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

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 If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission.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

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

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

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

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

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

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 5—Examinations

PROPOSED RESCISSION

4 CSR 30-5.030 Standards for Admission to Examination Architects. This rule set out standards for admission to architectural examinations.

PURPOSE: This rule is being rescinded and readopted to bring the rule language into compliance with section 327.131, RSMo as amended by HB 567 of the 91st General Assembly (2001).

AUTHORITY: section 327.041, RSMo Supp. 1989. Original rule filed March 16, 1970, effective April 16, 1970. Amended: Filed Dec. 8, 1981, effective March 11, 1982. Amended: Filed Sept. 13, 1983, effective Dec. 11, 1983. Amended: Filed Sept. 12, 1985, effective Dec. 12, 1985. Amended: Filed Feb. 4, 1992, effective June 25, 1992. Rescinded: Filed May 13, 2005.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 5—Examinations

PROPOSED RULE

4 CSR 30-5.030 Standards for Admission to Examination—Architects

PURPOSE: This rule sets out standards for admission to architectural examinations.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Every graduate from a curriculum fully accredited by the National Architectural Accreditation Board (NAAB), or other designated agencies as recognized by the National Council of Architectural Registration Boards (NCARB), who shall apply for architectural licensure shall submit with and as a part of the application documents as required in section 327.131, RSMo, a fully certified and completed Intern Development Program (IDP) record.

(2) Prior to January 1, 2012, every nongraduate applying for architectural licensure shall submit with and as part of the application documents as required in section 327.131, RSMo, a weekly record or log of diversified architectural experience covering a period of not fewer than two hundred eight (208) weeks immediately prior to application. Every weekly record or log shall be witnessed by the signature of a licensed architect having direct personal supervision of that experience. In addition to the experience log, there also shall be included in the application a chronological list of the education and architectural experience the applicant claims prior to the period of

the log which will furnish a total of eight (8) years of architectural experience.

(3) The standard for satisfactory architectural experience shall be the criteria set forth in the National Council of Architectural Registration Board's Circular of Information No. 1, Appendix A dated 1990–1991, which is incorporated herein by reference. A copy of the information may be obtained by contacting the National Council of Architectural Registration Boards, 1801 K Street NW, Suite 1100, Washington DC 20006-1301. The referenced material does not include any later amendments or additions.

(4) The standard for satisfactory architectural education shall be the criteria set forth in the National Council of Architectural Registration Board's Circular of Information No. 1, Appendix A dated 1978, which is incorporated herein by reference. A copy of the information may be obtained by contacting the National Council of Architectural Registration Boards, 1801 K Street NW, Suite 1100, Washington DC 20006-1301. The referenced material does not include any later amendments or additions.

AUTHORITY: section 327.041, and *327.121, 327.131, RSMo Supp. 2004 and 327.141, RSMo 2000. Original rule filed March 16, 1970, effective April 16, 1970. For intervening history, please consult the* ***Code of State Regulations****. Rescinded and readopted: Filed May 13, 2005.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately one thousand one hundred eleven dollars and seventy-six cents ($1,111.76) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed rule will cost private entities approximately three thousand two hundred eleven dollars and eighty-four cents ($3,211.84) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 5 - Examinations

Proposed Rule - 4 CSR 30-5.030 Standards for Admission to Examination - Architects

Prepared March 29, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Annual Cost of Compliance
Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects	$1,111.76

Total Annual Cost of Compliance for the Life of the Rule $1,111.76

III. WORKSHEET

CALCULATION OF EXPENSE AND EQUIPMENT AND PERSONAL SERVICE COSTS:
Licensure Technician IIs will perform the follow duties:
· **APPLICATIONS FOR ARCHITECTURAL LICENSURE** - Review application for completeness, update division's licensing system, prepare and sends follow up letters, respond to telephone inquiries, process all documentation and issue and mail the license.
· **APPLICATIONS FOR NON-GRADUATES** - Review application for completeness, update division's licensing system, prepare and send follow up letters, respond to telephone inquiries, process all documentation, prepare application for board review, notify applicant of any deficiencies noted by the board, schedule applicant for the examination and issue and mail the license.

APPLICATIONS FOR ARCHITECTURAL LICENSURE

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	COST PER MINUTE	TIME PER APPLICATION	COST PER APPLICATION	TOTAL COST
Licensing Technician II	$26,292	$36,932	$17.76	$0.30	30 minutes	$8.88	$177.56

APPLICATIONS FOR NON GRADUATES

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	TIME PER APPLICATION	COST PER APPLICATION	TOTAL COST
Licensing Technician II	$26,292	$36,932	$17.76	4 hours	$71.02	$852.29

Total Personal Service Costs $1,029.84

Expense and Equipment and Personal Service Dollars	
Application Printing	$0.80
Letterhead Printing	$0.15
Envelope for Mailing Application	$0.16
Postage for Mailing Application	$1.03
Printing of Registration	$0.05
Postage for Mailing registration	$0.37
Total Per Applicant:	$2.56

Total Expense and Equipment Costs: $81.92

IV. ASSUMPTION

1. Based on FY04 actuals and FY05 projections, the board anticipates 20 applications for architectural licensure and 12 non graduate applications will be received annually.
2. Employee's salaries were calculated using their annual salary multiplied by 40.47% for fringe benefits and then were divided by 2080 hours per year to determine the hourly salary. The hourly salary was then divided by 60 minutes to determine the cost per minute. The cost per minute was then multiplied by the amount of time the Licensure Technician II spent on the processing of the application. The total cost was based on the cost per request multiplied by the estimated number of requests received on an annual basis.
3. Applications for non-graduates are currently reviewed by the members of the board at their regularly scheduled board meetings, therefore, no additional per diem is included in this fiscal note.
4. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

NOTE: The public fiscal note for this rule only reflects the cost for this particular process. However, private entity fees are set at an amount to cover the total actual cost incurred by the board, which includes personal service, expense and equipment and transfers.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 5 - Examinations

Proposed Rule - 4 CSR 30-5.030 Standards for Admission to Examination - Architects

Prepared March 29, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the rule by affected entities:
32	Applicants (application fee @ $100)	$3,200.00
32	Applicants (notary @ $2.50)	$80.00
32	Applicants (postage @ $.37)	$11.84
	Estimated Annual Cost of Compliance for the Life of the Rule	**$3,211.84**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. Based on FY04 actuals and FY05 projections, the board anticipates 20 applications for architectural licensure and 12 non graduate applications will received annually.
2. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee

NOTE: The board is statutorily obligated to enforce and administer the provisions of Chapter 326, RSMo. Pursuant to Section 326.319, RSMo, the board shall by rule and regulation set the amount of fees authorized by Chapter 326, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of Chapter 326, RSMo. This proposed amendment is necessary because the board's projected revenue will not support the expenditures necessary to enforce and administer the provisions of Chapter 326, RSMo, which will result in an endangerment to the health, welfare, and safety of the public.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 5—Examinations

PROPOSED AMENDMENT

4 CSR 30-5.080 Standards for Admission to Examination—Engineers. The board is proposing to amend sections (1) and (3), add new language in section (4), renumber the remaining sections accordingly, and amend the newly renumbered sections (6)–(8).

PURPOSE: This rule sets out standards for admission to engineering examinations. It is being amended to require foreign-educated applicants to have their educational credentials evaluated by the Engineering Credentials Evaluation International (ECEI) and to provide clarification of the evaluation process. It also deletes reference to the doctorate degree and addresses several other minor housecleaning issues.

(1) Before being admitted to the examination, an applicant for *[registration]* **licensure** as a professional engineer shall have the knowledge, skills and experience as the board deems necessary to qualify the applicant for being placed in responsible charge of engineering work. The minimum length of experience required of the applicant, based on education, is three (3) years for any applicant holding a master's degree *[or a doctorate degree]* in engineering; however, an applicant will not be admitted to **the** examination sooner than four (4) years after the applicant has satisfied the educational requirements of sections 327.221 and 327.241, RSMo, provided, however, any applicant who shall have been conferred a master's degree *[or doctorate degree]* in engineering concurrently while acquiring three (3) years of satisfactory engineering experience, as provided in this rule, shall be admitted to the examination. The Engineers' Council for Professional Development (ECPD) has been succeeded by the Accreditation Board for Engineering and Technology, Inc. (ABET). For purposes of evaluating engineering curricula at the baccalaureate level, the programs accredited by the Engineering Accreditation Commission (EAC) of ABET shall be the basis used for evaluation of programs not accredited by EAC of ABET.

(3) *[When an engineering curriculum has not been accredited by ECPD, ABET, or its successor organizations, the professional engineering division shall evaluate the educational program of the applicant in order to determine whether or not, in its opinion, the educational program is equal to or exceeds the programs accredited by ECPD, ABET, or their successor organizations. The professional engineering division shall select one (1) registered engineer experienced in evaluating academic credentials to assist in making this determination.]* **Foreign-educated applicants holding an engineering degree not accredited by ECPD, ABET, or its successor organizations will be required to submit a favorable evaluation report completed by the Engineering Credentials Evaluation International (ECEI) or by another evaluation service acceptable by the professional engineering division of the board certifying equivalency to an ABET accredited degree. Applicants holding a United States of America (U.S.A.) engineering degree not accredited by ECPD, ABET, or its successor organizations will be required to have their educational degree program evaluated in order to determine whether or not it is equal to or exceeds the programs accredited by ECPD, ABET, or their successor organizations. The evaluation must be completed by an engineer(s) experienced in evaluating academic credentials selected by the professional engineering division or by an evaluation service acceptable by the professional engineering division of the board.** The evaluator, by evaluation of transcripts and an official publication describing the engineering degree program of the institution, personal interview, by examination, or both in any other manner deemed suitable, shall make an evaluation as to whether the academic program completed by the applicant meets the minimum educational requirements established by section 327.221, RSMo. The evaluator shall recommend to the professional engineering division and report how any deficiencies can be corrected, listing prescribed educational areas to bring the applicant's academic qualifications up to the required minimum. The report of the evaluator shall not be binding upon the division.

(4) A degree in engineering technology does not meet the educational requirements of section 327.221, RSMo.

*[(4)]***(5)** Any applicant deemed by the professional engineering division under section (3) of this rule to have completed an educational program which is equal to or exceeds those programs accredited by ECPD, ABET, or their successor organizations shall be required to have obtained the minimum engineering work experience as is required in section (1) of this rule. In all cases, the board will consider only that experience the applicant has obtained after satisfying the educational requirements of sections 327.221 and 327.241, RSMo.

*[(5)]***(6)** In evaluating the minimum engineering work experience required of all applicants, the professional engineering division shall grant maximum credit as follows:

(A) Engineering teaching at collegiate level (only advanced engineering subjects or courses related to advanced engineering at board-approved schools), assistant professor and higher—year-for-year;
(B) *[Graduate education, m]***M**aster's degree *[or PhD degree]* **in engineering—**one (1) year for completion *[of either]*;
(C) Military service (commissioned only—normally this service is in a technical branch such as engineering, ordinance, civil work services (CWS), civil engineering corps (CEC), etc.): Generally year-for-year subject to evaluation;
(D) Construction (technical decision-making level), above average complexity, non-standard design, or both involving field modification—year-for-year;
(E) Project planning including layout and twenty-five percent (25%) or more design—year-for-year;
(F) Research and development at the planning and decision-making level—year-for-year; and
(G) Engineering management and administration—year-for-year.

[(6)] **(7)** Individual evaluation may result in less than full credit.

[(7)] **(8)** In accordance with the authority conferred upon the board at section 327.241.6., RSMo, the board provides that any person, upon satisfactory showing of an urgent need, such as absence from the United States, economic hardship or professional necessity, and who has graduated from and holds an engineering degree from an accredited school of engineering, and has acquired at least three and one-half (3 1/2) years of satisfactory experience, and previously has been classified an engineer-in-training **or engineer-intern** by having successfully passed the first part of the examination, shall be eligible to take the second part of the examination and, upon passing, shall be entitled to receive a certificate of *[registration]* **licensure** to practice as a professional engineer subject, however, to other provisions of Chapter 327, RSMo, including having acquired four (4) years of satisfactory experience.

AUTHORITY: sections 327.041, RSMo [1994] ***Supp. 2004 and 327.221, and 327.241, RSMo 2000.*** *Original rule filed March 16, 1970, effective April 16, 1970. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed May 13, 2005.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately three thousand dollars ($3,000) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will cost private entities approximately eight thousand six hundred twenty-nine dollars ($8,629.15) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 5 - Examinations

Proposed Rule - 4 CSR 30-5.080 Standards for Admission to Examination - Engineers

Prepared March 29, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Annual Cost of Compliance
Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects	$3,000.00
Total Annual Cost of Compliance for the Life of the Rule	**$3,000.00**

III. WORKSHEET

See Assumptions

IV. ASSUMPTION

1. Based on FY05 projections, the board is estimating that approximately 20 applicants holding United States of America (U.S.A.) engineering degree not accredited by ECPD, ABET, or its successor organizations will be required to have their educational degree program evaluated in order to determine whether or not it is equal to or exceeds the programs accredited by ECPD, ABET, or their successor organizations. The board will collect $300 from each applicant of which $150 will be considered a pass through fee for the evaluator. Therefore, it is estimated that the board will pay the evaluator $3,000 annually to complete the education evaluations.

2. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

NOTE: The public fiscal note for this rule only reflects the cost for this particular process. However, private entity fees are set at an amount to cover the total actual cost incurred by the board, which includes personal service, expense and equipment and transfers.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 5 - Examinations

Proposed Rule - 4 CSR 30-5.080 Standards for Admission to Examination - Engineers

Prepared March 29, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the rule by affected entities:
25	Applicants - foreign educated (application fee @ $100)	$2,500.00
20	Applicants - U.S. non accredited engineering degree (application fee @ $300)	$6,000.00
45	Applicants (notary @ $2.50)	$112.50
45	Applicants (postage @ $.37)	$16.65
	Estimated Annual Cost of Compliance for the Life of the Rule	**$8,629.15**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. Based on FY05 projections the board estimates 25 foreign-educated applicants holding an engineering degree not accredited by ECPD, ABET, or its successor organizations will be required to submit a favorable evaluation report completed by the Engineering Credentials Evaluation International (ECEI). The ECEI offers several levels of service for various fees, which include basic service, rush service, etc. For the purpose of this fiscal note, the board is using the basic service fee of $425. It should be noted that this could be a cost savings for applicants as the evaluation report can be used for many states to meet the educational requirements versus having to pay each state individually for an educational review.

2. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

NOTE: The board is statutorily obligated to enforce and administer the provisions of Chapter 326, RSMo. Pursuant to Section 326.319, RSMo, the board shall by rule and regulation set the amount of fees authorized by Chapter 326, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of Chapter 326, RSMo. This proposed amendment is necessary because the board's projected revenue will not support the expenditures necessary to enforce and administer the provisions of Chapter 326, RSMo, which will result in an endangerment to the health, welfare, and safety of the public.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, *[and]* Professional Land Surveyors, ***and Landscape Architects***
Chapter 8—Land Surveying

PROPOSED AMENDMENT

4 CSR 30-8.020 Professional Land Surveyor—Professional Development Units. The board is proposing to amend section (1).

PURPOSE: This amendment requires a land surveyor to obtain a certain number of continuing education credits in Minimum Standards and limits the number of noncontact professional development units.

