Volume 28, Number 2
Pages 99–218
January 16, 2003

Matt Blunt

Secretary of State

MISSOURI REGISTER

The *Missouri Register* is an official publication of the state of Missouri, under the authority granted to the secretary of state by sections 536.015 and 536.033, RSMo 2000. Reproduction of rules is allowed; however, no reproduction shall bear the name *Missouri Register* or "official" without the express permission of the secretary of state.

The *Missouri Register* is published semi-monthly by

SECRETARY OF STATE

MATT BLUNT

Administrative Rules Division
James C. Kirkpatrick State Information Center
600 W. Main
Jefferson City, MO 65101
(573) 751-4015

DIRECTOR

LYNNE C. ANGLE

•

EDITORS

BARBARA MCDOUGAL • JAMES MCCLURE

ASSOCIATE EDITORS

CURTIS W. TREAT SALLY L. REID

TIFFANY M. DAVIS

•

PUBLISHING STAFF

WILBUR HIGHBARGER CARLA HERTZING

•

ADMINISTRATIVE STAFF

SANDY SANDERS

ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO
Subscription fee: $56.00 per year

POSTMASTER: Send change of address notices and undelivered copies to:

MISSOURI REGISTER
Office of the Secretary of State
Administrative Rules Division
PO Box 1767
Jefferson City, MO 65102

The *Missouri Register* and *Code of State Regulations* (CSR) are now available on the Internet. The Register address is http://www.sos.state.mo.us/adrules/moreg/moreg.asp and the CSR is http://www.sos.state.mo.us/adrules/csr/csr.asp. These web sites contain rulemakings and regulations as they appear in the Registers and CSR. These web sites do not contain the official copies of the Registers and CSR. The official copies remain the paper copies published by the Office of the Secretary of State pursuant to sections 536.015 and 536.031, RSMo 2000. While every attempt has been made to ensure accuracy and reliability, the Registers and CSR are presented, to the greatest extent practicable as they appear in the official publications. The Administrative Rules Division may be contacted by e-mail at rules@sosmail.state.mo.us.

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, PO Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.

MISSOURI REGISTER

January 16, 2003 Vol. 28 No. 2 **Pages 99–218**

IN THIS ISSUE:

EMERGENCY RULES

Office of Administration
Personnel Advisory Board and Division of Personnel 103
Department of Social Services
Division of Medical Services .103
Department of Health and Senior Services
Missouri Health Facilities Review Committee 106
Missouri Consolidated Health Care Plan
Health Care Plan 118

PROPOSED RULES

Office of Administration
Personnel Advisory Board and Division of Personnel 128
Department of Economic Development
Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects . .128
State Board of Cosmetology .135
State Board of Registration for the Healing Arts 139
State Board of Podiatric Medicine 139
Department of Natural Resources
Air Conservation Commission 141
Division of Geology and Land Survey 150
Department of Revenue
Director of Revenue 150
Department of Social Services
Division of Medical Services .150
Retirement Systems
The County Employees' Retirement Fund 155
Department of Health and Senior Services
Missouri Health Facilities Review Committee 157

ORDERS OF RULEMAKING

Department of Agriculture
Office of the Director 168
Department of Conservation
Conservation Commission 168
Department of Economic Development
Division of Credit Unions 169
Department of Revenue
Director of Revenue 169
Department of Social Services
Division of Medical Services .170
Elected Officials
Secretary of State 171
Department of Health and Senior Services
Division of Environmental Health and Communicable Disease Prevention 180
Department of Insurance
Financial Examination 180
Market Conduct Examinations 183
Life, Annuities and Health 185
Statistical Reporting 185
Licensing 185

IN ADDITIONS

Department of Economic Development
Division of Credit Unions 190

BID OPENINGS

Office of Administration
Division of Purchasing 191

RULE CHANGES SINCE UPDATE 192
EMERGENCY RULES IN EFFECT 203
REGISTER INDEX 205

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
November 1, 2002	**December 2, 2002**	December 31, 2002	January 30, 2003
November 15, 2002	**December 16, 2002**	December 31, 2002	January 30, 2003
December 2, 2002	**January 2, 2003**	January 29, 2003	February 28, 2003
December 16, 2002	**January 16, 2003**	January 29, 2003	February 28, 2003
January 2, 2003	**February 3, 2003**	February 28, 2003	March 30, 2003
January 16, 2003	**February 18, 2003**	February 28, 2003	March 30, 2003
February 3, 2003	**March 3, 2003**	March 31, 2003	April 30, 2003
February 18, 2003	**March 17, 2003**	March 31, 2003	April 30, 2003
March 3, 2003	**April 1, 2003**	April 30, 2003	May 30, 2003
March 17, 2003	**April 15, 2003**	April 30, 2003	May 30, 2003
April 1, 2003	**May 1, 2003**	May 31, 2003	June 30, 2003
April 15, 2003	**May 15, 2003**	May 31, 2003	June 30, 2003
May 1, 2003	**June 2, 2003**	June 30, 2003	July 30, 2003
May 15, 2003	**June 16, 2003**	June 30, 2003	July 30, 2003
June 2, 2003	**July 1, 2003**	July 31, 2003	August 30, 2003
June 16, 2003	**July 15, 2003**	July 31, 2003	August 30, 2003
July 1, 2003	**August 1, 2003**	August 31, 2003	September 30, 2003
July 15, 2003	**August 15, 2003**	August 31, 2003	September 30, 2003

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

Missouri Depository Libraries

The *Missouri Register* and the *Code of State Regulations*, as required by the Missouri Depository Documents Law (section 181.100, RSMo 2000), are available in the listed depository libraries, as selected by the Missouri State Library:

Jefferson County Library
PO Box 1486, 3021 High Ridge
High Ridge, MO 63049-1486
(314) 677-8689

Jefferson College Library
1000 Viking Drive
Hillsboro, MO 63050-2441
(314) 789-3951

St. Louis Public Library
1301 Olive St.
St. Louis, MO 63103-2389
(314) 539-0376

St. Louis University Law Library
3700 Lindell Blvd.
St. Louis, MO 63108-3478
(314) 977-2756

Eden Theological Seminary/
Webster University
Eden/Webster Library
475 East Lockwood Ave.
St. Louis, MO 63119-3192
(314) 961-2660

Thomas Jefferson Library
University of Missouri-St. Louis
8001 Natural Bridge Road
St. Louis, MO 63121-4499
(314) 516-5084

Washington University
Washington University Law Library
Campus Box 1171, Mudd Bldg.,
One Brookings Dr.
St. Louis, MO 63130-4899
(314) 935-6484

St. Louis County Library
1640 S. Lindbergh Blvd.
St. Louis, MO 63131-3598
(314) 994-3300

Maryville University Library
13550 Conway Road
St. Louis, MO 63141-7232
(314) 529-9494

St. Charles City-County Library
Middendorf-Kredell Branch
2750 Hwy K
O'Fallon, MO 63366-7859
(314) 978-7997

Truman State University
Pickler Memorial Library
100 E. Normal
Kirksville, MO 63501-4221
(660) 785-7416

Learning Resources Center
Mineral Area College
PO Box 1000
Park Hills, MO 63601-1000
(573) 431-4593

Cape Girardeau Public Library
711 N. Clark
Cape Girardeau, MO 63701-4400
(573) 334-5279

Kent Library
Southeast Missouri State University
One University Plaza
Cape Girardeau, MO 63701-4799
(573) 651-2757

Riverside Regional Library
PO Box 389, 204 South Union St.
Jackson, MO 63755-0389
(573) 243-8141

Rutland Library
Three Rivers Community College
2080 Three Rivers Blvd.
Poplar Bluff, MO 63901-2393
(573) 840-9656

Ward Edwards Library
Central Missouri State University
142 Edwards Library
Warrensburg, MO 64093-5020
(660) 543-4149

Kansas City Public Library
311 East 12th St.
Kansas City, MO 64106-2454
(816) 701-3400

Law Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

University of Missouri-Kansas City
Miller Nichols Library
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-1281

B.D. Owens Library
Northwest Missouri State University
800 University Drive
Maryville, MO 64468-6001
(660) 562-1841

River Bluffs Regional Library
927 Felix Street
St. Joseph, MO 64501-2799
(816) 232-8151

Missouri Western State College
Hearnes Learning Resources Ctr.
4525 Downs Drive
St. Joseph, MO 64507-2294
(816) 271-5802

Library
North Central Missouri College
PO Box 111, 1301 Main Street
Trenton, MO 64683-0107
(660) 359-3948

Missouri Southern State College
Spiva Library
3950 East Newman Road
Joplin, MO 64801-1595
(417) 625-9770

Missouri State Library
600 West Main, PO Box 387
Jefferson City, MO 65102-0387
(573) 751-3075

Missouri State Archives
600 West Main, PO Box 778
Jefferson City, MO 65102-0778
(573) 526-6711

Elmer Ellis Library
University of Missouri-Columbia
104 Ellis Library
Columbia, MO 65211-5149
(573) 882-6733

Library
State Historical Society of Missouri
1020 Lowry St.
Columbia, MO 65201-7298
(573) 882-7083

Daniel Boone Regional Library
PO Box 1267, 100 West Broadway
Columbia, MO 65205-1267
(573) 443-3161

School of Law
University of Missouri-Columbia
224 Hulston Hall
Columbia, MO 65211-0001
(573) 882-1125

Central Methodist College
Smiley Memorial Library
411 Central Methodist Square
Fayette, MO 65248-1198
(660) 248-6292

Library
University of Missouri-Rolla
1870 Miner Circle
Rolla, MO 65409-0060
(573) 341-4007

Kinderhook Regional Library
135 Harwood Ave.
Lebanon, MO 65536-3017
(417) 532-2148

ESTEP Library
Southwest Baptist University
1601 S. Springfield Street
Bolivar, MO 65613-2597
(417) 326-5281

Barry-Lawrence Regional Library
213 6th St.
Monett, MO 65708-2147
(417) 235-6646

Lyons Memorial Library
College of the Ozarks
General Delivery
Point Lookout, MO 65726-9999
(417) 334-6411

West Plains Campus Library
Southwest Missouri State University
123 N. Minnesota
West Plains, MO 65775-3414
(417) 256-9865

Springfield-Greene County Library
PO Box 737, 397 E. Central
Springfield, MO 65801-0760
(417) 869-4621

Meyer Library
Southwest Missouri State University
PO Box 175, 901 S. National
Springfield, MO 65804-0095
(417) 836-4533

HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 26, *Missouri Register*, page 27. The approved short form of citation is 26 MoReg 27.

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

Title	*Code of State Regulations*	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—Cite material in the RSMo by date of legislative action. The note in parentheses gives the original and amended legislative history. The Office of the Revisor of Statutes recognizes that this practice gives users a concise legislative history.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

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

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

Title 1—OFFICE OF ADMINISTRATION
Division 20—Personnel Advisory Board and Division of Personnel
Chapter 2—Classification and Pay Plans

EMERGENCY AMENDMENT

1 CSR 20-2.015 Broad Classification Bands for Managers. The Personnel Advisory Board is amending paragraph (6)(B)2.

PURPOSE: This amendment is necessary to allow for consistent application of rules governing layoffs.

