	X	X	
Adolescent Immunization Status	X	X	
Breast Cancer Screening	X		X
Cervical Cancer Screening		X	
Controlling High Blood Pressure	X		X
Cholesterol Management After Acute Cardiovascular Event	X		X
Comprehensive Diabetes Care	X		X
Antidepressant Medication Management	X		X
Advising Smokers to Quit (CAHPS)	X		
Flu Shots for Older Adults (CAHPS)			X
Annual Dental Visit		X	

*The plan may elect to use the prior year's data when the indicator is subject to rotation and is off-cycle for NCQA reporting.

File Content

For each of the quality indicators listed above, except for those collected via the CAHPS questionnaire, the plans shall report the following elements from the NCQA HEDIS Data Submission Tool:

1. Data collection methodology (Administrative or Hybrid.)
2. Eligible member population (i.e., members who meet all denominator criteria.)
3. Minimum required sample size (MRSS) or other sample size
4. Number of original sample records excluded because of valid data errors.
5. Number of records excluded because of contraindications identified through administrative data.
6. Number of records excluded because of contraindications identified through medical record review.
7. Additional records added from the auxiliary list.
8. Denominator
9. Numerator events by administrative data
10. Numerator events by medical record
11. Reported rate
12. Lower 95% confidence interval
13. Upper 95% confidence interval

All data elements above shall conform to the HEDIS technical specifications, as outlined in the NCQA-published technical manuals.

Table B

Quality Indicator Data Specifications
Reporting Period: CY 2000
(continued)

File format and media

The quality indicator data shall be submitted electronically, in a data file format to be specified by the Department. All other data specifications shall conform to those required by NCQA for submission of the audited quality indicator data.

File Consistency

Plans that elect to submit separate files for sub-groups of their enrollment population must consistently do so for all data submission categories required by this rule. Health care plans that contract with the Division of Medical Services to provide coverage in more than one Medicaid region, shall submit separate quality indicator data for the enrollees in each region.

Table D

Managed Health Care Services

File Specifications

Responses to the survey items in Table D must be submitted electronically, in a data file format specified by the Department.

Table D must be completed for each managed care product line (Commercial, Medicaid, or Medicare) offered by each licensed health care plan. Responses should be based on activity or status during the reporting period, within each product line (payer). Survey questions in Table D shall apply, except where otherwise noted, only to fully insured (ERISA exempt) enrollments.

Table D
Managed Health Care Services
Reporting Period: CY 2000

I. HEALTH PLAN INFORMATION

Instructions: Submit one set of Table D information, Parts I and II, for each product line (i.e. type of payor) offered by your organization.

1.) Product Line (CHECK ONE): ( ) Commercial ( ) Medicare ( ) Medicaid

2.) Missouri Department of Insurance Licensed Plan Name:

_____ Dba (if applicable): _____

3.) Extended NAIC Identification Number (7-digit): ___ ___ ___ ___ ___ ___ ___

4.) Name as marketed to your members (for Consumer's Guide display purposes):

_____

5.) List the following for each of your products within this product line:

Marketed		----------Phone Numbers----------	
a.) Product Name	b.) HMO/POS	c.) Customer Service	d.) RN Hotline

6.) Through what organization was your managed care organization accredited as of :

a.) *January 1, 2000*?
Accrediting organization: ( ) NCQA ( ) URAC ( ) JCAHO ( ) None
Level of Accreditation: _____ _____ _____

b.) *December 31, 2000*?
Accrediting organization: ( ) NCQA ( ) URAC ( ) JCAHO ( ) None
Level of Accreditation: _____ _____ _____

7.) Managed Care Organization Contact Person for Table D Information:

a.) Name: _____ b.) Title: _____

c.) Phone: _____ d.) Fax: _____ e.) E-mail: _____

Table D
Managed Health Care Services
Reporting Period: CY 2000

II. HEALTH PLAN SERVICES

1.) Please indicate for each of the following high risk conditions/diseases, if your managed care plan (A) has screening mechanisms, (B) provides case management, (C) provides specific educational materials to persons-at-risk, and (D) distributes educational material for all plan enrollees*. (CHECK ALL THAT APPLY)

High Risk Conditions/Diseases	(A) Screening Mechanisms	(B) Case Management	(C) Education for Persons-at-risk	(D) Education for All Plan Enrollees
Asthma	( )	( )	( )	( )
Stroke/Cardiovascular Disease	( )	( )	( )	( )
Breast Cancer	( )	( )	( )	( )
Cervical Cancer	( )	( )	( )	( )
Ovarian Cancer	( )	( )	( )	( )
Congestive Heart Failure (CHF)	( )	( )	( )	( )
Chronic Obstructive Pulmonary Disease (COPD)	( )	( )	( )	( )
Diabetes	( )	( )	( )	( )
Depression	( )	( )	( )	( )
HIV	( )	( )	( )	( )
Sickle Cell Disorders	( )	( )	( )	( )
High Risk Pregnancy	( )	( )	( )	( )
Obesity	( )	( )	( )	( )
Lead Poisoning	( )	( )	( )	( )
Chlamydia:				
Females	( )	( )	( )	( )
Males	( )	( )	( )	( )
High Blood Pressure	( )	( )	( )	( )
Tobacco Use	( )	( )	( )	( )
Other _____ (PLEASE SPECIFY)	( )	( )	( )	( )

*Education strategies for all plan enrollees may include but are not limited to newsletters, periodicals, direct mailings and similar types of media campaigns.