(1) Each licensed professional land surveyor, as a condition for renewal of his/her license, shall complete a minimum of twenty (20) professional development units (PDU) each two (2)-year period immediately preceding renewal, except as provided in section (2) of this rule.

(A) Of the required professional development units, licensed professional land surveyors shall complete a minimum of four (4) professional development units in Minimum Standards (4 CSR 30, Chapters 16, 17 and 19) during the four (4)-year period immediately preceding renewal.

(B) Of the required professional development units in the two (2)-year renewal period, not more than twelve (12) shall be obtained in nonpersonal contact activities. Nonpersonal contact activities include correspondence courses, video and televised courses, Internet and e-mail courses, or other activities where the presenter is not in physical proximity to the attendee.

*AUTHORITY: section 327.041, RSMo [2000] **Supp. 2004**. Original rule filed Dec. 8, 1981, effective March 11, 1982. For intervening history, please consult the **Code of State Regulations**. Amended: Filed May 13, 2005.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 10—Corporations

PROPOSED RESCISSION

4 CSR 30-10.010 Application for Certificate of Authority. This rule established standards for corporations to obtain and maintain certificates of authority.

PURPOSE: This rule is being rescinded and readopted in order to change the term "person in responsible charge" to "managing agent" and define the agent's responsibilities and when a certificate of authority is not required.

AUTHORITY: sections 327.041, RSMo Supp. 2001 and 327.401, RSMo 2000. Original rule filed Dec. 8, 1981, effective March 11, 1982. Amended: Filed Oct. 30, 2002, effective April 30, 2003. Rescinded: Filed May 13, 2005.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 10—Corporations

PROPOSED RULE

4 CSR 30-10.010 Application for Certificate of Authority

PURPOSE: This rule establishes standards for corporations to obtain and maintain certificates of authority.

(1) A corporation desiring a certificate of authority authorizing it to render architectural, professional engineering, land surveying or landscape architectural services in this state shall submit an application to the executive director of the board, listing the names and addresses of all officers and directors for a corporation or members and managers for a limited liability company. It shall also list the managing agent for each profession who is licensed in this state to practice architecture, engineering, surveying or landscape architecture.

(2) The managing agent shall be an owner, officer, partner, or a full-time employee. If the managing agent is also the person providing immediate personal supervision, as defined by board rule(s) 4 CSR 30-13.010 and/or 4 CSR 30-13.020, then that person must work in the same office where the work is being performed.

(3) The managing agent's responsibilities include:

(A) Renewal of the certificate of authority and notification to the board of any changes in the firm;

(B) Overall supervision of the professional and licensing activities of the firm and its employees;

(C) Assurance that the firm institutes and adheres to policies that are in accordance with Chapter 327, RSMo and 4 CSR 30; and

(D) Assurance, in the case of multiple offices, that the requirements for immediate personal supervision, as defined by board rule(s) 4 CSR 30-13.010 and/or 4 CSR 30-13.020, are being met.

(4) A certificate of authority is not required by a principal firm if the work is being done by a subconsultant who is licensed in this state. The principal firm cannot advertise itself as being able to provide architecture, engineering, land surveying, or landscape architecture services, or include the names of those professions in the name of their firm unless exempted pursuant to section 327.101(7), RSMo or section 327.191(5), RSMo.

(5) A corporation which is currently authorized by this board to provide professional services may continue to renew its certificate of authority under the rules that were in effect prior to October 30, 2005 so long as the persons listed in the corporation's application do not change. If there is any change in any of the persons listed in the corporation's application, the provisions in this section, 4 CSR 30-10.010 shall apply. The change shall be reported on a new form and submitted to the executive director of the board within thirty (30) days after the effective day of the change.

AUTHORITY: section 327.041, RSMo Supp. 2004. Original rule filed Dec. 8, 1981, effective March 11, 1982. Amended: Filed Oct. 30, 2002, effective April 30, 2003. Rescinded and readopted: Filed May 13, 2005.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately four thousand eight hundred ninety-five dollars and six cents ($4,895.06) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed rule will cost private entities approximately one hundred forty-five thousand nine hundred thirty-seven dollars and ninety-one cents ($145,937.91) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 10 - Corporations

Proposed Rule - 4 CSR 30-10.010 Application for Certificate of Authority

Prepared March 29, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Annual Cost of Compliance
Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects	$4,895.06

Total Annual Cost of Compliance for the Life of the Rule $4,895.06

III. WORKSHEET

CALCULATION OF EXPENSE AND EQUIPMENT AND PERSONAL SERVICE COSTS:
Licensure Technician IIs will review corporation applications for completeness, update division's licensing system, prepare and send follow up letters, respond to telephone inquiries, process all documentation, prepare application for board review, notify applicant of any deficiencies noted by the board, schedule applicant for the examination and issue and mail the license.

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	COST PER MINUTE	TIME PER APPLICATION	COST PER APPLICATION	TOTAL COST
Licensing Technician II	$26,292	$36,932	$17.76	$0.30	30 minutes	$8.88	$1,518.13

Total Personal Service Costs $1,518.13

Expense and Equipment and Personal Service Dollars	
Application Printing	$0.80
Letterhead Printing	$0.15
Envelope for Mailing Application	$0.16
Postage for Mailing Application	$1.03
Printing of Registration	$0.05
Postage for Mailing registration	$0.37
Total Per Applicant:	$2.56

Total Expense and Equipment Costs: $437.76

In order to even out the board's cash flow, the board implemented a biennial split renewal for the FY04 renewal period. Licenses are generally renewed for a 2 year period depending on the year of issuance (even or odd). The divisions central processing unit processes the renewal applications for the board. During FY04 the board transferred approximately $15,242.56 to the division to cover the cost of this service. In order to calculate the fiscal impact of this rule, the board estimates that approximately 944 certificates of authority were renewed representing approximately 7% of the total licensee renewed that fiscal year. Therefore, the board estimates that of the $15,242.56, approximately $1,066.97 was for the processing of corporation renewals in FY04.

Renewal Processing **$1,066.97**

Expense and Equipment and Personal Service Dollars	
Application Printing	$0.03
Envelope for Mailing Application	$0.16
Postage for Mailing Application	$0.34
Printing of Certificate of Authority	$0.05
Postage for Mailing registration	$0.34
Total Per Applicant:	$0.92

Total Expense and Equipment Costs: $1,872.20

IV. ASSUMPTION

1. Based on FY04 actuals and FY05 projections, the board anticipates 1,118 corporation applications will be received biennially.
2. Employee's salaries were calculated using their annual salary multiplied by 40.47% for fringe benefits and then were divided by 2080 hours per year to determine the hourly salary. The hourly salary was then divided by 60 minutes to determine the cost per minute. The cost per minute was then multiplied by the amount of time the Licensure Technician II spent on the processing of the application. The total cost was based on the cost per request multiplied by the estimated number of requests received on an annual basis.
3. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

NOTE: The public fiscal note for this rule only reflects the cost for this particular process. However, private entity fees are set at an amount to cover the total actual cost incurred by the board, which includes personal service, expense and equipment and transfers.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 30 - Missouri Board for Architects, Professional Engineers, Professional Land Surveyors and Landscape Architects

Chapter 10 - Corporations

Proposed Rule - 4 CSR 30-10.010 Application for Certificate of Authority

Prepared March 29, 2005 by the Division of Professional Registration

Annual

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the rule by affected entities:
171	Applicants (corporation application fee @ $300)	$51,300.00
171	Applicants (postage @ $.37)	$63.27
472	Corporations (corporation renewal fee @ $200)	$94,400.00
472	Corporations (postage @ $.37)	$174.64
	Estimated Annual Cost of Compliance for the Life of the Rule	**$145,937.91**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The figures above are based on FY04 actuals.
2. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee

NOTE: The board is statutorily obligated to enforce and administer the provisions of Chapter 326, RSMo. Pursuant to Section 326.319, RSMo, the board shall by rule and regulation set the amount of fees authorized by Chapter 326, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of Chapter 326, RSMo. This proposed amendment is necessary because the board's projected revenue will not support the expenditures necessary to enforce and administer the provisions of Chapter 326, RSMo, which will result in an endangerment to the health, welfare, and safety of the public.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 30—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 21—Professional Engineering

PROPOSED RULE

4 CSR 30-21.010 Design of Fire Suppression Systems

PURPOSE: This rule requires the design of fire suppression systems to be designed, prepared, and sealed by a professional engineer.

(1) Pursuant to section 327.181, RSMo the design of fire suppression systems is engineering and therefore the plans for those systems must be designed, prepared, and sealed by a professional engineer. This can be accomplished two (2) ways:

(A) The design engineer seals the construction documents that specify the design and criteria for the fire suppression system, including sprinklers, fire alarms, and other suppression systems. The layout and sizing of these systems, done by a Level III Technician certified by the National Institute for Certification in Engineering Technologies (NICET) or a professional engineer, can be submitted as a shop drawing. These shop drawings may be sealed by a professional engineer. The design engineer must review and approve the shop drawings for compliance with the design and specifications shown on the construction documents; and

(B) If there is no design engineer for the fire suppression system, then the shop drawings for the sprinklers, fire alarms, and other suppression systems must be designed and prepared under the immediate personal supervision of a professional engineer. These shop drawings must be sealed by the professional engineer who prepared them.

(2) Nothing in this section shall prohibit the design engineer, at his/her discretion, to specify and require the shop drawings to be designed, prepared, and sealed, by a professional engineer.

AUTHORITY: section 327.041, RSMo Supp. 2004. Original rule filed May 13, 2005.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via e-mail at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 40—Office of Athletics
Chapter 3—Ticket Procedures

PROPOSED RESCISSION

4 CSR 40-3.011 Tickets and Taxes. This rule defined the procedures for printing, selling and counting tickets.

AUTHORITY: section 317.006, RSMo 2000. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: Filed March 2, 1989, effective May 11, 1989. Amended: Filed July 25, 1994, effective Jan. 29, 1995. Rescinded and readopted: Filed Nov. 15, 2001, effective May 30, 2002. Rescinded: Filed May 13, 2005.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573)751-5649 or via e-mail at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 40—Office of Athletics
Chapter 3—Ticket Procedures

PROPOSED RULE

4 CSR 40-3.011 Tickets and Taxes

PURPOSE: This rule defines the procedures for printing, selling and counting tickets.

(1) The right of admission to a contest of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate shall not be sold or otherwise granted to a person or entity unless that person or entity is provided with a ticket.

(2) The promoter of a contest of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate shall:

(A) Prepare an inventory that identifies all tickets that were printed for the contest and that accounts for any tickets that are overprints, changes or extras;

(B) Sign the inventory acknowledging that the inventory is true and correct;

(C) Send the inventory to the office with the permit application; and

(D) Submit with the permit application, a copy of the contract if the event was sold in part or in whole by means of a contract or other agreement for a contracted or otherwise agreed amount on partial sale and/or a contracted amount.

(3) Every ticket shall have the price, the name of the promoter and the date of the contest.

(4) A notice specifying a change in ticket prices or the dates of a contest or a notice specifying an amendment to the contract value of a contest of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate shall be made in writing to the office within ten (10) business days of the event. The promoter shall obtain prior approval from the office for any date changes for the contest.

(5) A promoter shall not issue complimentary tickets for more than four percent (4%) of the seats in the house without the office's written authorization. The promoter shall be responsible to pay the athletic tax prescribed in section 317.006.1(3), RSMo, for all complimentary tickets over and above the four percent (4%) maximum cap on complimentary tickets. If the office approves the issuance of complimentary tickets over and above the four percent (4%) cap, the complimentary tickets that are exempt from the athletic tax shall be based on the lowest value complimentary tickets distributed. All complimentary tickets must indicate on the ticket that it is a complimentary ticket and its value had the ticket actually been purchased.

(6) A promoter shall be assessed the athletic tax prescribed in section 317.006.1(3), RSMo, for any complimentary ticket that the office allows to be distributed over the four percent (4%) maximum cap. The face value of the complimentary tickets over the four percent (4%) maximum cap shall be the same as other like tickets sold in that particular section of the venue.

(7) Each promoter shall provide a ticket and/or credential without charge to:
(A) Licensed contestants, seconds and managers who are engaged in a bout which is part of the contest of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate; and
(B) Journalists who are performing his/her duties as such. Each ticket issued to a journalist must be clearly marked "PRESS." No more tickets may be issued to journalists than will permit seating in the press area.

(8) Notwithstanding other provisions of law in this regulation, the promoter of a contest of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate shall admit to such contest the division director, executive director, administrator, and inspectors of the office, or authorized firefighters, police officers, security officers and any other individuals authorized by the office assigned to work the event, any referee, judge, timekeeper, ringside physician, and medical personnel who are independent contractors of the office who are assigned to the event and who presents photo identification and an official badge or other credential evidencing such status. The promoter of a contest and officials of the venue shall allow a person listed in this section full access to the site of the contest and dressing rooms.

(9) Tickets of different prices shall be printed on cardstock of distinctly different colors. The ticket stub shall indicate the price of the ticket.

(10) The inspector shall have supervision over the sale of tickets, ticket boxes and entrances and exits for the purpose of checking admission controls. All ticket stubs collected by a ticket taker shall be deposited in a lock box provided by the office or other containers approved by the office. The inspector shall ensure that all tickets are counted and that the final accounting includes the number of complimentary tickets, the face value of each ticket and the total number of each ticket price category sold and the gross receipts from all ticket sales.

(11) The final accounting shall be completed. The final accounting shall include the amount of tax due from the promoter to the office.

(12) Any promoter holding a license and permit under these rules shall pay the office five percent (5%) of its gross receipts, less state, county and city taxes, derived from admission charges. The gross receipts shall be the amount received from the face value of all tickets sold, any complimentary tickets redeemed in excess of the four percent (4%) cap, and the value of any contracted amount, if applicable.

(13) The promoter is liable for payment of the athletic tax prescribed in section 317.006.1(3), RSMo, based upon the gross receipts. Such payment shall be made within ten (10) days of the event or two (2) days prior to the promoter's next scheduled event in Missouri, whichever occurs first.

(14) The office's executive director, administrator or their designee shall collect all fees and taxes due.

AUTHORITY: section 317.006, RSMo 2000. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: FIled March 2, 1989, effective May 11, 1989. Amended: Filed July 25, 1994, effective Jan. 29, 1995. Rescinded and readopted: Filed Nov. 15, 2001, effective May 30, 2002. Rescinded and readopted: Filed May 13, 2005.

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

PRIVATE COST: This proposed rule will cost private entities approximately eight thousand five hundred dollars ($8,500) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-5649 or via e-mail at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development
Division 40 - Division of Professional Registration/Office of Athletics
Chapter 3 -Ticket Procedures
Proposed Rule - 4 CSR 40-3.011 Ticket and Taxes
Prepared March 16, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated annual cost of compliance with the amendment by affected entities:
171	Promoter - Athletic Event Tickets (printing tickets @ $50/per event)	$8,550
	Estimated Annual Cost of Compliance for the Life of the Rule	**$8,550**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The reported figures are based on actual figures from FY04 and projected figures in FY05.
2. Pursuant to section 317.006, the office shall assess a tax of five percent of the gross receipts derived from admission charges connected with the holding of any professional boxing, sparring, professional wrestling, professional kickboxing or professional full-contact karate contest in this state. The costs associated with this athletic tax was outlined in the legislative fiscal note that accompanied Senate Bill 524 (1996).
3. The total costs will recur each year for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 40—Office of Athletics
Chapter 4—Licensees and Their Responsibilities

PROPOSED RESCISSION

4 CSR 40-4.090 Contestants. This rule defined and clarified the duties and responsibilities of contestants.

PURPOSE: This rule is being rescinded and readopted to clarify the duties and responsibilities of contestants.