EMERGENCY STATEMENT: This emergency amendment is necessary and justified as meeting a compelling governmental interest. Agencies need as much flexibility and consistency of application as possible when considering layoff implementation for this budget year, as a response to the serious budget reductions currently being imposed on agencies. A proposed amendment to the rule, which covers the same material, is published in this issue of the ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Office of Administration believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed January 2, 2003, effective January 12, 2003, and expires July 10, 2003.*

(6) Separation, Suspension and Demotion. The provisions of 1 CSR 20-3.070 are applicable in the administration of broad classification bands for managers in agencies covered by the merit system provisions of the State Personnel Law, except as specifically outlined in this section, or necessary for implementation.

(B) Demotions and Transfers. An appointing authority may demote an employee in accordance with the following:

1. No demotion for cause shall be made unless the employee to be demoted meets the minimum qualifications for the lower position demoted to, and shall not be made if any regular employee in the affected class and band or range would be laid off by reason of the action; and

2. An appointing authority, upon written request of the regular employee affected, shall demote such employee in lieu of layoff to a position in a lower band in the same class; or shall demote or transfer such employee *[to another class for which the employee meets the qualifications; or]* to an appropriate class and pay range in the same occupational job series; or to a position in which the employee previously has served and has obtained regular status in the division of service involved; even though these actions may result in additional layoffs. **An appointing authority may also, upon written request of the regular employee affected, demote or transfer such employee in lieu of layoff to another class for which the employee meets the qualifications, even if these actions may result in additional layoffs.** In the event of a demotion to a lower band, or a demotion or transfer to a class and pay range in lieu of layoff, an employee shall have his/her name placed on the appropriate register.

AUTHORITY: section 36.070, RSMo [Supp. 1998] ***2000****. Original rule filed March 11, 1999, effective Sept. 30, 1999. Emergency amendment filed Jan. 2, 2003, effective Jan. 12, 2003, expires July 10, 2003. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 10—Nursing Home Program

EMERGENCY AMENDMENT

13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services. The division is amending section (13).

PURPOSE: This emergency amendment amends the high volume adjustment to allow partial year cost reports to be combined to comprise a full year and to include hospice days paid by Medicaid in determination of occupancy.

EMERGENCY STATEMENT: This emergency amendment is necessary to implement the increased reimbursement to providers of nursing facility services who serve a high volume of Medicaid residents. It must be implemented on a timely basis to ensure that quality nursing facility services continue to be provided to Medicaid patients in nursing facilities. As a result, the Division of Medical Services finds an immediate danger to the public health, safety and/or welfare and a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Division of Medical Services believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed January 3, 2003, effective January 17, 2003, and expires July 15, 2003.*

(13) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed elsewhere in this regulation, a facility's reimbursement rate may be adjusted as described in this section.

(B) Special Per-Diem Rate Adjustments. Special per-diem rate adjustments may be added to a qualifying facility's rate without regard to the cost component ceiling if specifically provided as described below.

1. Patient care incentive. Each facility with a prospective rate on or after January 1, 1995, shall receive a per-diem adjustment equal to ten percent (10%) of the facility's allowable patient care per diem subject to a maximum of one hundred thirty percent (130%) of the patient care median when added to the patient care per diem as determined in subsection (11)(A). This adjustment will not be subject to the cost component ceiling of one hundred twenty percent (120%) for the patient care median.

2. Ancillary incentive. Each facility with a prospective rate on or after January 1, 1995, and which meets one (1) of the following criteria shall receive a per-diem adjustment:

A. If the facility's allowable ancillary per diem as determined in subsection (11)(B) is below ninety percent (90%) of the ancillary median, the adjustment is equal to one-half (1/2) of the difference between one hundred twenty percent (120%) and ninety percent (90%) of the ancillary median. The following is an illustration of how the ancillary per-diem adjustment is calculated:

120% of median	$6.62
90% of median	$4.97
Difference	$1.65
1/2 the difference	2
Per-diem adjustment	$ .83

B. If the facility's allowable ancillary per diem as determined in subsection (11)(B) is between ninety percent (90%) and one hundred twenty percent (120%) of the median, the adjustment is equal to one-half (1/2) of the difference between one hundred twenty percent (120%) of the median and the facility's allowable ancillary per diem. The following is an illustration of how the ancillary per-diem adjustment is calculated:

90% of median	$4.97
120% of median	$6.62
Ancillary per diem	$5.21
Difference	$1.41
1/2 the difference	2
Per-diem adjustment	$ .71

3. Multiple component incentive. Each facility with a prospective rate on or after January 1, 1995, and meets the following criteria shall receive a per-diem adjustment:

A. If the sum of the facility's patient care per diem and ancillary per diem, as determined in subsections (11)(A) and (B), is greater than or equal to sixty percent (60%) but less than or equal to eighty percent (80%), rounded to four (4) decimal places (.5985 or .8015 would not receive the adjustment), of the facility's total per diem, the adjustment is as follows:

Percent of Total Per-Diem Rate	Incentive
< 60%	$0.00
> or = 60% but < 65%	$1.15
> or = 65% but < 70%	$1.30
> or = 70% but < 75%	$1.45
> or = 75% but < or 80% =	$1.60

B. A facility shall receive an additional incentive if it receives the adjustment in subparagraph (13)(B)3.A. and the following calculation is greater than seventy-five percent (75%), rounded to four (4) decimal places (.7485 would not receive the adjustment): Medicaid days divided by the licensed nursing facility patient days from the facility's desk audited and/or field audited 1992 cost report. The adjustment is as follows:

Calculated Percentage	Incentive
< 75%	$0.00
> or = 75% but < 80%	$0.15
> or = 80% but < 85%	$0.30
> or = 85% but < 90%	$0.45
> or = 90% but < 95%	$0.60
> or = 95%	$0.75

4. 1967 *Life Safety Code* (LSC). Currently certified nursing facilities that must comply with a recent interpretation of paragraph 10-133 of the 1967 LSC which requires corridor walls to extend to the roof deck or achieve equivalency under the Fire Safety Evaluation System (FSES) will be reimbursed the reasonable and necessary cost to meet those standards required for compliance through their reimbursement rate. The reimbursement shall not be effective until the Division of Aging has confirmed that the corrective action to comply with the 1967 LSC or FSES is operational and has reviewed the cost for compliance. Fire sprinkler systems shall be reimbursed over a depreciation life of twenty-five (25) years, and other alternative corrective action will be reimbursed over a depreciable life of fifteen (15) years. The division will use a desk audited and/or field audited cost report with the latest period ending in calendar year 1992 which is on file with the division as of December 31, 1993. This adjustment will be computed based on the documented cost submitted to the division as follows:

A. Depreciation. The cost incurred for the approved corrective action to continue in compliance divided by the depreciable useful life;

B. Interest. The interest cost incurred to finance this project shall be documented by a statement from the lending institution detailing the total interest cost of the loan period. The total interest cost will be divided by the loan period on a straight line basis; and

C. The total of subparagraph (13)(B)4.A. and B. will be divided by twelve (12) and then multiplied by the number of months covered by the 1992 cost report. This amount will be divided by the greater of actual patient days from the 1992 cost report or eighty-five percent (85%) of the licensed bed days from the 1992 cost report.

5. Any facility that had a 1967 LSC adjustment included in their December 31, 1994 reimbursement rate shall have that adjustment added to their January 1, 1995 reimbursement rate.

6. Replacement beds. A facility with a prospective rate in effect on or after January 1, 1995, may request a rate adjustment for replacement beds that resulted in the same number of beds being delicensed with the Division of Aging or the Department of Health. The facility shall provide documentation from the Division of Aging or the Department of Health that verifies the number of beds used for replacement have been delicensed from that facility. The rate adjustment will be calculated as the difference between the capital component per diem (fair rental value (FRV)) prior to the replacement beds being placed in service and the capital component per diem (FRV) including the replacement beds placed in service as calculated in subsection (11)(D) including the replacement beds placed in service. The capital component is calculated for the replacement beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the replacement beds are placed in service.

7. Additional beds. A facility with a prospective rate in effect on or after January 1, 1995, may request a rate adjustment for additional beds. The facility must obtain an approved certificate of need or applicable waiver for the additional beds. The rate adjustment will be calculated as the difference between the capital component per diem (FRV) prior to the additional beds being placed in service and

the capital component per diem (FRV) including the additional beds as calculated in subsection (11)(D) including the additional beds placed in service. The capital component is calculated for the additional beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the additional beds are placed in service.

8. Extraordinary circumstances. A participating facility which has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request must be submitted in writing to the division within one (1) year of the occurrence of the extraordinary circumstance. The request must clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment must be supported by complete, accurate and documented records satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

A. When the provider can show that it incurred higher costs due to circumstances beyond its control, the circumstances were not experienced by the nursing home industry in general and the costs have a substantial cost effect;

B. Extraordinary circumstances include:

(I) Natural disasters such as fire, earthquakes and flood that are not covered by insurance and that occur in a federally declared disaster area; and

(II) Vandalism and/or civil disorder that are not covered by insurance; and

C. The rate increase shall be calculated as follows:

(I) The one (1)-time costs, (costs that will not be incurred in future fiscal years):

(a) To determine what portion of the incurred costs will be paid, the division will use the patient occupancy days from latest available quarterly occupancy survey from the Division of Aging for the time period preceding when the extraordinary circumstances occurred; and

(b) The costs directly associated with the extraordinary circumstances will be multiplied by the above percent. This amount will be divided by the paid days for the month the rate adjustment becomes effective per paragraph (13)(B)8. This calculation will equal the amount to be added to the prospective rate for only one (1) month, which will be the month the rate adjustment becomes effective. For this one (1) month only, the ceiling will be waived.

(II) For ongoing costs (costs that will be incurred in future fiscal years): Ongoing annual costs will be divided by the greater of: annualized (calculated for a twelve (12)-month period) total patient days from the latest cost report on file or eighty-five percent (85%) of annualized total bed days. This calculation will equal the amount to be added to the respective cost center, not to exceed the cost component ceiling. The rate adjustment, subject to ceiling limits will be added to the prospective rate.

(III) For capitalized costs, a capital component per diem (FRV) will be calculated as determined in subsection (11)(D). The rate adjustment will be calculated as the difference between the capital component per diem (FRV) prior to the extraordinary circumstances and the capital component per diem (FRV) including the extraordinary circumstances.

9. Quality Assurance Incentive.

A. Each nursing facility with an interim or prospective rate on or after July 1, 2000, shall receive a per-diem adjustment of $3.20. The Quality Assurance Incentive adjustment will be added to the facility's current rate.

B. The Quality Assurance Incentive per-diem increase shall be used to increase the expenditures to a nursing facility's direct patient care costs. Direct patient care costs include all expenses in the patient care cost component (i.e., lines 46 through 69 of Schedule B in the Title XIX Cost Report). Any increases in wages and benefits already codified in a collective bargaining agreement in effect as of July 1, 2000, will not be counted towards the expenditure requirements of the Quality Assurance Incentive as stated above. Nursing facilities with collective bargaining agreements shall provide such agreements to the division.