2.) Please indicate if your managed care plan provides any of the following:

a.) Routine distribution of educational materials on general health promotion, disease prevention and wellness ( ) YES ( ) NO

b.) Distribution of pre- and post-surgical information to enrollees ( ) YES ( ) NO

Note: The term *reminder/recall* in Questions 3a – 4b refers to notices intended to insure timely scheduling of the specific preventive screening/test or service indicated. General education materials or notices tied to anniversary dates, such as birthdays or enrollment dates, do not meet this definition.

3a.) **Commercial or Medicaid only** (If completing for a Medicare plan, skip to Question 3b)

Do you send reminder/recall letters and/or make telephone calls from your managed care plan office to your members to ensure usage of the following preventive services?

Mammograms	( ) YES	( ) NO
Immunizations	( ) YES	( ) NO
Pap smears	( ) YES	( ) NO
Diabetic Screens/Tests	( ) YES	( ) NO

3b.) **Medicare only**

Do you send reminder/recall letters and/or make telephone calls from your managed care plan office to your members to ensure usage of the following preventive services?

Mammograms	( ) YES	( ) NO
Immunizations	( ) YES	( ) NO
Well-woman checks	( ) YES	( ) NO
Diabetic Screens/Tests	( ) YES	( ) NO

4a.) **Commercial or Medicaid only** (If completing for a Medicare plan, skip to Question 4b)

Do you provide reminder/recall letters for your providers to use to notify your enrollees of the following preventive services?

Mammograms	( ) YES	( ) NO
Immunizations	( ) YES	( ) NO
Pap smears	( ) YES	( ) NO
Diabetic Screens/Tests	( ) YES	( ) NO

4b.) **Medicare only**

Do you provide reminder/recall letters for your providers to use to notify your enrollees of the following preventive services?

Mammograms	( ) YES	( ) NO
Immunizations	( ) YES	( ) NO
Well-woman checks	( ) YES	( ) NO
Diabetic Screens/Tests	( ) YES	( ) NO

5.) Commercial only

During the reporting period, did your plan provide coverage to your non-ASO members for the following health benefits? Please indicate if the benefit item was offered as standard coverage for all non-ASO products within the product line (commercial, Medicaid or Medicare), as standard coverage only for some non-ASO products in the product line, offered only by rider clause (employer option), or not covered at all. (CHECK ONLY ONE FOR EACH BENEFIT LISTED)

	Non-ASO Products Only			
	All Products	**Some Products**	**Offered only by rider clause**	**Not Offered**
Rx coverage of prenatal vitamins, including folic acid.....	( )	( )	( )	( )
Contraceptives:				
Birth control pills.....	( )	( )	( )	( )
IUDs.....	( )	( )	( )	( )
Norplant.....	( )	( )	( )	( )
Depo Provera.....	( )	( )	( )	( )
Immunizations:				
Hepatitis A.....	( )	( )	( )	( )
Hepatitis B.....	( )	( )	( )	( )
Annual eye exam for refractive errors.....	( )	( )	( )	( )
Insulin pumps.....	( )	( )	( )	( )
Autologous bone marrow transplants.....	( )	( )	( )	( )
Stem cell rescue for breast cancer.....	( )	( )	( )	( )
Access to chiropractic services	( )	( )	( )	( )
Psychotherapy services				
Individual.....	( )	( )	( )	( )
Group.....	( )	( )	( )	( )
Family.....	( )	( )	( )	( )
Marital.....	( )	( )	( )	( )
Substance abuse services:				
Inpatient/residential.....	( )	( )	( )	( )
Outpt./partial hospitalization	( )	( )	( )	( )
Unrestricted annual flu shots	( )	( )	( )	( )
Smoking cessation classes or cessation medications..	( )	( )	( )	( )
Conduct wellness surveys*	( )	( )	( )	( )

*A wellness survey is a questionnaire on health behaviors. It does not refer to a physical exam.

6.) During the reporting period, did your plan manage the following health services for your ASO group contracts? For each of the health services listed below, please indicate if it was elected as a covered benefit in all the ASO contracts with your plan, in some of the ASO contracts, or in none of the ASO contracts. (CHECK ONE COLUMN ONLY) Also indicate the proportion of your total ASO member enrollment who have coverage for the health service.

	Selected Covered Benefits: ASO Contracts			
	All Contracts	Some Contracts	None of the Contracts	Percent of ASO Enrollment Covered
Immunizations	( )	( )	( )	_____
Mammograms	( )	( )	( )	_____
Pap Smears	( )	( )	( )	_____

7.) For each preventive service listed below, please indicate (A) if your plan provided physicians routine status reports on the delivery of these services to their panel members and (B) if your plan sent comparative information to the physicians, during the reporting year. Following each response, enter a brief description of the report(s) or information that you sent.