AUTHORITY: sections 317.006 and 317.015, RSMo 2000. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: Filed March 2, 1989, effective May 11, 1989. Amended: Filed Nov. 15, 2001, effective May 30, 2002. Rescinded: Filed May 13, 2005.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-5649 or via e-mail at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 40—Office of Athletics
Chapter 4—Licensees and Their Responsibilities

PROPOSED RULE

4 CSR 40-4.090 Contestants

PURPOSE: This rule outlines the procedures for applying for and renewal of a license and clarifies the duties and responsibilities of contestants.

(1) An applicant applying for a license as a contestant shall:

(A) Complete an application as required in section (2) of 4 CSR 40-2.011. Any person who provides incorrect information in an application for license as a contestant may be disciplined by the office;

(B) Be at least sixteen (16) years of age;

(C) Submit a signed notarized affidavit from their legal guardian approving them to participate in a contest if he/she is under the age of eighteen (18);

(D) Disclose in writing on a form provided by the office a complete medical history including any prior or existing medical conditions;

(E) Within thirty (30) days of application for licensure successfully complete a physical examination by physician with the designation "medical doctor" or "doctor of osteopathy" and submit a written statement from the physician attesting to the physical and mental health of the applicant. The office may increase the thirty (30)-day limit under special circumstances approved by the office; and

(F) Submit a certified copy of medical tests performed by a certified laboratory verifying the applicant is not infected with the human immunodeficiency virus (HIV) or hepatitis B or C virus. The medical tests shall not be dated more than ninety (90) days before the application is submitted.

(2) A contestant applying for renewal of a license:

(A) Complete an application as required in section (2) of 4 CSR 40-2.011. Any person who provides incorrect information in an application for license as a contestant may be disciplined by the office;

(B) Disclose in writing on a form provided by the office a complete medical history including any prior or existing medical conditions;

(C) Within thirty (30) days of application for licensure successfully complete a physical examination by physician with the designation "medical doctor" or "doctor of osteopathy" and submit a written statement from the physician attesting to the physical and mental health of the licensee. The office may increase the thirty (30)-day limit under special circumstances approved by the office; and

(D) Submit a certified copy of medical tests performed by a certified laboratory verifying the licensee is not infected with the human immunodeficiency virus (HIV) or hepatitis B or C virus. The medical tests shall not be dated more than ninety (90) days before the application is submitted.

(3) An applicant or contestant who does not pass the physical examination or receives positive results from any of the tests required in sections (1) and (2) shall be denied the right to fight for that bout.

(4) All fees involved with medical examinations and/or tests required in sections (1) and (2), in addition to any drug test required in section (11), shall be the responsibility of the promoter, contestant or applicant.

(5) Submit a written statement from a physician with the designation "medical doctor" or "doctor of osteopathy" verifying a negative pregnancy if the applicant is female. The test shall be within seven (7) days of the scheduled contest.

(6) The office will issue an identification card to each boxing contestant for the purpose of registration pursuant to the Professional Boxing Safety Act of 1996, 15 U.S.C. section 6301 et seq., to each boxer who so applies. The boxer shall provide a recent photograph for the identification card and any other information that is requested by the office. An identification card may not be substituted for the license to engage in boxing held by the boxer.

(7) Each contestant for professional boxing, professional kickboxing or professional full-contact karate must be weighed in the presence of the public, his/her opponent, a representative of the office and an official representing the promoter, on scales approved by the office at any place designated by the office. If a contestant cannot be present at the designated time set by the office, a contestant shall waive his/her rights under this section.

(8) The contestant for professional boxing, professional kickboxing or professional full-contact karate must have all weights stripped from his/her body before he/she is weighed in, but male contestants may wear shorts. Female contestants may wear shorts and a sports bra.

(9) The office may require contestants to be weighed more than once for any cause deemed sufficient to the office.

(10) Immediately preceding the contest, at a time designated by the office, all contestants must pass a physical examination given by a physician licensed by the office, in accordance with the office's rules and regulations. A contestant who does not pass the physical examination shall be denied the right to fight for that bout.

(11) The office may require a contestant to submit to a drug test. Failure to submit to a drug test upon notification by an inspector may result in disciplinary action being taken against the contestant's license.

(12) A contestant licensed by the office may be required to submit to any medical examination or test ordered by the office prior to participation in a bout.

(13) A boxing contestant shall present his/her identification card to the office representative at weigh-in for a bout and at any other time ordered by the office or its representative. Failure to possess the card shall result in the boxing contestant being disallowed to participate in a bout.

(14) A boxing contestant licensed by the office is subject to disciplinary action by the office if the contestant knowingly:

(A) Provides false information for an identification card or falsifies or attempts to falsify an identification card, or aids in such acts;

(B) Uses or attempts to use an identification card in an unlawful manner or in a manner that is not in the best interests of professional boxing; or

(C) Otherwise violates the provisions of this section.

(15) Each contestant must report to the representative of the office in charge of dressing rooms at least thirty (30) minutes before the scheduled time of the first bout of professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate contest. Failure to do so may result in the contestant being disallowed to participate in the bout.

(16) Contestants shall at all times abide by the statutes and rules of Missouri governing professional boxing, professional wrestling, professional kickboxing or professional full-contact karate.

(17) Contestants shall at all times observe the directions and decisions of all officials.

(18) A contestant of boxing may not have a promoter or any of its members, stockholders, officials, matchmakers or assistant matchmakers—

(A) Act directly or indirectly as his/her manager; or

(B) Hold any financial interest in his/her management or his/her earnings from each contest.

(19) Contestants for professional wrestling shall include anyone participating in any wrestling activities whether inside or outside the ring during a contest.

(20) The belt of the trunks must not extend above the waist line.

(21) Each boxing, full-contact karate or martial arts contestant must wear:

(A) A mouthpiece which has been individually fitted; and

(B) An abdominal protector which will protect him against injury from a foul blow.

(22) Each contestant must be clean and present a tidy appearance.

(23) The excessive use of petroleum jelly shall not be used on the face or body of a contestant. The referees or the office's representative in charge shall cause any excessive petroleum jelly to be removed.

(24) The office's representative shall determine whether head and facial hair presents any hazard to the safety of the contestant or his/her opponent or would interfere with the supervision and conduct of the bout. If the head and facial hair of the contestant present such a hazard or would interfere with the supervision and conduct of the bout, the contestant shall not compete in the bout unless the circumstances creating the hazard or potential interference are corrected to the satisfaction of the office's representative.

(25) A contestant may not wear any jewelry or other piercing accessories while competing in a bout.

(26) The office may honor the suspension of a contestant by an agency that regulates professional boxing, professional wrestling, professional kickboxing, and professional full-contact karate in another jurisdiction if the suspension is ordered for:

(A) Medical safety;

(B) A violation of a law or regulation governing professional boxing, professional kickboxing, and professional full-contact karate which also exists in this state; or

(C) Any other conduct which discredits professional boxing, professional kickboxing, and professional full-contact karate, as determined by the office.

AUTHORITY: sections 317.006 and 317.015, RSMo 2000. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: Filed March 2, 1999, effective May 11, 1989. Amended: Filed Nov. 15, 2001, effective May 30, 2002. Rescinded and readopted: Filed May 13, 2005.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately five hundred seventy dollars and seventy-five cents ($570.75) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed rule will cost private entities approximately forty thousand seven hundred forty-six dollars ($40,746) annually and approximately one hundred eight thousand seven hundred fifty-six dollars ($108,756) biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-5649 or via e-mail at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 40 - Office of Athletics

Chapter 4 - Licensees and Their Responsibilities

Proposed Amendment - 4 CSR 40-4.090 Contestants

Prepared March 16, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Annual Cost of Compliance
Office of Athletics	$570.75
Total Annual Cost of Compliance for the Life of the Rule	**$570.75**

III. WORKSHEET

1. CALCULATION OF EXPENSE AND EQUIPMENT AND PERSONAL SERVICE COSTS:

The board anitipcates the staff will perform the following duties:

Licensure Technician II - Reviews application for completeness, updates division's licensing system, prepares and sends follow up letters, follows up with applicant for any additional information needed, responds to telephone inquiries, processes all documentation, prepares flow sheet for board review, prepares file for board review, updates divsion's licensing system after board review, and issues the license.

Clerk IV - Prepares decision letter for executive review and approval, prints seal application, prints wall hanging license, copies letter and wall hanging license for file, and mails licensure documentation to license.

Executive Director - Reviews file prior to board review and prepares and reviews decision letter.

Salaries for the staff are shared with other boards within the division. The figures below represent the personal service costs supported by the State Board of Chiropractic Examiners.

Employee's salaries were calculated using their annual salary multiplied by 40.77% for fringe benefits and then were divided by 2080 hours per year to determine the hourly salary. The hourly salary was then divided by 60 minutes to determine the cost per minute. The cost per minute was then multiplied by the amount of time individual staff spent on the processing of applications. The total cost was based on the cost per application multiplied by the estimated number of applications.

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	TIME PER APPLICATION	COST PER APPLICATION	TOTAL COST
Executive Director	$51,300	$72,215.01	$34.72	15 minutes	$8.68	$130.20
Clerk IV	$28,740	$40,457.30	$19.45	15 minutes	$4.86	$72.90
Licensure Technican II	$24,144	$33,987.51	$16.34	90 minutes	$24.51	$367.65

IV. ASSUMPTIONS

1. In the event inadequate information is submitted, it may be necessary for the board to review an application but it is not anticipated.
2. The board does not anticipate any growth in the number of applications received each year.
3. The total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

NOTE: The public fiscal note for this rule only reflects the cost for this particular process. However, private entity fees are set at an amount to cover the total actual cost incurred by the board, which includes personal service, expense and equipment and transfers.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 145 - Missouri Board of Geologist Registration

Chapter 2 - Licensure Requirements

Proposed Amendment - 4 CSR 40-4.090 Contestants

Prepared February 18, 2005 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Annual Cost

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated annual cost of compliance with the amendment by affected entities:
237	Contestant Applicants (Physical Examination @ $50)	$11,850
237	Contestant Applicants (Medical Tests @ $108)	$25,596
66	Female Contestant Applicants (Pregnancy Test @ $20)	$3,300
	Estimated Annual Cost of Compliance for the Life of the Rule	**$40,746**

Biennial Cost

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated biennial cost of compliance with the amendment by affected entities:
1,007	Contestants (Physical Examination @ $50)	$50,350
1,007	Contestants (Medical Tests @ $108)	$108,756
	Estimated Biennial Cost of Compliance for the Life of the Rule	**$108,756**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The above figures were based on FY04 actuals and FY05 projections. The board estimates approximately 142 boxing, 1 marital arts and 94 wrestling applicants will apply for licensure annually. The board further estimates that approximately 633 wrestling, 8 marital arts, and 368 boxing contestants will apply for licensure renewal biennially.

2. The board does not anticipate any growth in the number of applications received each year.
3. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 40—Office of Athletics
Chapter 5—Inspector Duties and Rules for Professional Boxing, Professional Wrestling, Professional Kickboxing and Professional Full-Contact Karate

PROPOSED AMENDMENT

4 CSR 40-5.030 Rules for Professional Wrestling. The division is proposing to amend section (1), delete sections (2)–(4) and (6) and renumber the remaining sections appropriately.

PURPOSE: This rule is being amended as a result of the rescission and readoption of 4 CSR 40-4.090.

(1) *[All professional wrestling contests shall be subject to the laws and regulations governing professional wrestling.]* The promoter shall be liable for ensuring that all statutes and rules promulgated by the office are strictly observed and carried out, including using only licensed individuals at all contests.

[(2) A person may not be issued a license to wrestle by the office if s/he is under sixteen (16) years of age. An applicant for a license as a wrestler must be in writing on a form furnished by the office. Any person who gives incorrect information in an application for license as a wrestler may be disciplined by the office.
(A) A wrestler who is under the age of eighteen (18) years of age, must have a signed notarized affidavit from their legal guardian approving them to participate as a wrestling contestant.

(3) Any wrestler applying for a license or renewal first must be examined by a physician licensed with the designation of "medical doctor" or "doctor of osteopathy" to establish physical fitness. The office may order the examination of any wrestler at any time to determine whether the wrestler is fit and qualified to engage in further contests. The professional wrestler must successfully complete an annual physical examination by a physician of the wrestler's choice within thirty (30) days of application for initial licensure and within thirty (30) days of application for license renewal, the office may increase the thirty (30)-day limit under special circumstances approved by the office. A wrestler who has applied for a license to engage in professional wrestling, or a wrestler who has applied for renewal of his/her license must:
(A) Provide with his/her application an original or certified copy of the results of the following medical tests performed by a certified laboratory no earlier than one hundred eighty (180) days before the application is submitted, which shall:
1. Verify that the contestant is not infected with the human immunodeficiency virus (HIV); and
2. Verify that the contestant is not infected with the hepatitis B or C virus. The office may require a wrestler to submit to additional medical testing as deemed necessary.

(4) The office may require:
(A) A contestant to undergo a drug test. All fees involved with drug tests are the responsibility of the promoter or contestant. A positive reading may result in the suspension or discipline of a license.
(B) The promoter to have a licensed "medical doctor" or "doctor of osteopathy" and/or ambulance present at the contest, as deemed necessary.]

[(5)] **(2)** The referee and/or the office shall decide all questions arising out of a contest not specifically covered by the statutes and these rules. In all other respects, wrestling shall be subject to the statutes and rules governing this sport.

[(6) Wrestlers shall appear at the location of the event at least one (1) hour before the scheduled contest begins.]

[(7)] **(3)** Wrestler's Equipment.
(A) A wrestler shall be clothed in clean apparel.
(B) A wrestler may wear two (2) pair of trunks, one (1) over the other.
(C) If a wrestler wears shoes, they shall be fitted with soft tops, soft smooth soles, soft laces and equipped with eyelets only.
(D) A wrestler may not have any grease, lotion, or foreign substances on the body.
(E) A female wrestler must wear trunks and a top.
(F) The inspector present at the event may disallow the use of inappropriate attire or disqualify a wrestling participant for the lack of appropriate attire.

[(8)] **(4)** Contestants shall have their fingernails trimmed closely.

[(9)] **(5)** Ring Barrier.
(A) A ring shall be enclosed within a barrier which shall be erected between the ring and the seating area in the arena.
(B) The barrier shall be at least:
1. Six feet (6') away from the ring; and
2. Four feet (4') away from the first row of the seating area.
(C) The ring barrier shall conform to the following requirements:
1. Be constructed of metal or other shatterproof material;
2. Be designed to prevent a wrestler from exiting through the barrier into the seating area during a contest;
3. Be built to a height of at least forty-two inches (42") from the floor of the arena; and
4. Be stable.
(D) The ring barrier shall be approved by the office or the office's representative before its use during a contest.

[(10)] **(6)** Time Limits.
(A) A wrestling match shall have a maximum time limit of sixty (60) minutes.
(B) The office may authorize any other time limit.

[(11)] **(7)** A timekeeper shall begin the beginning of the time limit of a contest upon the referee's signal and shall sound the bell at the referee's command.