10. High Volume Adjustment. Effective for dates of service July 1, 2000, a high volume adjustment shall be granted to qualifying providers. A provider must qualify each July 1, the beginning of each state fiscal year (SFY), for the high volume adjustment and the adjustment will be effective for services rendered during the SFY, July 1 through June 30. For a provider who has a high volume adjustment on June 30, but does not qualify for the high volume adjustment on July 1 of the subsequent SFY, that provider's prospective rate will be reduced by the amount of the high volume adjustment included in the facility's prospective rate in effect June 30.

A. Each facility with a prospective rate on or after July 1, 2000, and which meets all of the following criteria shall receive a per-diem adjustment:

(I) Have on file at the division a full twelve (12)-month cost report ending in the third calendar year prior to the state fiscal year in which the adjustment is being determined (i.e., for SFY 2001, the third prior year would be 1998, for SFY 2002, the third prior year would be 1999, etc.);

(II) The Medicaid patient days as determined from the cost report identified in part (13)(B)10.A.(I) exceeds eighty-five percent (85%) of the total patient days for all nursing facility licensed beds;

(III) The allowable cost per patient day as determined by the division from the applicable cost report for the patient care, ancillary and administration cost components, as set forth in paragraphs (11)(A)1., (11)(B)1. and (11)(C)1., exceeds the per-diem ceiling for each cost component in effect at the end of the cost report period; and

(IV) State owned or operated facilities shall not be eligible for this adjustment.

B. The adjustment will be equal to ten percent (10%) of the sum of the per-diem ceilings for the patient care, ancillary and administration cost components in effect on July 1 of each year. Effective July 1, 2002, the adjustment shall not accumulate from year to year.

C. The division may reconstruct and redefine the qualifying criteria and payment methodology for the high volume adjustment.

D. Second Tier High Volume Adjustment. Effective for dates of service July 1, 2002, a second tier high volume adjustment shall be granted to qualifying providers.

(I) If a nursing facility qualifies for the first tier high volume adjustment, as set forth above in subparagraph (13)(B)10.A., it may qualify for the second tier adjustment if it meets the following criteria:

(a) The Medicaid patient days as determined from the cost report identified in part (13)(B)10.A.(I) exceeds ninety-three percent (93%) of the total patient days for all nursing facility licensed beds;

(b) The allowable cost per patient day as determined by the division from the applicable cost report for the patient care cost component, as set forth in paragraph (11)(A)1., exceeds one hundred twenty percent (120%) of the per-diem ceiling for the patient care cost component in effect at the end of the cost report period; and

(c) The allowable cost per patient day as determined by the division from the applicable cost report for the administration

cost component, as set forth in paragraph (11)(C)1., is less than one hundred fifty percent (150%) of the per-diem ceiling for the administration cost component in effect at the end of the cost report period.

(II) The second tier high volume adjustment will be calculated as a percentage, to be determined by the Department of Social Services, of the sum of the per-diem ceilings for the patient care, ancillary and administration cost components in effect on July 1 of each year. The adjustment for state fiscal year 2003 shall be eighteen dollars and fifty-six cents ($18.56) per Medicaid day.

(a) The adjustment shall be distributed based on a quarterly amount, in addition to per-diem payments, based on Medicaid days determined from the paid day report from Missouri's fiscal agent for pay cycles during the immediately preceding state fiscal year.

(b) The state share of the second tier high volume adjustment shall come from certified public funds. If the aggregate certified public funds are less than the state match required, the total aggregate second tier high volume adjustment will be adjusted downward accordingly.

(III) A nursing facility must qualify for the adjustment each year to receive the additional quarterly payments.

E. High volume adjustment for nursing facilities without a full twelve (12)-month cost report. Effective for dates of service on or after January 17, 2003, the full twelve (12)-month cost report requirement set forth in (13)(B)10.A.(I) shall include nursing facilities that have on file at the division two (2) partial year cost reports that when combined cover a full twelve (12)-month period.

F. Medicaid hospice days to be included in determination of Medicaid occupancy. Effective for dates of service on or after January 17, 2003, the Medicaid patient days used to determine the Medicaid occupancy requirement set forth in (13)(B)10.A.(II) shall be calculated by adding the days paid for by the Medicaid nursing facility program plus the days paid for by the Medicaid hospice program from the cost report identified in part (13)(B)10.A.(I).

11. Minimum Rate Adjustment. A minimum rate adjustment shall be granted to qualifying providers, as follows:

A. Effective for dates of service beginning July 1, 2001, the minimum Medicaid reimbursement rate for nursing facility services shall be eighty-five dollars ($85).

AUTHORITY: sections 208.153, 208.159 and 208.201, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Jan. 3, 2003, effective Jan. 17, 2003, expires July 15, 2003. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RESCISSION

19 CSR 60-50.300 Definitions for the Certificate of Need Process. This rule defined the terms used in the Certificate of Need (CON) review process.

PURPOSE: This rule is rescinded because the Missouri CON Rulebook has been rewritten to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo.

EMERGENCY STATEMENT: This emergency rescission is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rescission because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rescission to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

This emergency rescission limits its scope to the circumstances creating the emergency and complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. The Committee finds that an emergency rescission is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rescission was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

AUTHORITY: section 197.320, RSMo 2000. Original rule filed June 2, 1994, effective Nov. 30, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RULE

19 CSR 60-50.300 Definitions for the Certificate of Need Process

PURPOSE: This rule defines the terms used in the Certificate of Need (CON) review process.

EMERGENCY STATEMENT: This emergency rule is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rule because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rule to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. The Committee finds that an emergency rule is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rule was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

(1) Applicant means all owner(s) and operator(s) of any new institutional health service.

(2) By or on behalf of a health care facility includes any expenditures made by the facility itself as well as capital expenditures made by other persons that assist the facility in offering services to its patients/residents.

(3) Cost means:

(A) Price paid or to be paid by the applicant for a new institutional health service to acquire, purchase or develop a health care facility or major medical equipment; or

(B) Fair market value of the proposed health care facility or major medical equipment as determined by the current selling price at the date of the application as quoted by builders or architects for similar facilities or normal suppliers of the requested equipment.

(C) For the development of a new health care facility to be licensed under Chapter 198, RSMo, on the campus of an existing health care facility, but of a different licensure category, where support space and services such as administration, dining and laundry would be acquired from the existing facility, the following specific proportional and new costs shall apply:

1. If existing licensed bed space is to be utilized for the new facility, the cost (f) shall be determined by using the formula $[((a \div b) \times c) + d + e = f]$ in the following manner:

A. Divide the number of beds in the proposed new facility (a), by the total number of beds in the existing facility (b);

B. Multiply the above result by the total appraised value of the existing facility, including land, building, equipment and other improvements (c); and

C. Add the above result to all additional renovations (d), and/or new equipment (e), needed for the proposed new facility; or

2. If a newly constructed unit is to be added to an existing licensed facility, cost (f) shall be determined by using the formula $[((a \div (a + b)) \times c) + d + e = f]$ in the following manner:

A. Divide the number of beds in the proposed new facility (a), by the total number of beds in the existing facility (b) added to the proposed new facility (a);

B. Multiply the above result by the total appraised value of the existing support space and equipment (c); and

C. Add the above result to all new capital costs (d), and/or new equipment costs (e) to be incurred.

(4) Construction of a new hospital means the establishment of a newly-licensed facility at a specific location under the Hospital Licensing Law, section 197.020.2, RSMo, as the result of building, renovation, modernization, and/or conversion of any structure not licensed as a hospital.

(5) Expedited application means a shorter than full application and review period as defined in 19 CSR 60-50.420 and 19 CSR 60-50.430 for any long-term care expansion or replacement as defined in sections 197.318.8–10, RSMo, long-term care renovation and modernization, or the replacement of any major medical equipment as defined in section (14) of this rule which holds a Certificate of Need (CON) previously granted by the Missouri Health Facilities Review Committee (Committee). Applications for replacement of major medical equipment not previously approved by the Committee should apply for a full review.

(6) Full review means the complete analytical period for applications as described in 19 CSR 60-50.420 and 19 CSR 60-50.430 for the development of health care facilities and acquisition of major medical equipment.

(7) Generally accepted accounting principles pertaining to capital expenditures include, but are not limited to:

(A) Expenditures related to acquisition or construction of capital assets;

(B) Capital assets are investments in property, plant and equipment used for the production of other goods and services approved by the Committee; and

(C) Land is not considered a capital asset until actually converted for that purpose with commencement of aboveground construction approved by the Committee.

(8) Health care facility means those described in section 197.366, RSMo, which replaces section 197.305.7, RSMo.

(9) Health care facility expenditure includes the capital value of new construction or renovation costs, architectural/engineering fees, equipment not in the construction contract, land acquisition costs, consultants'/legal fees, interest during construction, predevelopment costs as defined in section 197.305(13), RSMo, in excess of one hundred fifty thousand dollars ($150,000), any existing land and building converted to medical use for the first time, and any other capitalizable costs as listed on the "Proposed Project Budget" form MO 580-1863.

(10) Health maintenance organizations means entities as defined in section 354.400(10), RSMo, except for activities directly related to the provision of insurance only.

(11) Interested party means any licensed health care provider or other affected person who has expressed an interest in the CON process or a CON application.

(12) Long-Term Acute Care (LTAC) hospital means any facility licensed under Chapter 197, RSMo, meeting the requirements described in 42 CFR section 412.23(e).

(13) Long-term care beds include:

(A) Beds in a facility licensed in accordance with Chapter 198, RSMo, including residential care facility (RCF) I and II, intermediate care facility (ICF) and skilled nursing facility (SNF);

(B) Beds designated as ICF or SNF in a Chapter 197, RSMo, licensed hospital as described in subdivision (3) of subsection 1 of section 198.012, RSMo; or

(C) Beds in a LTAC hospital meeting the requirements described in 42 CFR section 412.23(e).

(14) Major medical equipment means any piece of equipment and collection of functionally related devices acquired to operate the equipment and additional related costs such as software, shielding, and installation, with an aggregate cost of one million dollars ($1,000,000) or more, when the equipment is intended to provide the following services:

(A) Cardiac Catheterization;
(B) CT (Computed Tomography);
(C) Gamma Knife;
(D) Hemodialysis;
(E) Lithotripsy;
(F) MRI (Magnetic Resonance Imaging);
(G) PET (Positron Emission Tomography);
(H) Linear Accelerator;
(I) Open Heart Surgery;
(J) EBCT (Electron Beam Computed Tomography);
(K) PET/CT (Positron Emission Tomography/Computed Tomography); or
(L) Evolving Technology.

(15) Nonsubstantive project includes, but is not limited to, at least one (1) of the following situations:

(A) An expenditure which is required solely to meet federal or state requirements or involves predevelopment costs or the development of a health maintenance organization;

(B) The construction or modification of nonpatient care services, including parking facilities, sprinkler systems, heating or air-conditioning equipment, fire doors, food service equipment, building maintenance, administrative equipment, telephone systems, energy conservation measures, land acquisition, medical office buildings, and other projects or functions of a similar nature; or

(C) Expenditures for construction, equipment, or both, due to an act of God or a normal consequence of maintenance, but not replacement, of health care facilities, beds, or equipment.