	(CHECK IF YES) (A) Plan Provided Reports	Description of Report(s)	(CHECK IF YES) (B) Plan Sent Comparative Data	Description of Report(s)
Childhood Immunizations	( )	_____	( )	_____
Adolescent Immunizations	( )	_____	( )	_____
Breast Cancer Screenings	( )	_____	( )	_____
Pap Smears	( )	_____	( )	_____
Chlamydia Screenings:				
Females	( )	_____	( )	_____
Males	( )	_____	( )	_____
Lead Screenings:				
12 and 24 months	( )	_____	( )	_____
Under 6 if no prior blood test	( )	_____	( )	_____
Cholesterol Management after Acute Cardiovascular Event: LDL-C Screenings	( )	_____	( )	_____
Beta Blocker Treatment After Heart Attack	( )	_____	( )	_____
Comprehensive Diabetic Care:				
Hemoglobin Testing	( )	_____	( )	_____
Retinal Disease Eye Exam	( )	_____	( )	_____
LDL-C (Lipids) Testing	( )	_____	( )	_____
Nephropathy Screenings	( )	_____	( )	_____
Annual Flu Shots for Older Adults	( )	_____	( )	_____
Tobacco Cessation Counseling	( )	_____	( )	_____
Other (Please specify)_____	( )	_____	( )	_____

8.) Does your plan routinely conduct continuing education with your providers to improve their knowledge on current clinical practice recommendations?

( ) YES ( ) NO

9.) Please indicate the administrative policies for your HMO (non-POS) plan products, as they applied to your non-ASO members during the reporting year. (CHECK A RESPONSE FOR EACH POLICY LISTED)

	YES All HMO Product	YES Some HMO Products	NO No HMO Products
a.) Allow access to within-network OB/GYNs other than the once per year visit without referral	( )	( )	( )
b.) PCP must obtain prior authorization from HMO or its agency for referral to within-network, non-OB/GYN medical/surgical specialists	( )	( )	( )
c.) Allow members to self-refer to within-network medical/surgical specialists, other than OB/GYN	( )	( )	( )
d.) Allow members to self-refer to within-network mental health specialists	( )	( )	( )
e.) Allow medical specialists other than OB/GYN to be designated as PCP for patients with a chronic disease	( )	( )	( )
f.) Members can access some health practitioners, other than medical/surgical or mental health specialists, without referral or prior authorization	( )	( )	( )

g.) If YES for all or some products on Question 9f.), list the additional types of providers that can be accessed without referral or prior authorization:

All Products	Some Products
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

10.) For each of the practitioner categories below, indicate the number you had in your plan network during the reporting year and the number of that total which your MCO verified, within the past two years, as being board certified.

	Number of Practitioners	**Number Who Are Board Certified**
a.) Primary Care Physicians (excluding OB/GYNs)	_____	_____
b.) Medical/Surgical Specialists (excluding OB/GYNs)	_____	_____
c.) OB/GYNs	_____	_____
d.) Chiropractors	_____	_____
e.) Mental Health Providers	_____	_____
f.) General Dentists	_____	_____

Table D
Managed Health Care Services
Reporting Period: CY 2000

III. HEALTH PLAN SELECTED PROCEDURES

For each procedure category listed below, please indicate the number of discharges/encounters that occurred, within each facility where the procedure was performed for your plan membership. Counts should be summarized at the discharge or encounter level. For example, if more than one of the procedure codes (ICD-9-CM or CPT) in a category was performed during a given hospital stay or encounter, only count them as one.)

(ENTER AS MANY LINES AS NEEDED TO RECORD DATA FOR ALL HOSPITALS UTILIZED DURING THE REPORTING YEAR. USE THE ICD-9-CM AND CPT CODES SPECIFIED IN THE CHART BELOW TO SELECT THE ENCOUNTERS FOR THE PROCEDURE CATEGORIES.)

Procedure Category	Hospital Name	Federal ID #	Number of Discharges/Encounters
1) Cardiac Catheterization			
2) Cardiac Angiography			
3) Coronary Artery By-pass Graft (CABG)			
4) Total Hip Replacement			
5) Prostatectomy			

CODES TO IDENTIFY SELECTED PROCEDURES

Description	CPT Codes	ICD-9CM CODES
Cardiac Catheterization	36013, 93501, 93503, 93505, 93510, 93511, 93514, 93524, 93526-93533, 93561, 93562	37.21, 37.22, 37.23
Cardiac Angiography	75756, 93508, 93542, 93543, 93545, 93555,	88.50, 88.52, 88.53, 88.54, 88.55, 88.56, 88.57
Coronary Artery Bypass Graft	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536	36.10, 36.11, 36.12, 36.13, 36.14, 36.15, 36.16, 36.17, 36.19
Total Hip Replacement	27130	81.51
Prostatectomy	52601, 52612, 52614, 52620, 52630, 52648, 53850, 53852, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845	60.3, 60.4, 60.5, 60.21, 60.29, 60.61, 60.62, 60.69