[(12)] **(8)** Conduct of Wrestling Contest.
(A) A wrestling contest shall be determined by:
1. One (1) fall; or
2. Two (2) out of three (3) falls.

[(13)] **(9)** Scoring a Fall.
(A) A fall is scored by a wrestler when the wrestler's opponent has both shoulders touching the mat for a count of three (3) seconds.
(B) The referee shall signal the wrestler scoring a fall by immediately slapping the mat.

[(14)] **(10)** Breaking.
(A) A wrestler:
1. Shall break a hold when instructed by the referee;
2. Failing to break upon instruction by the referee, the offending contestant shall be given a count of ten (10) to release the hold; and
3. Failing to release the hold after the count of ten (10), the offending contestant shall be disqualified and the opponent shall be awarded the match by the referee.

[(15)] **(11)** When any part of a contestant's body is touching the ropes or is outside the ropes or if, in the judgment of the referee, the contestant is no longer able to properly protect him/herself, the referee shall call time and the contestants at once shall release any holds and return to the center of the ring to standing positions and resume the bout.

[(16)] **(12)** Prohibited Activities.
(A) The following actions are prohibited:
1. Inhibiting breathing by covering the nose and mouth at the same time; and
2. Unsportsmanlike or physically dangerous conduct.
(B) A wrestler continuing to engage in prohibited activities after sufficient warning may be disqualified by the referee.
(C) No wrestling contestant shall use a foreign object(s) or prop(s) with the deliberate intent to lacerate himself or herself, or one's opponent. No animal blood or human blood, other than that of the wrestling contestants that is incidentally introduced during a match, may be used as a prop or special effect in any wrestling match. Vials, capsules or any vessel containing a gel substance appearing to be or simulating blood may be used as a prop or special effect during a wrestling contest so long as the container cannot cause lacerations upon breakage. The intent to use a foreign object(s) or prop(s) during a wrestling match must be disclosed to the office prior to any wrestling contest and shall be subject to the approval of the inspector present at the event. This shall include any vial, capsule or container holding a gel substance that is meant to simulate blood.

[(17)] **(13)** Refusal or Inability to Continue.
(A) If a wrestler refuses or is physically unable to continue a match, the match shall be ended and the decision awarded to the wrestler's opponent.

[(18)] **(14)** Tag Team Wrestling.
(A) "Tag Team Wrestling" means a contest between two (2) teams each composed of two (2) or more wrestlers.
(B) The time limit for this type of contest shall be a maximum of sixty (60) minutes.
(C) A team shall be awarded a fall when a member of the team scores a fall against a member of the opposing team.
(D) A two (2)-minute rest period may be permitted between falls.
(E) A tag team contest shall be conducted as follows:
1. The contest shall begin with one (1) wrestler from each team inside the ring while the respective partners remain outside the ring on the apron;
2. The wrestler(s) outside the ring may not enter the ring unless a fall is scored or his/her partner has tagged his/her hand;
3. In order to be eligible to receive a tag, the wrestler's partner shall be outside the ring on the apron in the proper corner with both feet on the ring apron and only receive the tag over the top ring rope;
4. When the tag is made, the wrestler making the tag shall leave the ring as the partner enters the ring;
5. Only two (2) wrestlers from opposing teams shall be permitted to be in the ring at any one (1) time;
6. After the scoring of a fall a wrestler may relieve the partner;
7. If a wrestler is unable to continue, the wrestler's partner shall continue the contest alone;
8. The referee may call time after an injury to permit the injured wrestler to be removed from the ring; and
9. Release the rope provided in the team corner until officially tagged by the partner.

[(19)] **(15)** The referee shall warn a team of any prohibited conduct and may disqualify a team for persisting in prohibited conduct after a warning.

[(20)] **(16)** A wrestler may have a second who:
(A) Shall remain in the wrestler's corner outside the ring enclosure; and
(B) The referee may immediately eject from the ring area any second engaging in prohibited activities after sufficient warning.

[(21)] **(17)** Referee.
(A) The referee shall have the authority to conduct the contest and enforce the regulations of the office;
(B) The referee's decision on any matter, whether arising under these regulations or not, shall be final; and
(C) Referees assigned to officiate a contest shall:
1. Be properly attired thirty (30) minutes before the scheduled time of the opening contest; and
2. Remain attired and available until all matches have been concluded.

[(22)] **(18)** Responsibility of Promoter.
(A) A promoter shall be responsible to the office for the conduct of its representatives and employees, including officials and contestants affiliated with the event.
(B) The promoter shall be responsible for conducting the wrestling contest in a safe, peaceable, and orderly fashion.
(C) Violation of the office's regulations by a representative or employee of the promoter, including officials and contestants affiliated with the event, may be grounds for disciplinary action against the promoter.

AUTHORITY: sections 317.006 and 317.015, RSMo 2000. Original rule filed April 30, 1982, effective Sept. 11, 1982. Rescinded and readopted: Filed March 2, 1989, effective May 11, 1989. Rescinded and readopted: Filed Nov. 15, 2001, effective May 30, 2002. Amended: Filed July 1, 2004, effective Oct. 30, 2004. Amended: Filed May 13, 2005.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of Athletics, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-5649 or via e-mail at athletic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 195—Division of Job Development and Training
Chapter 3—General Rules, Missouri Community College New Jobs Training Program

PROPOSED RESCISSION

4 CSR 195-3.010 New Jobs Training Program. This rule established guidelines for program coordination and project evaluation of the Missouri Community College New Jobs Training Program.

PURPOSE: This rule is being rescinded in order to be readopted (also under 4 CSR 195-3.010) to include updated language and fiscal information.

AUTHORITY: section 178.895, RSMo Supp. 1995. Original rule filed Dec. 16, 1988, effective April 27, 1989. Amended: Filed Oct.

16, 1990, effective March 14, 1991. Amended: Filed July 29, 1994, effective Feb. 26, 1995. Amended: Filed May 14, 1996, effective Dec. 30, 1996. Amended: Filed Nov. 1, 1996, effective May 30, 1997. Rescinded: Filed May 16, 2005.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Economic Development, Division of Workforce Development, Amy Deem, Assistant Director, 421 East Dunklin, PO Box 1087, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 195—Division of Workforce Development
Chapter 3—Missouri Bond-Funded Industry Training Programs

PROPOSED RULE

4 CSR 195-3.010 New Jobs Training Program

PURPOSE: The Department of Economic Development, Division of Workforce Development, has the responsibility to coordinate the Missouri Community College New Jobs Training Program, approve company eligibility, and evaluate the project within the overall job training efforts of the state to ensure that the project will not duplicate other job training programs. This rule establishes guidelines for program coordination and project evaluation.

(1) Administrative responsibilities for the Missouri Community College New Jobs Training Program shall be divided between the Division of Workforce Development (DWD), the Missouri Department of Revenue (DOR) and any Missouri community college district participating in the New Jobs Training Program.

(A) DWD shall review potential projects for nonduplication with known state and federally subsidized training programs.

1. A project will be considered as nonduplicative if subsidies from separate sources are not concurrently received to fund training for the same employee in the same training activity or cost as described in 4 CSR 195-3.010(4).

2. Separate training activities or costs for the same employee but subsidized by different sources shall not be considered as duplicative whether concurrent or not.

(B) DWD shall review potential projects for company eligibility in accordance with section 178.892, RSMo.

(C) DWD shall disburse monies from the Missouri Community College Job Training Program Fund pursuant to requirements stipulated in section 178.896, RSMo.

(D) DOR shall make deposits to the Missouri Community College Job Training Program Fund from the new jobs credit from withholding claims by employers participating in the Missouri Community College New Jobs Training Program.

(E) DOR shall notify DWD, on a monthly basis, of—

1. The total balance of the Missouri Community College Job Training Program Fund; and

2. The total contribution to that fund by, or on the behalf of, each participating employer, and the proportion of each employer's contribution to the total fund balance.

(F) DWD will generate a monthly report that tracks expenditures relative to the annual appropriation and provide this report, as well as information provided by DOR, to the community college districts.

(G) Any Missouri community college district participating in the Missouri Community College New Jobs Training Program shall bear responsibility for—

1. Determining of training eligibility for participation in the Missouri Community College New Jobs Training Program;

2. Monitoring each training project to ensure that funds are used in accordance with the training agreement;

3. Providing a quarterly report to be received by DWD no later than thirty (30) calendar days after the quarterly ending date. This report, for each new jobs training project, shall include the total amount of certificates sold, the total amount of certificates retired, and the remaining balance of outstanding certificates sold. If the total amount of the outstanding certificates sold by the community college districts nears the twenty (20) million dollar limit, DWD may request that the community college districts provide a report to DWD on a monthly basis.

4. Including an annual financial audit that contains each project's Missouri Community Colleges New Jobs Training Program Activities as part of the regular audit of the community college district. This responsibility shall include:

A. Review of the audit;

B. Resolution of any management findings and questioned and disallowed costs; and

C. A reasonable attempt to collect disallowed costs resulting therefrom;

5. Identifying any balances in the special funds and accounts for each project;

6. Notifying the employer, DWD and DOR when the new jobs credit from withholding has expired or when the certificate has been retired;

7. Submitting to DOR any excess funds in accordance with 4 CSR 195-3.010(21); and

8. Complying with all other requirements identified pursuant to sections 178.892–178.896, RSMo and 4 CSR 195-3.010.

(2) DWD bears no responsibility for any disallowed costs determined in the annual audit of the community college district or collection from it.

(3) The new jobs training program provides assistance to eligible new or expanding industries through training projects established by a Missouri community college district that will provide education and training of workers for new jobs, pursuant to requirements in sections 178.892–178.896, RSMo.

(A) A new industry is an employer who initiates production, research and development or service subsequent to, or one hundred eighty (180) days prior to, the date the notification of intent to submit a Missouri Community College New Jobs Training Program Application is received by DWD.

(B) A change of ownership of an industry currently operating within the state is not a new industry but is an expanding industry if new jobs are created.

(C) An expanding industry is an existing employer that creates new jobs.

(D) New jobs are those positions newly created by a new or expanding industry or employer as follows:

1. A new job is not a job intended to replace a current job;

2. A new job is not a job created to replace or supplant the job of an existing employee engaged in an authorized work stoppage; or

3. A new job includes a job that was created by the employer during a period of time that does not precede one hundred eighty (180) days prior to the date DWD receives a notification of intent to submit a Missouri Community College New Jobs Training Program Application from a community college district.

(E) The terms New Jobs Training Program and Missouri Community College Job Training Program are synonymous and interchangeable with the term Missouri Community College New Jobs Training Program.

(4) Assistance is available for all necessary and incidental costs of providing New Jobs Training Program services for new and existing employees directly affected by the expansion that may include, but are not limited to:

(A) New jobs training that allows employees in newly created jobs to acquire, refine and improve the level of their occupational skills in order to perform the requirements of their particular job in a more proficient and effective manner;

(B) Basic skills and job-related instructional costs, including wages and fringe benefits of instructors, who may or may not be employees of the industry or employer and training development costs, including the cost of training of instructors;

(C) Activities designed to assess the skills or aptitudes of individuals applying for employment in the newly created jobs designated to receive training assistance through the program;

(D) Training facilities;

(E) The cost of a facility used in training and subsequently used in production shall be prorated to the project in that proportion chargeable to the training program with the remaining facility cost being the responsibility of the industry or employer;

(F) Training Equipment.

1. Training equipment shall be leased, purchased, maintained and disposed of in accordance with established policies and procedures and training standards of the community college district.

2. The community college district shall retain inventory and disposition records of all training equipment purchased for a project.

3. The cost of equipment used in training and subsequently used in production shall be prorated to the project in that proportion chargeable to the training program with the remaining equipment cost being the responsibility of the industry or employer.

4. Title of that equipment shall be vested with the community college district until disposed of by the community college district;

(G) Training Materials and Supplies.

1. Training materials and supplies shall be defined and purchased in accordance with established policies and procedures and training standards of the community college district.

2. The cost of materials and supplies used in training which are subsequently used in production shall be prorated to the project in that proportion chargeable to the training program and the remainder of the cost of materials and supplies will be the responsibility of the industry or employer;

(H) On-the-Job Training (OJT).

1. OJT is on-site training provided to an employee engaged in productive work.

2. Payments for OJT will not exceed the average of fifty percent (50%) of the total wages paid to each participant during the training period. Payment for OJT may continue for up to six (6) months after the placement of the participant in the new job.

3. OJT payments for a new job may not be paid to an employer who is receiving other sources of funds to provide OJT for the same new job when the costs would result in the employer receiving more than fifty percent (50%) of the total wages for each OJT trainee during training.

4. The maximum amount of OJT cannot exceed fifty percent (50%) of the total training project;

(I) Administrative expenses or costs shall include:

1. All costs directly or indirectly associated with the supervision and administration of a training project and also directly associated with New Jobs Training Program activities of an individual community college district, including the negotiation of a training activities proposal with the employer, submission of the training activities proposal and required report, advertising, interviewing and selecting staff for a New Jobs Training Program project, procuring materials and service for a training project, direct clerical support to the training project, and mileage for the travel of administrative and supervisory project staff;

2. The dollar amount expended for administrative expenses or costs shall equal fifteen percent (15%) of the total training costs of a New Jobs Training Program project. Total training costs are the costs of training including:

A. Supplies;

B. Wages and benefits of instructors;

C. Subcontracted services;

D. OJT;

E. Training facilities;

F. Equipment;

G. Skill assessment; and

H. All program services, provided however, that no costs associated with the issuance of certificates shall be included.

(J) Contracted services with state institutions of higher education, private colleges or universities, area career technical schools, other federal, state or local agencies or other professional services shall be procured in the manner provided by the community college district board of trustees.

(K) Issuance of Certificates.

1. Financial institution shall include any bank acting in a fiduciary capacity, any broker/dealer of securities presently registered with the commissioner of securities or any discount bank brokerage service executing an unsolicited order.

2. Sales of certificates issued under these rules, which constitute securities, are subject to the provisions of Chapter 409, RSMo and the rules and orders promulgated under it; and

3. Nothing in these rules precludes reliance on the exemption from securities registration set forth in Chapter 409, RSMo and payment of the principal, of premium, if any, and interest on certificates, including capitalized interest issued to finance a project, and funding and maintenance of a debt service reserve fund to secure those certificates.

(5) The community college district will notify DWD and the Workforce Investment Board (WIB) of its intent to submit a Missouri Community College New Jobs Training Program Application with an eligible industry or employer. This notification will serve to avoid duplication of training and provide opportunity for economically disadvantaged citizens to pursue employment in newly created jobs.

(A) The notification is to be made in writing on forms approved by and available from DWD.

(B) The notification must include, but need not be limited to:

1. The employer's name, telephone number, location, the industry or employer Missouri Integrated Tax System Number and the industry or employer Unemployment Insurance Identification Number, unless these numbers have not yet been assigned to the employer;

2. The tentative dates that training will begin and end;

3. The occupational title and wage or salary for new jobs which will receive training, if known; and

4. The location of the training site(s), if known.

(C) Upon receipt of the notice of intent, DWD will forward a copy to the commissioner of administration.

(D) DWD will accept written comments from the WIB submitted as a result of the community college district's intent to submit a Missouri Community College New Jobs Training Program application, or any subsequent Missouri Community College New Jobs Training Program Application.

1. Comments must be received by DWD prior to approval of the Missouri Community College New Jobs Training Program application.

2. Comments should be restricted to areas relating to duplication with other job training programs that would be caused by the project proposed by the community college district.