(16) Offer, when used in connection with health services, means that the applicant asserts having the capability and the means to provide and operate the specified health services.

(17) Predevelopment costs mean expenditures as defined in section 197.305(13), RSMo, including consulting, legal, architectural, engineering, financial and other activities directly related to the proposed project, but excluding the application fee for submission of the application for the proposed project.

(18) Related organization means an organization that is associated or affiliated with, has control over or is controlled by, or has any direct financial interest in, the organization applying for a project including, without limitation, an underwriter, guarantor, parent organization, joint venturer, partner or general partner.

(19) Service area means:

(A) A fifteen (15)-mile radius for long-term care bed proposals; or

(B) A geographic region appropriate for any other proposed service, documented by the applicant and approved by the Committee.

(20) The most current version of Form MO 580-1863 may be obtained by mailing a written request to the Certificate of Need Program (CONP), 915G Leslie Boulevard, Jefferson City, MO 65101, or in person at the CONP Office, or, if technically feasible, by downloading a copy of the form from the CONP website at www.dhss.state.mo.us/con.

AUTHORITY: section 197.320, RSMo 2000. Original rule filed June 2, 1994, effective Nov. 30, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RESCISSION

19 CSR 60-50.400 Letter of Intent Process. This rule delineated the process for submitting a Letter of Intent to begin the Certificate of Need (CON) review process and outlined the projects subject to CON review.

PURPOSE: This rule is rescinded because the Missouri CON Rulebook has been rewritten to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo.

EMERGENCY STATEMENT: This emergency rescission is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rescission because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rescission to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

This emergency rescission limits its scope to the circumstances creating the emergency and complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. The Committee finds that an emergency rescission is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rescission was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

AUTHORITY: section 197.320, RSMo 2000. Original rule filed June 2, 1994, effective Nov. 30, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RULE

19 CSR 60-50.400 Letter of Intent Process

PURPOSE: This rule delineates the process for submitting a Letter of Intent to begin the Certificate of Need (CON) review process and outlines the projects subject to CON review.

EMERGENCY STATEMENT: This emergency rule is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rule because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rule to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. The Committee finds that an emergency rule is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rule was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

(1) Applicants shall submit a Letter of Intent (LOI) package to begin the Certificate of Need (CON) review process at least thirty (30) days prior to the submission of the CON application and will remain valid in accordance with the following time frames:

(A) For full reviews, expedited equipment replacements, expedited long-term care (LTC) renovation or modernization reviews and expedited LTC facility replacement reviews, a LOI is valid for six (6) months;

(B) For expedited LTC bed expansion reviews in accordance with section 197.318.8, RSMo, a LOI is valid for twenty-four (24) months; and

(C) For non-applicability reviews, a LOI is valid for six (6) months.

(2) Once filed, a LOI may be amended, except for project address, not later than ten (10) days in advance of the CON application filing, or it may be withdrawn at any time without prejudice.

(3) A LTC bed expansion or replacement as defined in these rules includes all of the provisions pursuant to section 197.318.8 through 197.318.10, RSMo, requiring a CON application, but allowing shortened information requirements and review time frames. When a LOI for a LTC bed expansion, except replacement(s), is filed, the Certificate of Need Program (CONP) staff shall immediately request certification for that facility of average licensed bed occupancy and final Class 1 patient care deficiencies for the most recent six (6) consecutive calendar quarters by the Division of Health Standards and Licensure (DHSL), Department of Health and Senior Services, through a LTC Facility Expansion Certification (Form MO 580-2351) to verify compliance with occupancy and deficiency requirements pursuant to section 197.318.8, RSMo. Occupancy data shall be taken from the DHSL's most recently published Six Quarter Survey of Hospital and Nursing Home (or Residential Care Facility) Licensed Bed Utilization reports. For LTC bed expansions or replacements, the sellers and purchasers shall be defined as the owner(s) and operator(s) of the respective facilities, which includes building, land, and license. On the Purchase Agreement (Form MO 580-2352), both the owner(s) and operator(s) of the purchasing and selling facilities should sign.

(4) The CONP staff, as an agent of the Missouri Health Facilities Review Committee (Committee), will review LOIs according to the following provisions:

(A) Major medical equipment is reviewed as an expenditure on the basis of cost, regardless of owners or operators, or location (mobile or stationary);

(B) The CONP staff shall test the LOI for applicability in accordance with statutory provisions for expenditure minimums, exemptions, and exceptions;

(C) If the test verifies that a statutory exception or exemption is met on a proposed project, or is below all applicable expenditure minimums, the Committee chair may issue a Non-Applicability CON letter indicating the application review process is complete; otherwise, the CONP staff shall add the proposal to a list of Non-Applicability proposals to be considered at the next regularly scheduled Committee meeting;

(D) If an exception or exemption is not met, and if the proposal is above any applicable expenditure minimum, then a CON application will be required for the proposed project;

(E) A Non-Applicability CON letter will be valid subject to the following conditions:

1. Any change in the project scope, including change in type of service, cost, operator, ownership, or site, could void the effectiveness of the letter and require a new review; and

2. Final audited project costs must be provided on a Periodic Progress Report (Form MO 580-1871);

(F) A CON application must be made if:

1. The project involves the development of a new hospital costing one million dollars ($1,000,000) or more, except for a facility licensed under Chapter 197, RSMo, meeting the requirements described in 42 CFR, section 412.23(e);

2. The project involves the acquisition or replacement of major medical equipment in any setting not licensed under Chapter 198, RSMo, costing one million dollars ($1,000,000) or more;

3. The project involves the acquisition or replacement of major medical equipment for a health care facility licensed under Chapter 198, RSMo, costing four hundred thousand dollars ($400,000) or more;

4. The project involves the acquisition of any equipment or beds in a long-term acute care hospital meeting the requirements found in 42 CFR section 412.23(e) at any cost;

5. The project involves a capital expenditure for renovation, modernization or replacement, but not additional beds, by or on behalf of an existing health care facility licensed under Chapter 198, RSMo, costing six hundred thousand dollars ($600,000) or more; or

6. The project involves either additional LTC (licensed or certified residential care facility I or II, intermediate care facility, or skilled nursing facility) beds or LTC bed expansions or replacements licensed under Chapter 198, RSMo, as defined in section (3) above of this rule, costing six hundred thousand dollars ($600,000) or more; or

7. The project involves the expansion of an existing health care facility as described in subdivisions (1) and (2) of section 197.366, RSMo, that either:

A. Costs six hundred thousand dollars ($600,000) or more; or

B. Exceeds ten (10) beds or ten percent (10%) of that facility's existing licensed capacity, whichever is less; and

(G) An exception may exist if the LOI test verifies that the proposed new long-term care beds (excluding LTAC beds) cost less than six hundred thousand dollars ($600,000) or do not exceed ten (10) beds or ten percent (10%) of that facility's existing licensed capacity, whichever is less, and the proposed beds are in the same licensure category as the existing facility's license.

(5) For an LTC bed expansion proposal pursuant to section 197.318.8(1)(e), RSMo, the CONP staff shall request occupancy verification by the DHSL who shall also provide a copy to the applicant.

(6) Nonsubstantive projects are waived from review by the authority of section 197.330.1(8), RSMo, and any projects seeking such a determination shall submit information through the LOI process; those meeting the nonsubstantive definition shall be posted for review on the CON website at least twenty (20) days in advance of the Committee meeting when they are scheduled to be confirmed by the Committee.

(7) The most current version of forms MO 580-2351, MO 580-2352, and MO 580-1871 may be obtained by mailing a written request to the CONP, 915G Leslie Boulevard, Jefferson City, MO 65101, or in person at the CONP Office, or, if technically feasible, by downloading a copy of the forms from the CONP website at www.dhss.state.mo.us/con.

*AUTHORITY: section 197.320, RSMo 2000. Original rule filed June 2, 1994, effective Nov. 30, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RESCISSION

19 CSR 60-50.410 Letter of Intent Package. This rule provided the information requirements and the details of how to complete the Letter of Intent package to begin the Certificate of Need (CON) review process.

PURPOSE: This rule is rescinded because the Missouri CON Rulebook has been rewritten to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo.

EMERGENCY STATEMENT: This emergency rescission is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rescission because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rescission to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

*This emergency rescission limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The Committee finds that an emergency rescission is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rescission was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

*AUTHORITY: section 197.320, RSMo 2000. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RULE

19 CSR 60-50.410 Letter of Intent Package

PURPOSE: This rule provides the information requirements and the details of how to complete the Letter of Intent package to begin the Certificate of Need (CON) review process.

EMERGENCY STATEMENT: This emergency rule is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rule because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the

scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rule to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

*This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The Committee finds that an emergency rule is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rule was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

(1) The Letter of Intent (LOI) (Form MO 580-1860) shall be completed as follows:

(A) Project Information: sufficient information to identify the intended service, such as construction, renovation, new or replacement equipment, and address or plat map identifying a specific site rather than a general area (county designation alone is not sufficient);

(B) Applicant Identification: the full legal name of all owner(s) and operator(s) which compose the applicant(s) who, singly or jointly, propose to develop, offer, lease or operate a new institutional health service within Missouri; provide the corporate entity, not individual names, of the corporate board of directors or the facility administrator;

(C) Type of Review: the applicant shall indicate if the review is for a full review, expedited review or a non-applicability review;

(D) Project Description: information which provides details of the number of beds to be added, deleted, or replaced, square footage of new construction and/or renovation, services affected and equipment to be acquired. If a replacement project, information which provides details of the facilities or equipment to be replaced, including name, location, distance from the current site, and its final disposition;

(E) Estimated Project Cost: total proposed expenditures necessary to achieve application's objectives—not required for long-term care (LTC) bed expansions pursuant to section 197.318.8(1), RSMo;

(F) Authorized Contact Person Identification: the full name, title, address (including association), telephone number, e-mail, and fax number; and

(G) Applicability: Item 7 of the LOI must be filled out by applicants requesting a non-applicability review to provide the reason and rationale for the exemption or exception being sought.

(2) If a non-applicability review is sought, applicants shall submit the following additional information:

(A) Proposed Expenditures (Form MO 580-2375) including information which details all methods and assumptions used to estimate project costs;

(B) Schematic drawings and evidence of site control, with appropriate documentation; and

(C) In addition to the above information, for exceptions or exemptions, documentation of other provisions in compliance with the Certificate of Need (CON) statute, as described in sections (3) through (6) below of this rule.

(3) If an exemption is sought for a RCF I or II pursuant to section 197.312, RSMo, applicants shall submit documentation that this facility had previously been owned or operated for or, on behalf of St. Louis City.

(4) If an exemption is sought pursuant to section 197.314(1), RSMo, for a sixty (60)-bed stand-alone facility designed and operated exclusively for the care of residents with Alzheimer's disease or dementia and located in a tax increment financing district established prior to 1990 within any county of the first classification with a charter form of government containing a city with a population of over three hundred fifty thousand (350,000) and which district also has within its boundaries a skilled nursing facility (SNF), applicants shall submit documentation that the health care facility would meet all of these provisions.

(5) The LOI must have an original signature for the contact person until the Certificate of Need Program (CONP), when technically ready, shall allow for submission of electronic signatures.

(6) The most current version of forms MO 580-1860 and MO 580-2375 may be obtained by mailing a written request to the CONP, 915G Leslie Boulevard, Jefferson City, MO 65101, or in person at the CONP office, or, if technically feasible, by downloading a copy of the forms from the CONP website at www.dhss.state.mo.us/con.

*AUTHORITY: section 197.320, RSMo 2000. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RESCISSION

19 CSR 60-50.420 Application Process. This rule delineated the process for submitting a Certificate of Need (CON) application for a CON review.

PURPOSE: This rule is rescinded because the Missouri CON Rulebook has been rewritten to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo.

EMERGENCY STATEMENT: This emergency rescission is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rescission because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rescission to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians,

investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

*This emergency rescission limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The Committee finds that an emergency rescission is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rescission was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

*AUTHORITY: section 197.320, RSMo 2000. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RULE

19 CSR 60-50.420 Review Process

PURPOSE: This rule delineates the process for submitting a Certificate of Need (CON) application for a CON review.

EMERGENCY STATEMENT: This emergency rule is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rule because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rule to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

*This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The Committee finds that an emergency rule is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rule was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

(1) The Certificate of Need (CON) filing deadlines are as follows:
(A) For full applications, at least seventy-one (71) days prior to each Missouri Health Facilities Review Committee (Committee) meeting;
(B) For expedited equipment replacement applications, expedited long-term care (LTC) facility renovation or modernization applications, and expedited LTC bed expansions and replacements pursuant to section 197.318.8 through 197.318.10, RSMo, the tenth day of each month, or the next business day thereafter if that day is a holiday or weekend;
(C) For non-applicability reviews, the Letter of Intent (LOI) filing may occur at any time.

(2) A CON application filing that does not substantially conform with the LOI, including any change in owner(s), operator(s), scope of services, or location, shall not be considered a CON application and shall be subject to the following provisions:
(A) The Certificate of Need Program (CONP) staff shall return any nonconforming submission; or
(B) The Committee may issue an automatic denial unless the applicant withdraws the attempted application.

(3) All filings must occur at the principal office of the Committee during regular business hours. The CONP staff, as an agent of the Committee, shall provide notification of applications received through publication of the Application Review Schedule (schedule), as follows:
(A) For full applications and expedited applications, the schedule shall include the filing date of the application, a brief description of the proposed service, the time and place for filing comments and requests for a public hearing, and the tentative date of the meeting at which the full application is scheduled for review or tentative decision date for expedited applications. Publication of the schedule shall occur on the next business day after the filing deadline. The publication of the schedule is conducted through the following actions:
1. A press release about the CON application schedule shall be sent by e-mail to all legislators, affected persons and all newspapers of general circulation in Missouri as supplied by the Office of Public Information, Department of Health and Senior Services; and
2. The schedule shall be published on the CON website.
(B) For non-applicability reviews, the listing of non-applicability letters to be confirmed shall be published on the CON website at least twenty (20) days prior to each scheduled meeting of the Committee where confirmation is to take place.

(4) The CONP staff shall review CON applications relative to the Criteria and Standards in the order filed.

(5) The CONP staff shall notify the applicant in writing regarding the completeness of a full CON application within fifteen (15) calendar days of filing or within five (5) working days for an expedited application.

(6) Verbal information or testimony shall not be considered part of the application.

(7) Subject to statutory time constraints, the CONP staff shall send its written analysis to the Committee as follows:
(A) For full CON applications, the CONP staff shall send the analysis twenty (20) days in advance of the first Committee meeting following the seventieth (70th) day after the CON application is filed.

The written analysis of the CONP staff shall be sent to the applicant no less than fifteen (15) days before the meeting.

(B) For expedited applications which meet all statutory and rules requirements and which have no opposition, the CONP staff shall send its written analysis to the Committee and the applicant within two (2) working days following the expiration of the thirty (30)-day public notice waiting period or the date upon which any required additional information is received, whichever is later.

(C) For expedited applications which do not meet all statutory and rules requirements or those which have opposition, they will be considered at the earliest scheduled Committee meeting where the written analysis by the CONP staff can be sent to the Committee and the applicant at least seven (7) days in advance.

(8) See rule 19 CSR 60-50.600 for a description of the CON decision process.

(9) An applicant may withdraw an application without prejudice by written notice at any time prior to the Committee's decision. Later submission of the same application or an amended application shall be handled as a new application with a new fee.

(10) In addition to using the Community Need Criteria and Standards as guidelines, the Committee may also consider other factors to include, but not be limited to, the number of patients requiring treatment, the changing complexity of treatment, unique obstacles to access, competitive financial considerations, or the specialized nature of the service.

*AUTHORITY: section 197.320, RSMo 2000. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RESCISSION

19 CSR 60-50.430 Application Package. This rule provided the information requirements and the application format of how to complete a Certificate of Need (CON) application for a CON review.

PURPOSE: This rule is rescinded because the Missouri CON Rulebook has been rewritten to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo.

EMERGENCY STATEMENT: This emergency rescission is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rescission because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rescission to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

*This emergency rescission limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The Committee finds that an emergency rescission is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rescission was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

*AUTHORITY: section 197.320, RSMo 2000. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RULE

19 CSR 60-50.430 Application Package

PURPOSE: This rule provides the information requirements and the application format of how to complete a Certificate of Need (CON) application for a CON review.

EMERGENCY STATEMENT: This emergency rule is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rule because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rule to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that

their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. The Committee finds that an emergency rule is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rule was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

(1) A Certificate of Need (CON) application package shall be accompanied by an application fee which shall be a nonrefundable minimum amount of one thousand dollars ($1,000) or one-tenth of one percent (0.1%), which may be rounded up to the nearest dollar, of the total project cost, whichever is greater, made payable to the "Missouri Health Facilities Review Committee."

(2) A written application package consisting of an original and eleven (11) bound copies (comb or three (3)-ring binder) shall be prepared and organized as follows:

(A) The CON Applicant's Completeness Checklists and Table of Contents should be used as follows:

1. Include at the front of the application;
2. Check the appropriate "done" boxes to assure completeness of the application;
3. Number all pages of the application sequentially and indicate the page numbers in the appropriate blanks;
4. Check the appropriate "n/a" box if an item in the Review Criteria is "not applicable" to the proposal; and
5. Restate (preferably in bold type) and answer all items in the Review Criteria.

(B) The application package should use one of the following CON Applicant's Completeness Checklists and Table of Contents appropriate to the proposed project, as follows:

1. New Hospital Application (Form MO 580-2501);
2. New or Additional Long-Term Care (LTC) Beds Application (Form MO 580-2502);
3. New or Additional Long-Term Acute Care (LTAC) Beds Application (use Form MO 580-2502);
4. New or Additional Equipment Application (Form MO 580-2503);
5. Expedited LTC Bed Replacement/Expansion Application (Form MO 580-2504);
6. Expedited LTC Renovation/Modernization Application (Form MO 580-2505); or
7. Expedited Equipment Replacement Application (Form MO 580-2506).

(C) The application should be formatted into dividers using the following outline:

1. Divider I. Application Summary;
2. Divider II. Proposal Description;
3. Divider III. Community Need Criteria and Standards; and
4. Divider IV. Financial Feasibility (only if required for full applications).

(D) Support Information should be included at the end of each divider section to which it pertains, and should be referenced in the divider narrative. For applicants anticipating having multiple applications in a year, master file copies of such things as maps, population data (if applicable), board memberships, IRS Form 990, or audited financial statements may be submitted once, and then referred to in subsequent applications, as long as the information remains current.

(E) The application package should document the need or meet the additional information requirements in 19 CSR 60-50.450(4)–(6) for the proposal by addressing the applicable Community Need Criteria and Standards using the standards in 19 CSR 60-50.440 through 19 CSR 60-50.460 plus providing additional documentation to substantiate why any proposed alternative Criteria and Standards should be used.

(3) An Application Summary shall be composed of the completed forms in the following order:

(A) Applicant Identification and Certification (Form MO 580-1861). Additional specific information about board membership may be requested, if needed;

(B) A completed Representative Registration (Form MO 580-1869) for the contact person and any others as required by section 197.326(1), RSMo; and

(C) A detailed Proposed Project Budget (Form MO 580-1863), with an attachment which details how each line item was determined including all methods and assumptions used.

(4) The Proposal Description shall include documents which:

(A) Provide a complete detailed description and scope of the project, and identify all the institutional services or programs which will be directly affected by this proposal;

(B) Describe the developmental details including:

1. A legible city or county map showing the exact location of the facility or health service, and a copy of the site plan showing the relation of the project to existing structures and boundaries;
2. Preliminary schematics for the project that specify the functional assignment of all space which will fit on an eight and one-half inch by eleven inch (8 1/2" × 11") format (not required for replacement equipment projects). The Certificate of Need Program (CONP) staff may request submission of an electronic version of the schematics, when appropriate. The function for each space, before and after construction or renovation, shall be clearly identified and all space shall be assigned;
3. Evidence of submission of architectural plans to the Division of Health Standards and Licensure, Department of Health and Senior Services, for long-term care projects and other facilities (not required for replacement equipment projects);
4. For long-term care proposals, existing and proposed gross square footage for the entire facility and for each institutional service or program directly affected by the project. If the project involves relocation, identify what will go into vacated space;
5. Documentation of ownership of the project site, or that the site is available through a signed option to purchase or lease; and
6. Proposals which include major and other medical equipment should include an equipment list with prices and documentation in the form of bid quotes, purchase orders, catalog prices, or other sources to substantiate the proposed equipment costs;

(C) Proposals for new hospitals, new or additional long-term care (LTC) beds, or new major medical equipment must define the community to be served:

1. Describe the service area(s) population using year 2005 populations and projections which are consistent with those provided by the Bureau of Health Data Analysis which can be obtained by contacting:

Chief, Bureau of Health Data Analysis
Center for Health Information Management and Evaluation (CHIME)
Department of Health and Senior Services
PO Box 570, Jefferson City, MO 65102
Telephone: (573) 751-6278

There will be a charge for any of the information requested, and seven to fourteen (7–14) days should be allowed for a response from the CHIME. Information requests should be made to CHIME such that the response is received at least two (2) weeks before it is needed for incorporation into the CON application; and

2. Use the maps and population data received from CHIME with the CON Applicant's Population Determination Method to determine the estimated population, as follows:

A. Utilize all of the population for zip codes entirely within the fifteen (15)-mile radius for LTC beds or geographic service area for hospitals and major medical equipment;

B. Reference a state highway map (or a map of greater detail) to verify population centers (see Bureau of Health Data Analysis information) within each zip code overlapped by the fifteen (15)-mile radius or geographic service area;

C. Categorize population centers as either "in" or "out" of the fifteen (15)-mile radius or geographic service area and remove the population data from each affected zip code categorized as "out";

D. Estimate, to the nearest ten percent (10%), the portion of the zip code area that is within the fifteen (15)-mile radius or geographic service area by "eyeballing" the portion of the area in the radius (if less than five percent (5%), exclude the entire zip code);

E. Multiply the remaining zip code population (total population less the population centers) by the percentage determined in (4)(C)2.D. (due to numerous complexities, population centers will not be utilized to adjust overlapped zip code populations in Jackson, St. Louis, and St. Charles counties or St. Louis City; instead, the total population within the zip code will be considered uniform and multiplied by the percentage determined in (4)(C)2.D.);

F. Add back the population center(s) "inside" the radius or region for zip codes overlapped; and

G. The sum of the estimated zip codes, plus those entirely within the radius, will equal the total population within the fifteen (15)-mile radius or geographic service area;

3. Provide other statistics, such as studies, patient origin or discharge data, Hospital Industry Data Institute's information, or consultants' reports, to document the size and validity of any proposed user-defined "geographic service area";

(D) Identify specific community problems or unmet needs which the proposed or expanded service is designed to remedy or meet;

(E) Provide historical utilization for each existing service affected by the proposal for each of the past three (3) years;

(F) Provide utilization projections through at least three (3) years beyond the completion of the project for all proposed and existing services directly affected by the project;

(G) If an alternative methodology is added, specify the method used to make need forecasts and describe in detail whether projected utilizations will vary from past trends; and

(H) Provide the current and proposed number of licensed beds by type for projects which would result in a change in the licensed bed complement of the LTC facility.