(6) DWD will review the notice of intent and determine company eligibility in accordance with section 178.892, RSMo.

(7) The commissioner of administration shall notify DWD within five (5) working days of any concerns regarding the issuance of certificates.

(8) Within ten (10) working days of receipt of the notification, DWD will notify the community college district if DWD is aware of assistance being provided to the employer by other job training programs that are potentially duplicative of the project proposed by the community college district. DWD will also notify the community college district of company ineligibility.

(9) If, within ten (10) working days, the community college does not receive notification from DWD regarding potential duplication with other job training programs, development of the Missouri Community College New Jobs Training Program application may proceed.

(10) The community college district will submit the Missouri Community College New Jobs Training Program application for a project to DWD, the DOR and the WIB on forms approved by and available from DWD.

(A) The Missouri Community College New Jobs Training Program application for a project must be signed by an authorized representative(s) from the community college district and the employer.

(B) The Missouri Community College New Jobs Training Program application for a project must include, but need not be limited to:

1. Any changes in, or additions to, information required to be submitted in the notification of intent to submit a Missouri Community College New Jobs Training application;

2. A description of the new jobs training project, including a description of each type of training program service (basic skills assessment and testing, lease of facilities and equipment, training materials and supplies, on-the-job training, administrative costs and other training and services procured for the employer);

3. Estimated program costs, including deferred costs;

4. Costs of the training project;

5. Estimated costs to issue certificates, such as bond counsel, underwriter's discount, trustees fees, etc.;

6. The time period involved for the project;

7. A description of the intended choice of financing program costs, either new jobs credit from withholding, tuition, student fees or special charges fixed by the community college district board of trustees or a combination of these sources.

A. Descriptions of the funding sources shall be provided in a manner that is clearly identified by the estimated amount and funding source.

B. A separate description of the first one hundred (100) jobs, including job titles, that shall be a part of the training agreement; and

8. A description of any funds that the community college knows the industry or employer has received, is receiving or intends to utilize to subsidize the training required for the newly created jobs that are proposed to be included in the project.

(C) The community college district shall demonstrate how the proposed New Jobs Training Project will not duplicate other job training programs.

(D) Where a collective bargaining agreement exists with the employer for the jobs to be trained through the training agreement, the employer shall send through registered mail, a formal request to the appropriate bargaining agent for written comments on the proposed training project.

1. The request for written comments shall be made through registered mail and shall notify the bargaining agent that if no comments are received within fifteen (15) days, the employer will assume the bargaining agent agrees with the proposed training.

2. The employer shall allow the bargaining agent no fewer than fifteen (15) days to comment on the proposed training.

3. A copy of the request for written comments shall be attached to the Missouri Community College New Jobs Training Program application.

(E) Upon receipt of the application, DWD will forward a copy to the commissioner of administration.

(F) Any Missouri Community College New Jobs Training Program application for a project initiated and operated by one (1) community college district within the boundaries of another community college district or any training project operated by a community college district for an employer creating new jobs in another community college district will require written concurrence from the community college district board of trustees where training will occur or where the new jobs are being created.

(G) The Missouri Community College New Jobs Training Program application for a project shall not be considered complete or acceptable for evaluation until approved and required forms are received by DWD with all required statements completed.

(11) DWD shall evaluate the project which is the subject of the Missouri Community College New Jobs Training Program application to ensure that the project will not duplicate other job training programs.

(12) The commissioner of administration shall notify DWD within nine (9) working days of any concerns about a potential project regarding the issuance of certificates.

(13) Within fourteen (14) working days after receipt of the Missouri Community College New Jobs Training Program application, DWD will notify the community college district of any duplication with other job training programs, training concerns or concerns regarding the issuance of certificates. Upon receipt of notice of duplication with other job training programs, the community college district will modify the Missouri Community College New Jobs Training Program application to eliminate the duplicate job training efforts specified by DWD.

(A) The modified Missouri Community College New Jobs Training Program application shall be submitted to DWD using the procedures specified for submission of the original Missouri Community College New Jobs Training Program application.

(B) DWD shall follow the same procedures followed in review of an original Missouri Community College New Jobs Training Program application to review a modified Missouri Community College New Jobs Training Program application.

(14) Approval of the Missouri Community College New Jobs Training Program application allows the community college district and an employer to enter into an agreement provided there are no significant changes to the application submitted.

(15) The effective date of the training agreement shall be the date of, or subsequent to, the date DWD received notification of intent to submit a Missouri Community College New Jobs Training Program application from the community college district. Program costs can be incurred prior to the effective date of the training agreement but not prior to the effective date of the notice of intent.

(16) An agreement may be for a period not to exceed ten (10) years when the total cost of the project is not in excess of five hundred thousand dollars ($500,000). If the total cost of a project is in excess of five hundred thousand dollars ($500,000), the agreement may be for a period not to exceed eight (8) years.

(17) Upon entering into a training agreement, the community college district shall provide a copy of the agreement to DWD.

(18) During the life of the training agreement, the community college district shall notify DWD and DOR of significant changes in the new jobs training project within fifteen (15) working days of project modification.

(A) Significant changes in a new jobs training project include, but are not limited to:

1. The new jobs that are identified as the first one hundred (100) included in the project;

2. The new jobs credit from withholding required by changes in business or employment conditions; or

3. The type of training to be provided, project cost or any change which shall duplicate any funding being received to train an employee for jobs contained in the training agreement.

(B) Notification must be made with a narrative explanation of changes and a copy of the revised training agreement.

(19) The community college district shall deliver a report to DWD, no later than the first day of October each year, on assistance provided during the previous fiscal year through each new jobs training program agreement.

(20) Notification of Payments and Claims for Credit.

(A) Any taxpayer claiming the Missouri Community College New Jobs Training Credit must acquire, complete and attach Form MO-JTC, provided by DOR to his/her Employers Report of Income Taxes Withheld, Form MO-941, for the last withholding return filed for the reporting period.

(B) Any amount of New Jobs Training Credit which exceeds the amount of withholding tax due shall not be refunded but shall be carried forward and applied to withholding tax liability in subsequent periods.

(C) The New Jobs Training Credit claimed by qualifying employers shall be the sum of the following:

1. The gross wages attributable to the first one hundred (100) qualifying jobs of the job training project multiplied by two and one-half percent (2 1/2%); plus

2. The gross wages attributable to qualifying jobs of the job training project, in excess of the first one hundred (100) qualifying jobs, multiplied by one and one-half percent (1 1/2%); plus

3. Any unused job training credit left over from the previous filing period. That credit amount shall be computed on Form MO-JTC and remitted as withholding tax on Form MO-941.

(D) The DOR shall credit to the Missouri Community College Job Training Program Fund that amount of withholding tax computed by the employer on Form MO-JTC and paid by the employer on Form MO-941.

(21) Any balances held in the community colleges' special funds after all program costs for each project are paid shall be returned to DOR for inclusion in the general revenue fund.

(22) Community college districts shall notify the DOR and the Department of Economic Development within fifteen (15) days after it is determined that payments for job training will no longer be applied against the costs of a qualified project.

(23) The Department of Economic Development shall notify the Legislative Oversight Committee and the community college districts should the total amount of outstanding certificates sold by all community college districts exceed eighteen (18) million dollars. Should the total amount of outstanding certificates sold reach the twenty (20) million dollar limitation, DWD will notify the community college districts and subsequent notice of intents received by DWD will be processed in the order received.

AUTHORITY: section 178.895, RSMo 2000. Original rule filed Dec. 16, 1988, effective April 27, 1989. Amended: Filed Oct. 16, 1990, effective March 14, 1991. Amended: Filed July 29, 1994, effective Feb. 26, 1995. Amended: Filed May 14, 1996, effective Dec. 30, 1996. Amended: Filed Nov. 1, 1996, effective May 30, 1997. Rescinded and readopted: Filed May 16, 2005.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions seven thousand two hundred nineteen dollars ($7,219) annually in the aggregate.

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Economic Development, Division of Workforce Development, Amy Deem, Assistant Director, 421 East Dunklin, PO Box 1087, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	4 CSR 195-3.010 New Jobs Training Program
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Division of Workforce Development	$7,219

III. WORKSHEET

PERSONNEL	FTE	ANNUAL SALARY	SUPPLIES	OTHER	**TOTALS**
Asst. Director/Manager	0.05	$4,242	$0	$0	$4,242
WFD Spec. IV	0.05	$2,685	$0	$0	$2,685
WFD Spec. IV	0.03	$146	$0	$0	$146
WFD Spec. IV	0.03	$146	$0	$0	$146
TOTAL ANNUAL COSTS		**$7,219**	**$0**	**$0**	**$7,219**

IV. ASSUMPTIONS

Costs are based on a pro-rated application of the portion of time (salary, fringe, space, supply) of the affected four staff associated with the program.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 195—Division of Workforce Development
Chapter 3—Missouri Bond-Fund Industry Training Programs

PROPOSED RULE

4 CSR 195-3.020 Job Retention Training Program

PURPOSE: The Department of Economic Development, Division of Workforce Development, has the responsibility to coordinate the Missouri Community College Job Retention Training Program, approve company eligibility, and evaluate the project within the overall job training efforts of the state to ensure that the project will not duplicate other job training programs. This rule establishes guidelines for program coordination and project evaluation.

(1) Administrative responsibilities for the Missouri Community College Job Retention Training Program shall be divided between the Division of Workforce Development (DWD), the Missouri Department of Revenue (DOR), and any Missouri community college district participating in the Job Retention Training Program.

(A) DWD shall review potential projects for nonduplication with known state and federally subsidized training programs.

1. A project will be considered as nonduplicative if subsidies from separate sources are not concurrently received to fund training for the same employee in the same training activity or cost as described in 4 CSR 195-3.020(4).

2. Separate training activities or costs for the same employee but subsidized by different sources shall not be considered as duplicative whether concurrent or not.

(B) DWD shall review potential projects for company eligibility in accordance with sections 178.760–178.764, RSMo.

(C) DWD shall disburse monies from the Missouri Community College Job Retention Training Program Fund pursuant to requirements stipulated in sections 178.760–178.764, RSMo.

(D) DOR shall make deposits to the Missouri Community College Job Retention Training Program Fund from the retained jobs credit from withholding claims by employers participating in the Missouri Community College Job Retention Training Program.

(E) DOR shall notify DWD on a monthly basis of—

1. The total balance of the Missouri Community College Job Retention Training Program Fund; and

2. The total contribution to that fund by, or on behalf of, each participating employer, and the proportion of each employer's contribution to the total fund balance.

(F) DWD will generate a monthly report that tracks expenditures relative to the annual appropriation and provide this report, as well as information provided by DOR, to the community college districts.

(G) Any Missouri community college district participating in the Missouri Community College Job Retention Training Program shall bear the responsibility for—

1. Determining of training eligibility for participation in the Missouri Community College Job Retention Training Program;

2. Monitoring each training project to ensure funds are used in accordance with the training agreement;

3. Providing a quarterly report to be received by DWD no later than thirty (30) calendar days after the quarterly ending date. This report, for each job retention training project, shall include the total amount of certificates sold, the total amount of certificates retired, and the remaining balance of outstanding certificates sold. If the total amount of outstanding certificates sold by the community college districts nears the fifteen (15) million dollar limit, DWD may request that the community college districts provide a report to DWD on a monthly basis;

4. Including an annual financial audit that contains each project's Missouri Community College Job Retention Training Program Activities as part of a regular audit of the community college district. This responsibility shall include:

A. Review of the audit;

B. Resolution of any management findings and questioned and disallowed costs; and

C. A reasonable attempt to collect disallowed costs resulting therefrom;

5. Identifying any balances in the special funds and accounts for each project;

6. Notifying the employer, DWD and DOR when the retained jobs credit from withholding has expired or when the certificate has been retired;

7. Submitting to DOR any excess funds in accordance with 4 CSR 195-3.020(17); and

8. Complying with all other requirements identified pursuant to sections 178.760–178.764, RSMo and 4 CSR 195-3.020.

(2) DWD bears no responsibility for any disallowed costs determined in the annual audit of the community college district or collection from it.

(3) The job retention training program provides assistance to eligible industries through projects established by a Missouri community college district that will provide education and retraining of workers for existing jobs, pursuant to requirements in sections 178.760–178.764, RSMo. An existing job is not one that replaces or supplants another existing job where the employee is engaged in an authorized work stoppage.

(4) Assistance is available for all necessary and incidental costs of providing job retaining program services for existing employees that may include, but are not limited to:

(A) Job retention training that allows employees in existing jobs to acquire, refine and improve the level of their occupational skills in order to perform the requirements of their particular job in a more proficient and effective manner;

(B) Basic skills and job-related instructional costs, including wages and fringe benefits of instructors, who may or may not be employees of the industry or employer and training development costs, including the cost of training of instructors;

(C) Activities designed to assess the skills or aptitudes of individuals in existing jobs designated to receive training assistance through the program;

(D) Training facilities;

(E) The cost of a facility used in training and subsequently used in production shall be prorated to the project in that proportion chargeable to the training program with the remaining facility cost being the responsibility of the industry or employer;

(F) Training Equipment.

1. Training equipment shall be leased, purchased, maintained and disposed of in accordance with established policies and procedures and training standards of the community college district.

2. The community college district shall retain inventory and disposition records of all training equipment purchased for a project.

3. The cost of equipment used in training and subsequently used in production shall be prorated to that project in proportion chargeable to the training program with the remaining equipment cost being the responsibility of the industry or employer.

4. Title of that equipment shall be vested with the community college district until disposed of by the community college district;

(G) Training Materials and Supplies.

1. Training materials and supplies shall be defined and purchased in accordance with established policies and procedures and training standards of the community college district.

2. The cost of training materials and supplies used in training which are subsequently used in production shall be prorated to the project in that proportion chargeable to the training program and the remainder of the cost of materials and supplies will be the responsibility of the industry or employer;

(H) On-the-Job Training (OJT).

1. OJT is on-site training provided to an employee engaged in productive work.

2. Payments for OJT will not exceed the average of fifty percent (50%) of the total wages paid to each participant during the training period. Payment for OJT may continue for up to six (6) months.

3. OJT payments for a retained job may not be paid to an employer who is receiving other sources of funds to provide OJT for the same retained job when the costs would result in the employer receiving more than fifty percent (50%) of the total wages for each OJT trainee during training.

4. The maximum amount of OJT cannot exceed fifty percent (50%) of the total training project;

(I) Administrative expenses or costs shall include:

1. All costs directly or indirectly associated with the supervision and administration of a training project and also directly associated with Job Retention Training Program activities of an individual community college district, including the negotiation of a training activities proposal with the employer, submission of the training activities proposal and required report, advertising, interviewing and selecting staff for a Job Retention Training Program project, procuring materials and service for a training project, direct clerical support to the training project, and mileage for the travel of administrative and supervisory project staff;

2. Training project costs are the costs for training including:

A. Supplies;

B. Wages and benefits of instructors;

C. Subcontracted services;

D. OJT;

E. Training facilities;

F. Equipment;

G. Skill assessment; and

H. All program services, provided however, that no costs associated with the issuance of certificates shall be included.

(J) Contracted services with state institutions of higher education, private colleges or universities, area career technical schools, other federal, state or local agencies or other professional services shall be procured in the manner provided by the community college district board of trustees.

(K) Issuance of Certificates.