(5) Document that consumer needs and preferences have been included in planning this project. Describe how consumers have had an opportunity to provide input into this specific project, and include in this section all petitions, letters of acknowledgement, support or opposition received.

(6) The most current version of forms MO 580-2501, MO 580-2502, MO 580-2503, MO 580-2504, MO 580-2505, MO 580-1861, MO 580-1869 and MO 580-1863 may be obtained by mailing a written request to the CONP, 915G Leslie Boulevard, Jefferson City, MO 65101, or in person at the CONP Office, or, if technically feasible, by downloading a copy of the forms from the CONP website at www.dhss.state.mo.us/con.

AUTHORITY: section 197.320, RSMo 2000. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RESCISSION

19 CSR 60-50.450 Criteria and Standards for Long-Term Care. This rule outlined the criteria and standards against which a project involving a long-term care facility would be evaluated in a Certificate of Need (CON) review.

PURPOSE: This rule is rescinded because the Missouri CON Rulebook has been rewritten to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo.

EMERGENCY STATEMENT: This emergency rescission is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rescission because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rescission to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

This emergency rescission limits its scope to the circumstances creating the emergency and complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. The Committee finds that an emergency rescission is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rescission was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

AUTHORITY: section 197.320, RSMo 2000. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RULE

19 CSR 60-50.450 Criteria and Standards for Long-Term Care

PURPOSE: This rule outlines the criteria and standards against which a project involving a long-term care facility would be evaluated in a Certificate of Need (CON) review.

EMERGENCY STATEMENT: This emergency rule is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rule because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rule to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. The Committee finds that an emergency rule is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rule was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

(1) For purposes of determining need and evaluating area occupancy, residential care facility (RCF) I and RCF II shall be one separate classification and intermediate care facility (ICF) and skilled nursing facility (SNF) shall be another separate classification. For purposes of defining facilities and determining need, RCF I and RCF II, ICF and SNF, and long-term acute care (LTAC) shall be recognized as three (3) separate classifications, consistent with the definition of health care facility in section 197.366 (1), (2), and (3), RSMo.

(2) The following population-based long-term care bed need methodology for the fifteen (15)-mile radius shall be used to determine the maximum size of the need:

(A) Approval of additional ICF/SNF beds will be based on a service area need determined to be fifty-three (53) beds per one thousand (1,000) population age sixty-five (65) and older minus the current supply of ICF/SNF beds shown in the Inventory of Hospital and Nursing Home ICF/SNF Beds as provided by the Certificate of Need Program (CONP) which includes licensed beds, Certificate of Need (CON)-approved beds, and non-applicability beds;

(B) Approval of additional RCF beds will be based on a service area need determined to be sixteen (16) beds per one thousand (1,000) population age sixty-five (65) and older minus the current supply of RCF beds shown in the Inventory of Residential Care Facility Beds as provided by the CONP which includes licensed beds and CON-approved beds, and non-applicability beds.

(3) The minimum annual average utilization for all other long-term care beds within a fifteen (15)-mile radius of the proposed site should have achieved at least eighty percent (80%) for the preceding six (6) consecutive calendar quarters at the time of application filing as reported in the Division of Health Standards and Licensure (DHSL), Department of Health and Senior Services, Six-Quarter Survey of Hospital and Nursing Home (or Residential Care Facility) Licensed and Available Bed Utilization and certified through a written finding by the DHSL.

(4) Replacement Chapter 198, RSMo, beds qualify shortened information requirements and review time frames if an applicant proposes to:

(A) Relocate RCF beds within a six (6)-mile radius pursuant to section 197.318.8(4), RSMo;

(B) Replace one-half (1/2) of its licensed beds within a thirty (30)-mile radius pursuant to section 197.318.9, RSMo; or

(C) Replace a facility in its entirety within a fifteen (15)-mile radius pursuant to section 197.318.10, RSMo, under the following conditions:

1. The existing facility's beds shall be replaced at only one (1) site;

2. The existing facility and the proposed facility shall have the same owner(s), regardless of corporate structure; and

3. The owner(s) shall stipulate in writing that the existing facility's beds to be replaced will not be used later to provide long-term care services; or if the facility is operated under a lease, both the lessee and the owner of the existing facility shall stipulate the same in writing.

(5) LTC bed expansions involving a Chapter 198, RSMo, facility qualify for shortened information requirements and review time frames, and applicants shall also submit the following information:

(A) If an effort to purchase has been successful pursuant to section 197.318.8(1), RSMo, a Purchase Agreement (Form MO 580-2352) between the selling and purchasing facilities, and a copy of the selling facility's reissued license verifying the surrender of the beds sold; or

(B) If an effort to purchase has been unsuccessful pursuant to section 197.318.8(1), RSMo, a Purchase Agreement (Form MO 580-2352) between the selling and purchasing facilities which documents the "effort(s) to purchase" LTC beds.

(6) An exception to the CON application filing fee will be recognized for any proposed facility which is designed and operated exclusively for persons with acquired human immunodeficiency syndrome (AIDS).

(7) Any newly-licensed Chapter 198, RSMo, facility established as a result of the Alzheimer's and dementia demonstration projects pursuant to Chapter 198, RSMo, or aging-in-place pilot projects pursuant to Chapter 198, RSMo, as implemented by the DHSL, may be licensed by the DHSL until the completion of each project. If a demonstration or pilot project receives a successful evaluation from the DHSL and a qualified Missouri school or university, and meets the DHSL standards for licensure, this will ensure continued licensure without a new CON.

(8) For LTC renovation or modernization projects which do not include increasing the number of beds, the applicant should document the following, if applicable:

(A) The proposed project is needed to comply with current facility code requirements of local, state or federal governments;

(B) The proposed project is needed to meet requirements for licensure, certification or accreditation, which if not undertaken, could result in a loss of accreditation or certification;

(C) Operational efficiencies will be attained through reconfiguration of space and functions;

(D) The methodologies used for determining need;

(E) The rationale for the reallocation of space and functions; and

(F) The benefits to the facility because of its age or condition.

(9) The most current version of Form MO 580-2352 may be obtained by mailing a written request to the CONP, 915G Leslie Boulevard, Jefferson City, MO 65101, or in person at the CONP Office, or, if technically feasible, by downloading a copy of the form from the CONP website at www.dhss.state.mo.us/con.

*AUTHORITY: section 197.320, RSMo 2000. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RESCISSION

19 CSR 60-50.700 Post-Decision Activity. This rule described the procedure for filing Periodic Progress Reports after approval of Certificate of Need (CON) applications, CONs subject to forfeiture, and the procedure for requesting a cost overrun.

PURPOSE: This rule is rescinded because the Missouri CON Rulebook has been rewritten to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo.

EMERGENCY STATEMENT: This emergency rescission is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rescission because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rescission to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

*This emergency rescission limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The Committee finds that an emergency rescission is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rescission was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.*

*AUTHORITY: section 197.320, RSMo 2000. Original rule filed June 2, 1994, effective Nov. 30, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY RULE

19 CSR 60-50.700 Post-Decision Activity

PURPOSE: This rule describes the procedure for filing Periodic Progress Reports after approval of Certificate of Need (CON) applications, CONs subject to forfeiture, and the procedure for requesting a cost overrun.

EMERGENCY STATEMENT: This emergency rule is necessary to preserve a compelling government interest in health care cost containment. It requires rewriting the CON Rules in order to implement the January 1, 2003, effective date of the long-term care sunset provisions in sections 197.305, 197.317 and 197.318, RSMo. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency rule because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The sunset provisions of sections 197.305, 197.317 and 197.318, RSMo, changes the scope of work and the manner in which the Committee conducts the review process for CON applications by eliminating the minimum occupancy and zero expenditure requirements for review of long-term care facilities.

The Committee believes this emergency rule to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. The Committee also wishes to reduce applicant risks of incurring substantial capital expenditures without a CON, only to find later that their projects may have been contrary to state law, which would result in the loss of their capital investments with no redress possible.

*This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The Committee finds that an emergency rule is necessary to preserve health care access, allow health care providers to implement the sunset provisions of sections*

197.305, 197.317 and 197.318, RSMo, process applications, and prevent the immediate danger to the public health, safety, and welfare of the citizens of Missouri. This emergency rule was filed on December 16, 2002, to become effective on January 1, 2003, and will expire on June 29, 2003.

(1) Applicants who have been granted a Certificate of Need (CON) or a Non-Applicability CON letter shall file reports with the Missouri Health Facilities Review Committee (Committee), using Periodic Progress Report (Form MO 580-1871). A report shall be filed by the end of each six (6)-month period after CON approval, or issuance of a Non-Applicability CON letter, until project construction and/or expenditures are complete. All Periodic Progress Reports must contain a complete and accurate accounting of all expenditures for the report period.

(2) Applicants who have been granted a CON and fail to incur a capital expenditure within six (6) months may request an extension of six (6) months by submitting a letter to the Committee outlining the reasons for the failure, with a listing of the actions to be taken within the requested extension period to insure compliance. The Certificate of Need Program (CONP) staff on behalf of the Committee will analyze the request and grant an extension, if appropriate. Applicants who request additional extensions must provide additional financial information or other information, if requested by the CONP staff.

(3) For those long-term care proposals receiving a CON in 2003 for which no construction can begin prior to January 1, 2004, such proposals shall not be subject to forfeiture until July 1, 2004, at which time reporting requirements shall commence. Applicants may request an extension of six (6) months for such proposals.