1. Financial institution shall include any bank acting in a fiduciary capacity, any broker/dealer of securities presently registered with the commissioner of securities or any discount bank brokerage service executing an unsolicited order.

2. Sales of certificates issued under these rules, which constitute securities, are subject to the provisions of Chapter 409, RSMo and the rules and orders promulgated under it; and

3. Nothing in these rules precludes reliance on the exemption from securities registration set forth in Chapter 409, RSMo and payment of the principal, of premium, if any, and interest on certificates, including capitalized interest issued to finance a project, and funding and maintenance of debt service reserve fund to secure those certificates.

(5) The community college district will notify DWD in writing of its intent to submit a Missouri Community College Job Retention Training Program application with an eligible industry or employer prior to the submission of an official application. DWD shall provide a written response to the community college district the notification has been received.

(6) The community college district will submit the Missouri Community College Job Retention Program application for a project to DWD, the DOR, and the Workforce Investment Board (WIB) on forms approved by and available from DWD.

(A) The Missouri Community College Job Retention Training Program application for a project must be signed by an authorized representative(s) from the community college district and the employer.

(B) The Missouri Community College Job Retention Training Program application for a project must include, but need not be limited to:

1. The employer's name, telephone number, location, the industry or employer Missouri Integrated Tax System Number, and the industry or employer Unemployment Insurance Identification Number;

2. The dates that training will begin and end;

3. The occupational title and wage or salary for the retained jobs which will receive training;

4. The location of the training site;

5. A description of the job retention training project, including a description of each type of training program service (basic skills, assessment and testing, lease of facilities and equipment, training materials and supplies, on-the-job training, administrative costs and other training and services procured for the employer);

6. Program costs, including deferred costs;

7. Cost of the training project;

8. Costs to issue certificates, such as bond counsel, underwriter's discount, trustees fees, etc.;

9. The time period involved for the project;

10. A description of the intended choice of financing program costs, either job retention credit from withholding, tuition, student fees or special charges fixed by the community college district board of trustees or a combination of these sources.

A. Descriptions of the funding sources shall be provided in a manner that is clearly identified by the estimated amount and funding source.

B. A separate description of the first one hundred (100) jobs, including jobs titles, that shall be a part of the training agreement; and

11. A description of any funds that the community college knows the industry or employer has received, is receiving or intends to utilize to subsidize the training required for the retained jobs that are proposed to be included in the project.

(C) The community college district shall demonstrate how the proposed job retention project will not duplicate other job training programs.

(D) Where a collective bargaining agreement exists with the employer for the jobs to be trained through the training agreement, the employer shall send through registered mail, a formal request to the appropriate bargaining agent for written comments on the proposed training project.

1. The request for written comments shall be made through registered mail and shall notify the bargaining agent that if no comments are received within fifteen (15) days, the employer will assume the bargaining agent agrees with the proposed training.

2. The employer shall allow the bargaining agent no fewer than fifteen (15) days to comment on the proposed training.

3. A copy of the request for written comments shall be attached to the Missouri Community College Job Retention Training Program application.

(E) Upon receipt of the application, DWD will forward a copy to the commissioner of administration.

(F) Any Missouri Community College Job Retention Training Program application for a project initiated and operated by one (1) community college district within the boundaries of another community college district or any training project operated by a community college district for an employer retaining jobs in another community college district, will require written concurrence from the community college district board of trustees where training will occur or where the jobs are being retained.

(G) The Missouri Community College Job Retention Training Program application for a project shall not be considered complete or acceptable for evaluation until approved and required forms are received by DWD with all required statements completed.

(7) DWD shall evaluate the project which is the subject of the Missouri Community College Job Retention Training Program application to ensure that the project will not duplicate other job training programs.

(8) The commissioner of administration shall notify DWD within nine (9) working days of any concerns about a potential project regarding the issuance of certificates.

(9) Within fourteen (14) working days after receipt of the Missouri Community College Job Retention Training Program application, DWD will notify the community college district of any duplication with other job training programs, training concerns or concerns regarding the issuance of certificates. Upon receipt of notice of duplication with other job training programs, the community college district will modify the Missouri Community College Job Retention Training Program application to eliminate the duplicate job training efforts specified by DWD.

(A) The modified Missouri Community College Job Retention Training Program application shall be submitted to DWD using the procedures specified for submission of the original Missouri Community College Job Retention Training Program application.

(B) DWD shall follow the same procedures followed in review of an original Missouri Community College Job Retention Training Program application to review a modified Missouri Community College Job Retention Training Program application.

(10) Approval of the Missouri Community College Job Retention Training Program application allows the community college district and an employer to enter into an agreement provided there are no significant changes to the application submitted.

(11) The effective date of the training agreement shall be the date of, or subsequent to, the date DWD received the college's written intent to submit a Job Retention Training Program application from the community college district. Program costs can be incurred prior to the effective date of the training agreement but not prior to the effective date of the college's written intent.

(12) An agreement may be for a period not to exceed ten (10) years when the total cost of the project is not in excess of five hundred thousand dollars ($500,000). If the total cost of a project is in excess of five hundred thousand dollars ($500,000), the agreement may be for a period not to exceed eight (8) years.

(13) Upon entering into a training agreement, the community college district shall provide a copy of the agreement to DWD.

(14) During the life of the training agreement, the community college district shall notify DWD and DOR of significant changes in the job retention training project within fifteen (15) working days of project modification.

(A) Significant changes in a job retention training project include but are not limited to:

1. The retained jobs that are identified as the first hundred (100) included in the project;

2. The retained jobs credit from withholding required by changes in business or employment conditions; or

3. The type of training to be provided, project cost or any change which shall duplicate any funding being received to train an employee for jobs contained in the training agreement.

(B) Notification must be made with a narrative explanation of changes and a copy of the revised training agreement.

(15) The community college district shall deliver a report to DWD, no later than the first day of October each year, on assistance provided during the previous fiscal year through each job retention training project.

(16) Notification of Payments and Claims for Credit.

(A) Any taxpayer claiming the Missouri Community College Job Retention Training Program Credit must acquire, complete, and attach Form MO-RJC, provided by DOR to his/her Employers Report of Income Taxes Withheld, Form MO-941, for the last withholding return filed for the reporting period.

(B) Any amount of Job Retention Training Credit which exceeds the amount of withholding tax due shall not be refunded but shall be carried forward and applied to withholding tax liability in subsequent periods.

(C) The Job Retention Training Credit claimed by qualifying employers shall be the sum of the following:

1. The gross wages attributable to the first one hundred (100) qualifying jobs of the job training project multiplied by two and one-half percent (2 1/2%); plus

2. The gross wages attributable to qualifying jobs of the job training project, in excess of the first one hundred (100) qualifying jobs, multiplied by one and one-half percent (1 1/2%); plus

3. Any unused job training credit left over from the previous filing period. That credit amount shall be computed on Form MO-RJC and remitted as withholding tax on Form MO-941.

(D) The DOR shall credit to the Missouri Community College Job Retention Training Program Fund that amount of withholding tax computed by the employer on Form MO-RJC and paid by the employer on Form MO-941.

(17) Any balances held in the community colleges' special funds after all program costs for each project are paid shall be returned to DOR for inclusion in the general revenue fund.

(18) Community college districts shall notify the DOR and the Department of Economic Development within fifteen (15) days after it is determined that payments for job training will no longer be applied against the costs of a qualified project.

(19) The Department of Economic Development shall notify the Legislative Oversight Committee and the community college districts should the total amount of certificates sold by all community college districts exceed thirteen (13) million dollars. Should the total amount of outstanding certificates sold reach the fifteen (15) million dollar limitation, DWD will notify the community college districts and subsequent applications received by DWD will be processed in the order received.

AUTHORITY: section 178.763, RSMo Supp. 2004. Original rule filed May 16, 2005.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions seven thousand two hundred nineteen dollars ($7,219) annually in the aggregate.

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Economic Development, Division of Workforce Development, Amy Deem, Assistant Director, 421 East Dunklin, PO Box 1087, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	4 CSR 195-3.020 Job Retention Training Program
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Division of Workforce Development	$7,219

III. WORKSHEET

PERSONNEL	FTE	ANNUAL SALARY	SUPPLIES	OTHER	**TOTALS**
Asst. Director/Manager	0.05	$4,242	$0	$0	$4,242
WFD Spec. IV	0.05	$2,685	$0	$0	$2,685
WFD Spec. IV	0.03	$146	$0	$0	$146
WFD Spec. IV	0.03	$146	$0	$0	$146
TOTAL ANNUAL SALARIES		**$7,219**	**$0**	**$0**	**$7,219**

IV. ASSUMPTIONS

Costs are based on a pro-rated application of the portion of time (salary, fringe, space, supply) of the affected five staff associated with the program.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 2—Practice and Procedure

PROPOSED RULE

4 CSR 240-2.071 Expedited Small Complaint Procedure

PURPOSE: This rule establishes a simplified procedure for the processing of customer complaints against utilities.

(1) This rule applies only to complaints against companies regulated by the Missouri Public Service Commission made by customers who receive or are seeking to receive service in Missouri. Individuals may use this procedure without an attorney when complaining about their own service, and are not bound by the rules concerning the form of pleading found elsewhere in this chapter.

(2) To begin the process, make a written complaint that contains the following information:

(A) The name, address, telephone number and e-mail address of the person filing the complaint (the complainant), and the best way of contacting that person;

(B) The address at which the service was received or refused;

(C) The name of the company that provided or refused to provide the service (including the contact person familiar with the matter, if there is one);

(D) A description of the complaint matter. To the extent possible, include any available details, including names, dates, telephone numbers, copies of correspondence, copies of bills, or any other information that may be helpful in understanding what happened;

(E) A statement of the outcome you are seeking from the commission; and

(F) The signature of the person filing the complaint.

(3) The complaint must be sent to:

Secretary of the Commission
PO Box 360
Jefferson City, MO 65102-0360

(4) When the complaint is received at the commission, the following will happen:

(A) A copy of the complaint will be sent to the company, and the company will have thirty (30) days to send an answer to the commission that admits or denies the matters in the complaint, and sets out any defenses the company has to the complaint;

(B) The matter will be assigned to a regulatory law judge and set for a hearing. The complainant or the company may request to appear at the hearing by telephone, instead of in person;

(C) The judge will notify the complainant and the company of the hearing date and require the parties to send such information as the judge may need, including a list of any witnesses either party may call or any other documents or information, and may set a deadline by which the information must be provided; and

(D) The judge will provide the Office of the Public Counsel and the commission technical staff with copies of the complaint and will notify them of the hearing. They may conduct a neutral investigation of the matter and present their findings at the hearing.

(5) After the conclusion of the hearing, the judge will give the parties a written decision. That decision will be mailed to the complainant and the company. If either of those parties believes the decision is wrong, then that party must request a rehearing within ten (10) days of the date of the judge's decision. A request for rehearing must set out the reasons why the decision is wrong or unlawful, and must be received at the commission no later than ten (10) days from the date of the decision.

AUTHORITY: sections 386.040 and 386.410, RSMo 2000. Original rule filed May 5, 2005.

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Public Service Commission, Dale Hardy Roberts, Secretary, PO Box 360, Jefferson City, MO 65102. To be considered, comments must be received no later than thirty (30) days after publication of this notice in the **Missouri Register**. Comments should refer to Case No. AX-2005-0364 and be filed with an original and six (6) copies. Comments may also be submitted using the commission's Electronic Filing and Information System at http://www.psc.mo.gov/efis.asp. A public hearing regarding this proposed rule is scheduled for July 19, 2005, at 10:00 a.m., in Room 310 of the Governor Office Building, 200 Madison Street, Jefferson City, Missouri. Interested persons may appear at this hearing to submit additional comments or testimony in support of or in opposition to this proposed rule, and may be asked to respond to commission questions. Any person who needs specific accessibility accommodations may call the Public Service Commission's Hotline at 1-800-392-4211 (voice) or Relay Missouri at 711 prior to the hearing.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 1—Organization

PROPOSED RULE

10 CSR 10-1.030 Air Conservation Commission Appeals and Requests for Hearings

PURPOSE: This rule contains all procedural regulations for all contested cases heard by the commission or assigned to a hearing officer by the commission.

(1) Subject. This rule contains all procedural regulations for all contested cases heard by the commission or assigned to a hearing officer by the commission.

(2) Definitions. As used in this rule, the following terms mean:

(A) Commission—The Missouri Air Conservation Commission;

(B) Department—The Department of Natural Resources, which includes the director thereof, or the person or division or program within the department delegated the authority to render the decision, order, determination, finding, or other action that is the subject of an initial pleading before the commission;

(C) Hearing—Any presentation to, or consideration by, the commission or hearing officer of evidence or argument on an initial pleading, motion or application;

(D) Hearing officer—The person or agency appointed by the commission to manage all delegated proceedings relating to the case;

(E) Initial pleading—A written appeal, request for hearing, or other document that initiates a contested case. An initial pleading shall be deemed to include subsequent amendments allowed by the presiding officer;

(F) Person—An individual, partnership, copartnership, firm, company, public or private corporation, association, joint stock company, trust, estate, political subdivision or any agency, board, department or bureau of the state or federal government or any other legal

entity whatever, which is recognized by law as the subject of rights and duties;

(G) Petitioner—The party filing the initial pleading;

(H) Presiding officer—The hearing officer for proceedings delegated by the commission, or the commission for proceedings not delegated to a hearing officer;

(I) Respondent—The department and any person later joined as respondent;

(J) Stay—A suspension of any action from which petitioner is seeking relief pending the final determination in the case.

(3) Appointment of Hearing Officers.

(A) As authorized by statute, in lieu of presiding over a hearing directly, the commission may select any of the following persons to preside over the hearing of an initial pleading—

1. Any one (1) or several members of the commission;
2. The Missouri Administrative Hearing Commission; or
3. An attorney qualified to practice in Missouri.

(B) The appointment, as authorized by statute and approved by the commission either as a general practice or on a case-by-case basis, may be made as follows:

1. By the chairman of the commission within the chairman's discretion;
2. By a vote of the majority of the commission; or
3. By the parties from a list of available hearing officers either by consensus or, when practical, by process of elimination that allows the parties, first the department and then the petitioner, an equal opportunity to strike names.

(4) Role of the Hearing Officer.

(A) Upon appointment, the department shall provide the hearing officer a letter confirming the appointment and copies of—

1. The initial pleading;
2. The written decision, order, determination, finding, or other action that is the subject of the initial pleading. This rule may be satisfied by providing a copy of the specific portion or portions of the action, such as a permit, that is contested;
3. Any entry of appearance by an attorney representing a party and any answer already filed with the commission; and
4. The names, addresses, phone and fax numbers of the parties or their attorneys, if this information is not already included in the above documents.

(B) The hearing officer has full authority to make rulings or issue orders on all matters that may arise except that the hearing officer shall not have the authority to render a final disposition on either jurisdictional grounds or the merits of a case that is not settled by the parties or voluntarily dismissed by the petitioner.

(C) For purposes of determining the final disposition of a cause on the basis of either the merits or the commission's jurisdiction, the hearing officer shall prepare a recommended decision, in writing, including findings of fact, conclusions of law, and a determination as to relief, for the commission's consideration. The hearing officer shall return the recommendation and the complete record of the proceedings in the cause to the commission.

(D) Upon receipt of the hearing officer's recommendation and the record in the case, the commission shall—

1. Distribute the hearing officer's recommendation to the parties or their counsel;
2. Allow the parties or their counsel an opportunity to submit written arguments regarding the recommendation;
3. Allow the parties or their counsel an opportunity to present oral arguments before the commission makes the final determination;
4. Complete its review of the record and deliberations as soon as practicable; the commission members may confer with the hearing officer during deliberations;
5. Deliberate and vote upon a final, written determination during an open meeting; and
6. Issue its final, written determination as soon as practicable.

(5) Computation of Time.

(A) In computing any period of time prescribed or allowed by this rule or by order of the presiding officer, the day of the act, event or default after which the designated period of time begins to run is not to be included. The last day of the period so computed is to be included, unless it is a Saturday, Sunday or legal holiday, in which event the period runs until the end of the next day that is neither a Saturday, Sunday nor legal holiday.

(B) Except for any period of time that establishes the commission's jurisdiction, the presiding officer may extend the time set by this rule either before or after the time period has expired.

(C) A party may move for an extension of the time set by this rule or by the presiding officer. The motion shall be in writing and shall state whether any party objects to the extension or that efforts to contact the parties have been futile.

(6) Practice by a Licensed Attorney; When Required.

(A) Any individual may present that individual's own case without a licensed attorney.

(B) Any individual may file an initial pleading on behalf of another person.

(C) Except as set forth in subsection (6)(B) of this rule, only a licensed attorney may represent any other person, including a corporation or other legal entity. The filing of any document with the presiding officer by a licensed attorney shall be deemed an entry of appearance. An attorney not authorized to practice in Missouri shall enter an appearance in accordance with Missouri Supreme Court Rules.

(7) Notice of Initiation of the Case.

(A) The department shall promptly mail a notice of institution of the case to all necessary parties, if any, and to all persons designated by the moving party and to any other persons to whom the department may determine that notice should be given. The department shall keep a permanent record of the persons to whom such notice was sent and of the addresses to which sent and the time when sent. Where a case would affect the rights, privileges or duties of a large number of persons whose interests are sufficiently similar that they may be considered as a class, notice may in a proper case be given to a reasonable number thereof as representatives of such class. In any case where the name or address of any proper or designated party or person is not known to the agency, and where notice by publication is permitted by law, then notice by publication may be given in accordance with any rule or regulation of the agency or if there is no such rule or regulation, then, in a proper case, the agency may by a special order fix the time and manner of such publication.

(B) The notice of institution of the case to be mailed as provided in this section shall state in substance:

1. The caption and number of the case;
2. That a writing seeking relief has been filed in such case, the date it was filed, and the name of the party filing the same;
3. A brief statement of the matter involved in the case unless a copy of the writing accompanies said notice;
4. Whether an answer to the writing is required, and if so the date when it must be filed;
5. That a copy of the writing may be obtained from the department, giving the address to which application for such a copy may be made. This may be omitted if the notice is accompanied by a copy of such writing; and
6. The location in the *Code of State Regulations* of the rules of the commission regarding discovery or a statement that the department shall send a copy of such rules on request.

(C) Unless the notice of hearing hereinafter provided for shall have been included in the notice of institution of the case, the agency shall, as promptly as possible after the time and place of hearing have been determined, mail a notice of hearing to the moving party and to all persons and parties to whom a notice of institution of the case was required to be or was mailed, and also to any other persons who may

thereafter have become or have been made parties to the proceeding. The notice of hearing shall state:

1. The caption and number of the case; and
2. The time and place of hearing.

(D) No hearing in a contested case shall be had, except by consent, until a notice of hearing shall have been given substantially as provided in this section, and such notice shall in every case be given a reasonable time before the hearing. Such reasonable time shall be at least ten (10) days except in cases where the public morals, health, safety or interest may make a shorter time reasonable; provided that when a longer time than ten (10) days is prescribed by statute, no time shorter than that so prescribed shall be deemed reasonable.

(8) Service of Filings Other Than the Initial Pleading.

(A) Unless otherwise provided by these rules or by other law, any party to a proceeding before the commission or any person who seeks to become a party shall serve upon the presiding officer and all attorneys of record and unrepresented parties a copy of any document or item the party files.

(B) Methods of Service.

1. A person may serve a document on an attorney by—

A. Delivering it to the attorney;

B. Leaving it at the attorney's office with a secretary, clerk or attorney associated with or employed by the attorney served;

C. Mailing it to the attorney's last known address; or

D. Facsimile transmitting (faxing) it to the attorney's last known fax number.

2. A person may serve a document on an unrepresented party by—

A. Delivering it to the party;

B. Mailing it to the party's last known address; or

C. Faxing it to the party's last known fax number.

(C) Service by mailing is complete upon placing in the mail. Service by fax is complete upon its transmission.

(D) Any document or item filed shall contain or be accompanied by a certification of how and when the filing party has met the provisions of this section.

(E) The presiding officer, after due notice, may waive the requirements of this section either on its own motion or on the motion of any party.

(F) The requirements of this section shall not apply to an initial pleading.

(9) Filing of Documents; Fax Filing.

(A) A party shall file a document with the presiding officer at the presiding officer's principle business office. Filings may be accomplished by—

1. Registered or certified mail. A document filed by registered or certified mail is deemed filed on the date shown on the United States Post Office records;

2. Electronic facsimile transmission (fax). A document filed by fax is deemed filed at the time the presiding officer receives a fax of the document. If a document arrives by fax after 5:00 p.m. and before 12:00 midnight or on a Saturday, Sunday or legal holiday, it is filed on the presiding officer's next business day, unless the presiding officer orders otherwise;

3. Actual delivery of a hard copy; or

4. Any other means as authorized by the Missouri Rules of Civil Procedure.

(B) A party filing by fax shall—

1. Notify the presiding officer in advance, if possible, of its intention to file the document by fax;

2. Fax the document to the presiding officer's dedicated fax number;

3. Fax the document, if possible, to all other parties having electronic facsimile equipment. If unable to fax, a party shall notify all other parties of its intention to file the document by fax. The notice need not be in writing. A good faith attempt at compliance shall satisfy the requirements of this subsection;

4. Send the original signed document to the presiding officer as the presiding officer so orders;

5. Certify in the documents—

A. The method of notice used to fulfill the requirements of paragraph (9)(B)3. of this rule; and

B. Compliance with the requirements of paragraph (9)(B)4. of this rule; and

6. Send a copy of the document to all parties. The presiding officer may order the party to send a copy of the document to any party by overnight mail.

(10) Stays.

(A) Scope and Content. The presiding officer may stay or suspend any action of the department pending the commission's findings and determination in the case. The presiding officer may require a bond or impose other conditions.

1. All motions for stay of the action from which petitioner is appealing shall be in writing.

2. The movant shall include in the motion:

A. The full name, address and telephone number of movant, any attorney representing movant and the respondent;

B. A clear heading, Motion for Stay;

C. Facts showing why the commission should grant the stay, set forth in numbered paragraphs, each of which shall contain, as far as practical, a single set of circumstances; and

D. A copy of any written notice of the action from which the petitioner is appealing.

3. The movant or movant's legal counsel shall sign the motion.

(B) The movant shall file the original and one (1) copy of the motion for stay with the presiding officer.

(C) The presiding officer, upon either party's request, shall hold or, on its own initiative, may hold an evidentiary hearing on whether to issue or dissolve a stay order.

(D) The denial of a motion for stay shall not prejudice the movant's initial pleading on the merits.

(E) The stay order shall remain effective until the commission finally disposes of the case unless the commission orders otherwise.

(11) Form of Initial Pleadings.

(A) In General. An initial pleading shall be in writing and shall include:

1. The full name, address and telephone number of—

A. Petitioner; and

B. Any attorney representing petitioner; and

2. An explanation of the relief sought and the reason for requesting it. The presiding officer shall construe the provisions of this section liberally. The presiding officer shall have the discretion to order the petitioner to amend the initial pleading by providing more detailed information regarding the relief sought and the basis for that relief before allowing the matter to proceed.

(B) Petitioner or petitioner's legal counsel shall sign the initial pleading.

(C) The initial pleading is deemed filed the day it is received by the commission.

(12) Answers.

(A) The respondent shall file an answer.

(B) An answer shall—

1. Be in writing;

2. Admit those portions of the initial pleading which the respondent believes are true and deny those portions that the respondent believes are not true and state that the respondent is without sufficient knowledge to admit or deny the portions not admitted or denied;

3. Assert any specific failure of the initial pleading to comply with this rule, or any other defenses; and

4. Be signed by the respondent or the respondent's attorney.

(C) The respondent shall file the answer within thirty (30) days after service of the notice of initial pleading.

(13) Intervention.

(A) The presiding officer shall follow Rule 52.12 of the Missouri Rules of Civil Procedure in determining any motion to intervene.

(B) A motion to intervene shall—

1. Be in writing;
2. Set forth facts showing that the person is entitled to intervene;
3. Be signed by the person or the person's attorney; and
4. Be accompanied by an initial pleading or answer.

(14) Discovery.

(A) Any party may conduct discovery in the manner provided for in the Rules of Civil Procedure adopted by the Supreme Court of Missouri.

(B) Written Interrogatories; Production of Documents or Things or Permission to Enter Upon Land or Other Property, for Inspection and Other Purposes.

1. A party serving written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes, shall include a certificate of service in substantially the following form:

I served the original and (*number of*) copies of these (*written interrogatories/ production of documents or things or permission to enter upon land or other property, for inspection and other purposes, requests for admission)* on (*name of parties*) this _______ day of ______________, 20______.

(*Signature*)__________________________

2. The party conducting discovery shall file a copy of the certificate with the presiding officer. The party shall not file written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes with the presiding officer unless the presiding officer so orders. The party may file requests for admissions with the presiding officer.

3. The party conducting discovery shall serve the original discovery on the interrogated party's counsel or on an unrepresented interrogated party, and copies on all other counsel or unrepresented parties.

4. Requests for admission and interrogatories shall include appropriate spaces for answers or objections.

5. The party responding to requests for admissions or interrogatories shall complete them by typewriting or printing the answer or objection to each question in the space provided. If the space is insufficient, the party shall reply by affidavit, clearly indicate so in the space provided, and attach the affidavit to the interrogatories or requests for admissions. Each response shall include a certificate of service in substantially the following form:

I served the original of these completed (*written interrogatories/requests for admission*) on (*name of party*) and sent (*number of*) copies to (*name of parties*) this ___________ day of ________________, 20_______.

(*Signature*)__________________________

6. The responding party shall file the certificate of service with the presiding officer and shall not file the response unless the presiding officer so orders. The responding party shall serve the original completed response on the interrogating party and copies on all other parties.

(C) Whenever a party files a motion to compel compliance with any discovery request, to sanction another party for failing to respond or responding inadequately to any discovery request, or alleging violation of any discovery rule, the moving party shall certify in its motion that it has made reasonable efforts to contact the party who is the subject of the motion and inform the presiding officer as to what steps the moving party has taken to resolve informally the discovery dispute or alleged discovery rule violation. The party seeking relief shall attach a copy of any disputed discovery to the motion to compel.

(D) No discovery or response to discovery shall be considered as evidence unless it is admitted into evidence upon hearing, or authenticated and attached to a motion for disposition without hearing, as an exhibit.

(E) No discovery order that permits entrance upon land or inspection of property without permission of the owner, or purports to hold any person in contempt shall be enforceable, unless the party seeking such enforcement obtains an order of the circuit court of the county in which the land or property is located, or the circuit court of Cole County, at the option of the person seeking enforcement.

(15) Sanctions.

(A) The presiding officer may impose a sanction upon any party for conduct including, without limitation, such party's failure to:

1. Comply with any rule of the commission or order of the presiding officer, including failure to file an answer;
2. Appear at any hearing; or
3. Apprise the presiding officer of a current mailing address.

(B) Sanctions available under this rule include without limitation:

1. Striking all or any part of the party's pleading;
2. Deeming all or any part of an opposing party's pleading admitted; or
3. Barring or striking all or any evidence on any issue.

(C) The presiding officer shall determine whether to impose any sanction, and the appropriate degree of such sanction, based on the facts of each case.

(16) Disposing of a Case Without a Hearing.

(A) Settlement. The parties may settle all or any part of the case without any action by the commission or by requesting agreed upon action by the commission, where such settlement is permitted by law. If the parties settle all of the case, petitioner shall file a notice of dismissal as described in subsection (16)(B) of this rule or a request for stipulated action by the commission.

(B) Notice of Dismissal. Petitioner may voluntarily dismiss the initial pleading at any time. Petitioner shall effect a voluntary dismissal by filing a notice of dismissal and is effective on the date petitioner files it, without any action by the commission.

(C) The commission may grant a motion for decision without hearing if the parties stipulate to undisputed facts and the commission determines that such facts entitle any party, including a party who did not file such motion, to a favorable decision on all or any part of the case as a matter of law.

(D) Involuntary Dismissal. Involuntary dismissal means a disposition of the case that does not reach the merits of the complaint. Grounds for involuntary dismissal of the complaint include without limitation:

1. Lack of jurisdiction; and
2. The bases for a sanction set forth in this rule.

(17) Prehearing Conferences. On its own motion or that of any party, the presiding officer may order a prehearing conference to discuss matters pertinent to the case. All parties or their legal counsels, or both shall participate in the prehearing conference and be prepared to discuss the matters, including the possibilities for settlement.

(18) Hearings on Motions. The presiding officer may rule upon any motion on the basis of the record and without oral argument. The presiding officer shall hear oral argument or evidence only upon a party's written motion or upon the presiding officer's own motion.

(19) Hearings; Default.

(A) Notice. The hearing officer shall serve an initial notice of hearing on all parties or their counsel by regular mail. The notice of hearing shall state the date, time and place of the hearing and shall be served at least ten (10) days prior to the hearing. The presiding officer may serve any other notice of hearing by any other method allowed by law.

(B) Location. The hearing officer shall hold all hearings in Jefferson City, Missouri, except as otherwise provided by statute or when a party shows good cause to hold the hearing elsewhere within the state.

(C) Date.

1. First setting. Unless otherwise provided by statute or with the consent of the parties, the hearing officer shall not conduct any hearing on less than ten (10) days notice.

2. Resettings. The hearing officer may reset the hearing by amended notice. If the reset date is later than the first setting, the hearing officer may hold the hearing fewer than ten (10) days from the date of the issuance of the amended notice.

(D) Expedited Hearings and Continuances. The hearing officer may expedite or continue the hearing date upon notice to the parties except as otherwise provided by law. Any party may file a motion for an expedited hearing or a continuance. The motion shall state good cause.

(E) Order of Proof. Regardless of which party has the burden of proof petitioner shall present evidence first unless the presiding officer orders otherwise.

(F) Default. If a party fails to appear at hearing, the party shall be in default.

1. If petitioner defaults, and petitioner has the burden of proof, the commission may dismiss the case for failure to prosecute.

2. If any party defaults, any other party may present evidence, and the defaulting party shall have waived any objection to such evidence. Such evidence shall constitute the sole evidentiary basis for disposition of the case, unless the commission orders otherwise.

(20) Transcripts.

(A) The court reporter shall file a transcript of all hearings with the commission. Any person may purchase a copy of the transcript through the court reporter.

(B) Any party may move to correct the transcript no more than ninety days after the court reporter files the transcript. The commission on its own motion may order the hearing reporter to correct the transcript any time before the commission finally disposes of the case.

(21) Fees and Expenses. A party may apply for litigation fees and expenses as authorized by law. Such application shall be an initial pleading in a separate case. The case for fees and expenses shall be governed by this rule.