(4) A Non-Applicability CON letter is valid for six (6) months from the date of issuance. Failure to incur a capital expenditure or purchase the proposed equipment within that time frame shall result in the Non-Applicability CON letter becoming null and void. The applicant may request one (1) six (6)-month extension unless otherwise constrained by statutory changes.

(5) A CON shall be subject to forfeiture for failure to:

(A) Incur a project-specific capital expenditure within twelve (12) months after the date the CON was issued through initiation of project above-ground construction or lease/purchase of the proposed equipment since a capital expenditure, according to generally accepted accounting principles, must be applied to a capital asset; or

(B) File the required Periodic Progress Report.

(6) If the CONP staff finds that a CON may be subject to forfeiture—

(A) Not less than thirty (30) calendar days prior to a Committee meeting, the CONP shall notify the applicant in writing of the possible forfeiture, the reasons for it, and its placement on the Committee agenda for action; and

(B) After receipt of the notice of possible forfeiture, the applicant may submit information to the Committee within ten (10) calendar days to show compliance with this rule or other good cause as to why the CON shall not be forfeited.

(7) If the Committee forfeits a CON or a Non-Applicability CON letter becomes null and void, CONP staff shall notify all affected state agencies of this action.

(8) Cost overrun review procedures implement the CON statute section 197.315.7, RSMo. Immediately upon discovery that a project's actual costs would exceed approved project costs by more than ten percent (10%), an applicant shall apply for approval of the cost variance. A nonrefundable fee in the amount of one-tenth of one percent (0.1%) of the additional project cost above the approved amount made payable to "Missouri Health Facilities Review Committee" shall be required. The original and eleven (11) copies of the information requirements for a cost overrun review are required as follows:

(A) Amount and justification for cost overrun shall document—

1. Why and how the approved project costs would be exceeded, including a detailed listing of the areas involved;

2. Any changes that have occurred in the scope of the project as originally approved; and

3. The alternatives to incurring this overrun that were considered and why this particular approach was selected.

(B) Provide a Proposed Project Budget (Form MO 580-1863).

(9) At any time during the process from Letter of Intent to project completion, the applicant is responsible for notifying the Committee of any change in the designated contact person. If a change is necessary, the applicant must file a Contact Person Correction (Form MO 580-1870).

(10) The most current version of forms MO 580-1871, MO 580-1863, and MO 580-1870 may be obtained by mailing a written request to the CONP, 915G Leslie Boulevard, Jefferson City, MO 65101, or in person at the CONP Office, or, if technically feasible, by downloading a copy of the forms from the CONP website at www.dhss.state.mo.us/con.

*AUTHORITY: section 197.320, RSMo 2000. Original rule filed June 2, 1994, effective Nov. 30, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 16, 2002, effective Jan. 1, 2003, expires June 29, 2003. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The board is amending section (1).

PURPOSE: This amendment includes changes in the definitions made by the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2003, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 20,*

2002, becomes effective January 1, 2003, and expires on June 29, 2003.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) When used in *[this]* **these rules or the** plan document, these words and phrases have the meaning—

(F) Benefits—Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions *[(22 CSR 10-2.040), (22 CSR 10-2.045), (22 CSR 10-2.050), (22 CSR 10-2.055), (22 CSR 10-2.060), (22 CSR 10-2.063), (22 CSR 10-2.064), (22 CSR 10-2.065), and (22 CSR 10-2.066)]* as interpreted by the plan administrator;

(H) Claims administrator—An organization or group responsible for the processing of claims and associated services for the **plan's self-insured benefit programs and** preferred provider organization (PPO) *[and co-pay plans]*;

(N) Dependents—The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as provided in *[this]* **the** plan document **and these rules**, for whom application has been made and has been accepted for participation in the plan;

(O) Eligibility date—Refer to 22 CSR 10-2.020 for effective date provisions.

1. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.

2. Employees transferred from a department or other public entity with coverage under another medical care plan into a department or other public entity covered by this plan and their eligible dependents who were covered by the other medical care plan will be eligible for participation subject to *[the provisions of 22 CSR 10-2.060(1)(Q)1.]* **any applicable pre-existing conditions as outlined in the plan document.**

3. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the *[PPO]* plan, will be eligible for participation immediately.

4. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the *[PPO]* plan, will be eligible for participation retroactive to the date following termination of participation;

(P) Emancipated child(ren)—A child(ren) who is—

1. Employed on a full-time basis;

2. Eligible for group health benefits in his/her own behalf;

3. Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; **or**

4. Married; *[or]*

[5. Not dependent upon parents or guardian for at least fifty percent (50%) support;]

[(BB) Medicare HMO (risk contract)—An HMO exclusively for members residing in specified areas and covered by Medicare whereby benefits are provided in accordance with a plan approved by federal regulation;]

[(CC)] **(BB)** Nurse—A registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule;

[(DD)] **(CC)** Open enrollment period—A period designated by the plan during which members may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year;

[(EE)] **(DD)** Out-of-area—Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria;

[(FF)] **(EE)** Out-of-network—Providers that do not participate in the member's health plan;

[(GG)] **(FF)** Participant—Any employee or dependent *[who has been]* accepted for membership in the plan;

[(HH)] **(GG)** Physically or mentally disabled—The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition;

[(II)] **(HH)** Physician/Doctor—A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under 334.021, RSMo;

[(JJ)] **(II)** Plan—The program of medical care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law;

[(KK)] **(JJ)** Plan administrator—The trustees of the Missouri Consolidated Health Care Plan;

[(LL)] **(KK)** Plan document—*[This]* **The** statement of the terms and conditions of the plan as adopted by the plan administrator **in the applicable "Missouri Consolidated Health Care Plan Member Handbook" and incorporated by reference**;

[(MM)] **(LL)** Plan year—Same as benefit year;

[(NN)] **(MM)** Point-of-service—A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized;

[(OO)] **(NN)** Pre-admission testing—X rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;

[(PP)] **(OO)** Preferred provider organization (PPO)—An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers;

[(QQ)] **(PP)** Premium option—A set of covered benefits with specified co-payment and coinsurance amounts;

[(RR)] **(QQ)** Prior plan—The terms and conditions of a plan in effect for the period preceding coverage in the MCHCP;

[(SS)] **(RR)** Provider—Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions and administrative guidelines of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized;

[(TT)] **(SS)** 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;

[(UU)] **(TT)** Review agency—A company responsible for administration of clinical management programs;

[(VV)] **(UU)** Second opinion program—A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service;

[(WW)] **(VV)** Skilled nursing facility (SNF)—An institution which meets fully each of the following requirements:

1. It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24) hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

2. It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

3. A skilled nursing facility shall be deemed to include institutions meeting the criteria in subsection (1)(VV) of this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97);

[(XX) Staff model—A set of covered benefits established by the HMO similar to the premium and standard options, but with varying co-payment and coinsurance amounts;]

[(YY)] **(WW)** Standard option—A set of covered benefits similar to the premium option, but with higher co-payment and coinsurance amounts;

[(ZZ)] **(XX)** State—Missouri;

[(AAA)] **(YY)** Unemancipated child(ren)—A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

1. Stepchild(ren);

2. Foster child(ren) for whom the employee is responsible for health care;

3. Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care;

4. Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator. *[This child(ren) must rely on the parent/custodian for his/her major financial support (appropriate documentation may be required).]* Except for a disabled child(ren) as described in subsection (1)(GG) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-three (23) (twenty-five (25) if attending school full-time and the public entity joining the plan had immediate previous coverage allowing this provision) (see 22 CSR 10-2.020(5)(D)2. for continuing coverage on handicapped child(ren) beyond age twenty-three (23)); and

5. Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan; and

[(BBB)] **(ZZ)** Usual, customary, and reasonable charge.

1. Usual—The fee a physician most frequently charges the majority of his/her patients for the same or similar services;

2. Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service;

3. Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service; and

4. A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported.

*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 Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.020 Membership Agreement and Participation Period. The board is amending subparagraph (4)(B)3.A., paragraphs (7)(B)3. and 4. and paragraph (8)(A)7.

PURPOSE: This amendment includes changes in the membership agreement and participation period made by the board of trustees regarding the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2003, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

(4) The effective date of participation shall be determined, subject to the effective date provision in subsection (4)(C), as follows:

(B) Dependent Coverage. Dependent participation cannot precede the employee's participation. Application for participants must be made in accordance with the following provisions. For family coverage, once an employee is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided;

1. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

2. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; and

3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is *[not]* **immediately** eligible for coverage *[until the next open enrollment period]* **if an application is submitted within thirty-one (31) days of regaining dependent status**; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (4)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan.)

(7) Continuation of Coverage.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility Criteria:

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

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the Missouri State Employees' Retirement System, Public School Retirement System, the retirement system of a participating public entity, or the Highway Retirement System may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, long-term disability recipients and their dependents are not later eligible if they discontinue their coverage at some future time*[.]***, except as noted in (7)(B)4.;**

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(8) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the **health plan** rate *[under the regular PPO plan]*, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

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 Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY RESCISSION

22 CSR 10-2.040 PPO Plan Summary of Medical Benefits. The rule provided a summary of the medical benefits under the PPO plan.

PURPOSE: This rule is being rescinded as this benefit plan is no longer available.

EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This benefit will no longer be available next year, Therefore, this emergency rescission must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

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 rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.045 Co-Pay *and PPO* Plan *[Summary of Medical Benefits]* ***Summaries***. The board is deleting sections (1)–(6) and (9) and renumbering sections (7) and (8) of this rule.

PURPOSE: This amendment includes changes made by the board of trustees regarding medical benefits for participants in the Missouri Consolidated Health Care Plan Co-Pay and PPO Plans.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2003, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the **Missouri** *and* **United States Constitutions** *and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

[(1) Lifetime Maximum:
(A) Network—no limit.
(B) Out-of-Network, Out-of-Area—three (3) million dollars.

(2) Automatic Annual Reinstatement—Maximum, five thousand dollars ($5,000).

(3) Non-Network and Out-of-Area Deductible Amount—
(A) Network—zero.
(B) Out-of-Network, Out-of-Area—three hundred dollars ($300) individual, nine hundred dollars ($900) family, per calendar year.

(4) Coinsurance.
(A) Individual—
1. Network—Eighty percent (80%) coinsurance applies to specific benefits. After satisfying the two thousand dollar ($2,000) individual out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year. Please refer to the schedule of benefits.
2. Non-network—Seventy percent (70%) coinsurance applies to covered services. After satisfying the four thousand five hundred dollar ($4,500) individual out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.
3. Out-of-area—Eighty percent (80%) coinsurance applies to covered services after satisfying one thousand five hundred dollar ($1,500) individual out-of-pocket maximum. Claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.
(B) Family—
1. Network—Eighty percent (80%) coinsurance applies to specific benefits. After satisfying the six thousand dollar ($6,000) family out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year. Please refer to the schedule of benefits.
2. Non-network—Seventy percent (70%) coinsurance applies to covered services. After satisfying the nine thousand dollar ($9,000) family out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.
3. Out-of-area—Eighty percent (80%) coinsurance applies to covered services after satisfying three thousand dollar ($3,000) family out-of-pocket maximum. Claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.
(C) Non-Network Services—Same as subsections (4)(A) and (B) of this rule, except covered charges are reimbursed on a seventy percent (70%) basis.

(5) The employee or dependent will only be responsible for a fifteen dollar ($15) co-payment for an office visit for covered services if a physician or provider is utilized who is enrolled in a preferred provider network that has contracted with the plan administrator.

(6) Hospital Room Charges—The hospital's most common charge for semi-private accommodations, unless a private room has been recommended by a physician and approved by the claims administrator or the plan's medical review agency.]

[(7)] **(1)** Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:
(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate review agency. For emergency hospital admissions, the review agency must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;
(B) Concurrent Review—The review agency will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;
(C) Large Case Management—Members that require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;
(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and
(E) Penalties—Members not complying with subsections *[(7)]***(1)**(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

[(8)] **(2)** Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of

this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, 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 was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

[(9) Prescription Drug Program—The co-pay plan provides coverage for prescription drugs, as described in the following:

(A) Medications.

1. In-Network.

A. Ten dollar ($10) co-pay for thirty (30)-day supply for generic drug on the formulary.

B. Twenty dollar ($20) co-pay for thirty (30)-day supply for brand drug on the formulary.

C. Thirty-five dollar ($35) co-pay for thirty (30)-day supply for non-formulary drug.

2. Prescriptions filled with a brand drug when a generic is available will be subject to the generic co-payment amount and the member must also pay the difference in the cost between the generic and brand drugs.

3. Mail Order Program—Prescriptions may be filled through a mail order program for up to a ninety (90)-day supply for twice the regular co-payment.

(B) Non-Network Pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable co-payment. Any difference between the amount paid by the member at a non-network pharmacy and the amount that would have been allowed at an in-network pharmacy will not be applied to the out-of-pocket maximum.]

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires 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 Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY RESCISSION

22 CSR 10-2.050 PPO Plan Benefit Provisions and Covered Charges. This rule provided a summary of the benefit provisions and covered charges under the PPO plan.

PURPOSE: This rule is being rescinded as this benefit plan is no longer available.

*EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This benefit will no longer be available next year. Therefore, this emergency rescission must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

*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 rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.055 Co-Pay *and PPO* Plan Benefit Provisions and Covered Charges. The board is amending this rule in regard to the modified benefit provisions and covered charges.

PURPOSE: This amendment includes changes made by the board of trustees regarding benefit provisions and covered charges in the Missouri Consolidated Health Care Plan Co-Pay and PPO Plans.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2003, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

[(1) Covered Charges.

(A) Allergy Injections—Fifteen dollar ($15) co-payment for office visit also covers injection. Ten dollar ($10) co-payment per injection received if not during office visit.

(B) Ambulance Service—Ground services covered with fifty dollar ($50) co-payment if medically necessary or with prior approval. Air services covered on same basis, twenty

percent (20%) coinsurance and deductible for non-emergencies.

(C) Birth Control Pills—Birth control pills on the formulary covered at one hundred percent (100%). Not covered out-of-network.

(D) Chiropractic Benefits—Charges subject to fifteen dollar ($15) co-payment; fifty dollar ($50) co-pay per visit maximum, two thousand dollar ($2,000) annual maximum (out-of-network only).

(E) Complications—Normally covered charges arising as a complication of a noncovered service.

(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restorative services that are a result of that injury. Fifteen dollar ($15) office visit co-pay, regardless of where services are rendered.

(G) Durable Medical Equipment—Twenty percent (20%) coinsurance. Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(H) Emergency Care—Fifty dollar ($50) co-payment in or out of service area. Waived if admitted.

(I) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a fifteen dollar ($15) co-payment.

(J) Growth Hormone Therapy—Subject to twenty percent (20%) coinsurance, medical necessity and prior authorization.

(K) Hearing Aids and Testing—Covered once every two (2) years, subject to twenty percent (20%) co-payment and fifteen dollar ($15) co-payment for annual hearing test.

(L) Home Health Care—Covered when authorized by claims administrator.

(M) Hospice Care—Covered with prior authorization.

(N) Hospital Benefit for Mental and Nervous Disorder—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual inpatient hospital maximum. Must be pre-certified.

(O) Hospital Benefits for Chemical Dependency—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual inpatient hospital maximum. Must be precertified.

(P) Hospital Room and Board—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual maximum. Must be precertified.

(Q) Injections—All injections provided in full (except allergy and contraceptive injections).

(R) Infertility—Coverage limited to fifty percent (50%) for in vivo services, including provider, and prescription drug charges. Exclusions include reversals of voluntary sterilization, in vitro fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). Not covered out-of-network. Deductible applies to out-of-area.

(S) Maternity Coverage—Fifteen dollar ($15) co-payment for initial visit. All other prenatal visits, delivery costs and routine post-natal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.

(T) Nutrient Supplement—Not covered out-of-network.

(U) Organ Transplants—The following organ transplants covered at one hundred percent (100%) through the National Transplant Program: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by the claims administrator. Donor expenses are covered. No waiting periods allowed. Non-network and out-of-area limited to maximum surgical schedule.

(V) Outpatient Diagnostic Lab and X-Ray—Provided in full.

(W) Outpatient Mental and Nervous Disorder and Chemical Dependency—Fifteen dollar ($15) co-payment per visit.

(X) Oxygen—(Outpatient) Subject to twenty percent (20%) coinsurance. Covered under Durable Medical Equipment.

(Y) Physical Therapy and Rehabilitation Services—Ten dollar ($10) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits if medically necessary.

(Z) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after fifteen dollar ($15) co-payment per office visit.

3. Internet—Covered when enrolled in the Care Support Program and registered for the service.

(AA) Plan Maximum—Not applicable for network services, out-of-network and out-of-area limited to three (3) million dollars with five thousand dollar ($5,000) reinstatement.

(BB) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.

1. Ten dollar ($10) co-pay for thirty (30)-day supply for generic drug on the formulary.

2. Twenty dollar ($20) co-pay for thirty (30)-day supply for brand drug on the formulary.

3. Thirty-five dollar ($35) co-pay for thirty (30)-day supply for non-formulary drug.

4. Ninety (90)-day supply of medication for two (2) co-payments (mail order only).

(CC) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well-woman exam without referral to a network provider.

(DD) Prosthetics—Provided in full for initial placement. Twenty percent (20%) coinsurance for coverage for repair or replacement due to change in medical condition.

(EE) Skilled Nursing—Provided in full. Limited to one hundred and twenty (120) days.

(FF) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Fifty dollar ($50) co-payment.]

(1) Benefit Provisions.

(A) Subject to the plan provisions and limitations and the written application of the employee, the benefits are payable for covered charges incurred by a participant while covered under the co-pay or PPO plans, provided the deductible requirement, if any, is met.

(B) Any deductible requirement applies each calendar year to covered charges. The requirement is met as soon as covered charges incurred in a calendar year, which are not paid in part or in whole by the plan, equals the deductible amount.

(C) Any family deductible requirement is met as soon as covered charges in a calendar year, which are not paid in part or in whole by the plan, equals the family deductible requirement.

(D) The total amount of benefits payable for all covered charges incurred out-of-network during an individual's lifetime shall not exceed the lifetime maximum.

(E) If both husband and wife are participating separately as employees under this plan, the family deductible and benefit features shall nevertheless apply to the benefit of the family unit.

(2) Covered Charges.

(A) Only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a noncovered service, and which are:

1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;

2. To the extent they do not exceed any limitation;

3. Not excluded by the limitations; and

4. For not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and

2. The usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

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 Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY RESCISSION

22 CSR 10-2.060 PPO and Co-Pay Plan Limitations. This rule provided the limitations of the PPO and Co-Pay plans.

PURPOSE: This rule is being rescinded as the information is contained in the Plan Document.

EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This benefit will no longer be available next year. Therefore, this emergency rescission must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

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 rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY RESCISSION

22 CSR 10-2.063 HMO/POS Premium Option Summary of Medical Benefits. This rule provided a summary of the medical benefits under the HMO/POS Premium Option.

PURPOSE: This rule is being rescinded as the information is contained in the Plan Document.

EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This benefit will no longer be available next year. Therefore, this emergency rescission must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY RESCISSION

22 CSR 10-2.064 HMO/POS Standard Option Summary of Medical Benefits. This rule provided a summary of the medical benefits of the HMO/POS Standard Option.

PURPOSE: This rule is being rescinded as the information is contained in the Plan Document.

EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This benefit will no longer be available next year. Therefore, this emergency rescission must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

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 rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY RESCISSION

22 CSR 10-2.067 HMO and POS Limitations. This rule provided the limitations of the HMO and POS plans.

PURPOSE: This rule is being rescinded as the information is contained in the Plan Document.

*EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This benefit will no longer be available next year. Therefore, this emergency rescission must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The board is amending section (5) and paragraph (5)(B)2.

PURPOSE: This amendment includes changes made by the board of trustees regarding the review and appeals procedure of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2003, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

(5) All insured members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health maintenance organization (HMO), point-of-service (POS)**,** *[or]* preferred provider organization (PPO) **or co-pay** health plan contract applicable to the insured member. Only after these procedures have been exhausted may the insured appeal to the Missouri Consolidated Health Care Plan Board of Trustees to review the decision of the health plan contractor.

(B) The board may utilize a hearing officer, such as the Administrative Hearing Commission, to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law.

1. The hearing will be scheduled by the MCHCP.
2. The parties to the hearing will be the insured and the applicable health plan *[contractor]*.
3. All parties shall be notified, in writing of the date, time and location of the hearing.
4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply.
5. The party appealing to the board shall carry the burden of proof.
6. The independent hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions and recommendations shall be sent to all parties.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired August 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.080 Miscellaneous Provisions. The board is amending section (2).

PURPOSE: This amendment includes changes made by the board of trustees regarding the miscellaneous provisions of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2003, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care

plan. This emergency amendment must become effective January 1, 2003, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 20, 2002, becomes effective January 1, 2003, and expires on June 29, 2003.*

(2) Facility of Payment. Preferred provider organization (PPO) **and co-pay** plan benefits will be paid to the employee if living and capable of giving a valid release for the payment due. If the participant, while living, is physically, mentally or for any other reason incapable of giving a valid release for any payment due, the claims administrator at his/her option, unless and until request is made by the duly appointed guardian, may pay benefits which may become due to any blood relative or relative connected by marriage to the participant, or to any other person or institution appearing to the claims administrator to have assumed responsibility for the affairs of the participant. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of the payment. Any benefit unpaid at the time of the employee's death will be paid to the employee's estate. If any benefits shall be payable to the estate of the employee, the claims administrator may pay these benefits to any relative by blood or connection by marriage of the employee who is deemed by the claims administrator to be equitably entitled to it. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of this payment. Subject to any acceptable written direction and assignment by the employee, any benefits provided, at the claims administrator's *[opinion]* **option**, may be paid directly to an eligible provider rendering covered services; but it is not required that the service be rendered by a particular provider.

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 Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003.*