AUTHORITY: section 643.050, RSMo 2000. Original rule filed May 12, 2005.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed rule will begin at 9:00 a.m., July 21, 2005. The public hearing will be held at the Holiday Inn, Salon D, 2781 North Westwood Boulevard, Poplar Bluff, Missouri. Opportunity to be heard at the hearing shall be afforded any interested person. Written request to be heard should be submitted at least seven (7) days prior to the hearing to Director, Missouri Department of Natural Resources' Air Pollution Control Program, 205 Jefferson Street, PO Box 176, Jefferson City, MO 65102-0176, (573) 751-4817. Interested persons, whether or not heard, may submit a written statement of their views until 5:00 p.m., July 28, 2005. Written comments shall be sent to Chief, Operations Section, Missouri Department of Natural Resources' Air Pollution Control Program, 205 Jefferson Street, PO Box 176, Jefferson City, MO 65102-0176.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

PROPOSED AMENDMENT

10 CSR 10-6.110 Submission of Emission Data, Emission Fees and Process Information. The commission proposes to amend subsection (3)(D). If the commission adopts this rule action, it will be submitted to the U.S. Environmental Protection Agency to replace the current rule in the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address and phone number listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Environmental Regulatory Agenda website, www.dnr.mo.gov/regs/regagenda.htm.

PURPOSE: This rule provides procedures for collecting, recording, and submitting emission data and process information so that the state can calculate emissions for the purpose of state air resource planning. This amendment will establish emission fees for Missouri facilities as required annually and split the fee payment schedule to better align the collection of fee revenue with the state fiscal year it is to cover. The evidence supporting the need for this proposed rulemaking, per section 536.016, RSMo, is section 643.079 of the Missouri state statutes and a December 10, 2004 E-mail Re: Proposed 2005 Changes for 10 CSR 10-6.110.

(3) General Provisions.

(D) Emission Fees.

1. Any air contaminant source required to obtain a permit under sections 643.010–643.190, RSMo, except sources that produce charcoal from wood, shall pay an annual emission fee, regardless of their EIQ reporting frequency, of *[thirty-three dollars and no cents ($33.00)]* **thirty-five dollars and fifty cents ($35.50)** per ton of regulated air pollutant emitted starting with calendar year *[2004]* **2005** in accordance with the conditions specified in paragraph (3)(D)2. of this rule. Sources which are required to file reports once every five (5) years may use the information in their most recent EIQ to determine their annual emission fee.

2. General requirements.

A. The fee shall apply to the first four thousand (4,000) tons of each regulated air pollutant emitted. However, no air contaminant source shall be required to pay fees on total emissions of regulated air pollutants in excess of twelve thousand (12,000) tons in any calendar year. A permitted air contaminant source which emitted less than one (1) ton of all regulated pollutants shall pay a fee equal to the amount of one (1) ton.

B. The fee shall be based on the information provided in the facility's EIQ.

C. An air contaminant source which pays emissions fees to a holder of a certificate of authority issued pursuant to section 643.140, RSMo, may deduct those fees from the emission fee due under this section.

D. The fee imposed under paragraph (3)(D)1. of this rule shall not apply to carbon oxide emissions.

E. The fees **for emissions produced during the previous calendar year** shall be due April 1 each year *[for emissions produced during the previous calendar year]* **for all United States Department of Labor Standard Industrial Classifications except for Standard Industrial Classification 4911 Electric Services which shall be due June 1 each year. The fees shall be payable to the Department of Natural Resources.**

F. *[The fees shall be payable to the Department of Natural Resources and shall be accompanied by the]* **All** Emissions Inventory Questionnaire forms or equivalent approved by the director **shall be due April 1 each year for all United States Department of Labor Standard Industrial Classifications except for Standard Industrial Classification 4911 Electric Services which shall be due June 1 each year**.

G. For the purpose of determining the amount of air contaminant emissions on which the fees are assessed, a facility shall be considered one (1) source under the definition of section 643.078.2, RSMo, except that a facility with multiple operating permits shall pay emission fees separately for air contaminants emitted under each individual permit.

3. Fee collection. The annual changes to this rule to establish emission fees for a specific year do not relieve any source from the payment of emission fees for any previous year.

AUTHORITY: section 643.050, RSMo 2000. Original rule filed June 13, 1984, effective Nov. 12, 1984. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed May 16, 2005.*

PUBLIC COST: This proposed amendment will result in an annualized aggregate gain in revenue of two hundred thirty-eight thousand five hundred forty-seven dollars ($238,547) for the Department of Natural Resources. This gain in revenue takes into account an annualized aggregate cost of two hundred thirty-five thousand nine hundred eighty-eight dollars ($235,988) for other public entities. Note attached fiscal note for assumptions that apply.

PRIVATE COST: This proposed amendment will result in an annualized aggregate cost of two hundred thirty-eight thousand five hundred forty-seven dollars ($238,547) for private entities. Note attached fiscal note for assumptions that apply.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed amendment will begin at 9:00 a.m., July 21, 2005. The public hearing will be held at the Holiday Inn, 2781 North Westwood Boulevard, Poplar Bluff, Missouri 63901. Opportunity to be heard at the hearing shall be afforded any interested person. Written request to be heard should be submitted at least seven (7) days prior to the hearing to Director, Missouri Department of Natural Resources' Air Pollution Control Program, 205 Jefferson Street, PO Box 176, Jefferson City, MO 65102-0176, (573) 751-4817. Interested persons, whether or not heard, may submit a written statement of their views until 5:00 p.m., July 28, 2005. Written comments shall be sent to Chief, Operations Section, Missouri Department of Natural Resources' Air Pollution Control Program, 205 Jefferson Street, PO Box 176, Jefferson City, MO 65102-0176.

FISCAL NOTE
PUBLIC ENTITY COST

I. RULE NUMBER

Title: 10 - Department of Natural Resources

Division: 10 - Air Conservation Commission

Chapter: 6 - Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

Type of Rulemaking: Proposed Amendment

Rule Number and Name: 10 CSR 10 - 6.110 Submission of Emission Data, Emission Fees and Process Information

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Misc. Public Entities (listed below)	$ 235,988 Cost For This Amendment
Missouri Department of Natural Resources	$ 238,547 Increase in Revenue

Cost estimates are reported as annualized aggregates.

III. WORKSHEET

	EIQ Fee Costs		
	FY2006	FY2007**	Annualized Aggregate
EIQ Fees ($35.50 Fee)	$1,520,658	$1,509,754	$1,472,517

	EIQ Fee Costs		
	FY2006	FY2007**	Annualized Aggregate
EIQ Fees ($33.00 Fee)	$1,181,900	$1,193,719	$1,236,529

Aggregate EIQ Fee Cost For This Amendment***	$235,988
Increase In Public Entity Fee Revenue For This Amendment***	$474,535
Resulting Gain In Public Entity Fee Revenue For This Amendment***	$238,547

*See Assumption 3.

**The first full fiscal year for this rulemaking is FY2007.

***Difference in annualized aggregate costs when raising $33.00 fee to $35.50 .

List of Affected Entities:

Source Description	Number of Facilities
Gas & Electric	47
Sanitary Services	32
Hospitals	21
Rehabilitation Centers	2
Schools	9
Correctional Facility	8
National Security	6
Post Office	2
Transportation	3
Other	14
Totals	144

IV. ASSUMPTIONS

1. For the convenience of calculating this fiscal note over a reasonable time frame, the life of the rule is assumed to be ten (10) years although the duration of the rule is indefinite. If the life of the rule extends beyond ten years, the annual costs for additional years will be consistent with the assumptions used to calculate annual costs as identified in this fiscal note.

2. The public entity costs are fee collection estimates. The costs are based on the most recent data available to the department and are expected to be more accurate than previous fiscal notes for the same fiscal years.

3. The fees for emissions produced during the previous calendar year shall be due April 1 each year for all United States Department of Labor Standard Industrial Classifications except for Standard Industrial Classification 4911 Electric Services which shall be due June 1 each year. For example, costs for all calendar year 2005 emission fees are received by the Missouri Department of Natural Resources between January 1, 2006 and June 30, 2006.

4. Cost and affected entity estimates are based on data presently entered in the tracking systems of the Missouri Department of Natural Resources' Air Pollution Control Program. This data is subject to change as additional information is reviewed, updated, and entered.

5. Fees for public entities are based on $35.50 per ton of regulated air pollutant for calendar 2005. This fee represents an $2.50 dollar increase from the emissions fee of $33.00 per ton of regulated air pollutant for calendar year 2004.

6. The emission fees paid by public entities may vary depending on their current information and their chargeable emissions with fees remaining relatively constant. However, new controls decrease the amount of their emission fees.

7. The percent difference between the two most recent years of actual facility emissions is used to project future year facility emissions.

8. Compliance and EIQ preparation costs reported on EIQs are not included in this fiscal note because these costs are not a result of this rulemaking. Compliance and preparation costs have been included in fiscal notes for the rulemakings that implemented these requirements.

9. The aggregate gain in public entity fee revenue for the Missouri Department of Natural Resources' Air Pollution Control Program is directly related to the difference in emission fees. The net gain in revenue is equivalent to the amount of gain realized by both public and private entities paying emission fees.

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 10 - Department of Natural Resources

Division: 10 - Air Conservation Commission

Chapter: Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

Type of Rulemaking: Proposed Amendment

Rule Number and Name: 10 CSR 10 - 6.110 Submission of Emission Data, Emission Fees and Process Information

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
2,340 Facilities (listed below)	Listed below	$ 238,547 Cost For This Amendment

Cost estimates are reported as annualized aggregates.

III. WORKSHEET

	EIQ Fee Costs		
	FY2006	FY2007**	Annualized Aggregate
EIQ Fees ($35.50 Fee)	$8,153,373	$8,094,908	$7,895,249

	EIQ Fee Costs		
	FY2006	FY2007**	Annualized Aggregate
EIQ Fees ($33.00 Fee)	$7,318,435	$7,391,619	$7,656,702

Total Aggregate Cost For This Amendment***	$238,547

*See Assumption 3.
**The first full fiscal year for this rulemaking is FY2007.
***Difference in annualized aggregate costs when raising $33.00 fee to $35.50 .

List of Affected Entities:

SIC Code	SIC Description	Number of Facilities
01	AGRICULTURAL PRODUCTION-CROPS	0
02	AGRICULTURAL PRODUCTION-LIVESTOCK AND ANIMAL SPECIALTIES	1
07	AGRICULTURAL SERVICES	50

SIC Code	SIC Description	Number of Facilities
08	FORESTRY	0
09	FISHING, HUNTING AND TRAPPING	0
10	METAL MINING	6
12	COAL MINING	4
13	OIL AND GAS EXTRACTION	0
14	MINING AND QUARRYING OF NONMETALLIC MINERALS, EXCEPT FUELS	303
15	BUILDING CONSTRUCTION-GENERAL CONTRACTORS AND OPERATIVE	1
16	HEAVY CONSTRUCTION OTHER THAN BUILDING CONSTRUCTION	0
17	CONSTRUCTION-SPECIAL TRADE CONTRACTORS	2
20	FOOD AND KINDRED PRODUCTS	114
21	TOBACCO PRODUCTS	0
22	TEXTILE MILL PRODUCTS	1
23	APPAREL AND OTHER FINISHED PRODUCTS MADE FROM FABRICS	0
24	LUMBER AND WOOD PRODUCTS, EXCEPT FURNITURE	59
25	FURNITURE AND FIXTURES	23
26	PAPER AND ALLIED PRODUCTS	22
27	PRINTING, PUBLISHING, AND ALLIED INDUSTRIES	61
28	CHEMICALS AND ALLIED PRODUCTS	129
29	PETROLEUM REFINING AND RELATED INDUSTRIES	120
30	RUBBER AND MISCELLANEOUS PLASTICS PRODUCTS	62
31	LEATHER AND LEATHER PRODUCTS	6
32	STONE, CLAY, GLASS, AND CONCRETE PRODUCTS	343
33	PRIMARY METAL INDUSTRIES	46
34	FABRICATED METAL PRODUCTS, EXCEPT MACHINERY AND TRANSPORTATION	77

SIC Code	SIC Description	Number of Facilities
35	INDUSTRIAL AND COMMERCIAL MACHINERY AND COMPUTER EQUIPMENT	46
36	ELECTRONIC AND OTHER ELECTRICAL EQUIPMENT AND COMPONENTS	35
37	TRANSPORTATION EQUIPMENT	66
38	MEASURING, ANALYZING, AND CONTROLLING INSTRUMENTS	3
39	MISCELLANEOUS MANUFACTURING INDUSTRIES	17
40	RAILROAD TRANSPORTATION	0
41	LOCAL AND SUBURBAN TRANSIT AND INTERURBAN HIGHWAY PASSENGER	1
42	MOTOR FREIGHT TRANSPORTATION AND WAREHOUSING	11
43	UNITED STATES POSTAL SERVICE	0
44	WATER TRANSPORTATION	3
45	TRANSPORTATION BY AIR	2
46	PIPELINES, EXCEPT NATURAL GAS	24
47	TRANSPORTATION SERVICES	4
48	COMMUNICATIONS	5
49	ELECTRIC, GAS, SANITARY SERVICES, AND LANDFILLS	94
50	WHOLESALE TRADE-DURABLE GOODS	18
51	WHOLESALE TRADE-NON-DURABLE GOODS	144
52	BUILDING MATERIALS, HARDWARE, GARDEN	0
53	GENERAL MERCHANDISE STORES	0
54	FOOD STORES	0
55	AUTOMOTIVE DEALERS AND GASOLINE SERVICE STATIONS	1
56	APPAREL AND ACCESSORY STORES	0
57	HOME FURNITURE, FURNISHINGS, AND EQUIPMENT STORES	0
58	EATING AND DRINKING PLACES	0
59	MISCELLANEOUS RETAIL	1
60	DEPOSITORY INSTITUTIONS	0

SIC Code	SIC Description	Number of Facilities
61	NONDEPOSITORY CREDIT INSTITUTIONS	0
62	SECURITY & COMMODITY BROKERS, DEALERS	0
63	INSURANCE CARRIERS	0
64	INSURANCE AGENTS, BROKERS AND SERVICES	0
65	REAL ESTATE	2
67	HOLDING AND OTHER INVESTMENT OFFICES	1
70	HOTELS, ROOMING HOUSES, CAMPS, AND OTHER LODGING PLACES	1
72	PERSONAL SERVICES AND DRY CLEANERS	331
73	BUSINESS SERVICES	4
75	AUTOMOTIVE REPAIR, SERVICES, AND PARKING	6
76	MISCELLANEOUS REPAIR SERVICES	1
78	MOTION PICTURES	0
79	AMUSEMENT AND RECREATION SERVICES	1
80	HEALTH SERVICES	36
81	LEGAL SERVICES	0
82	EDUCATIONAL SERVICES	6
83	SOCIAL SERVICES	1
84	MUSEUMS, ART GALLERIES, AND BOTANICAL AND ZOOLOGICAL GARDENS	0
86	MEMBERSHIP ORGANIZATIONS	0
87	ENGINEERING, ACCOUNTING, RESEARCH, MANAGEMENT, AND RELATED	4
88	PRIVATE HOUSEHOLDS	0
89	SERVICES NOT ELSEWHERE CLASSIFIED	0
91	EXECUTIVE, LEGISLATIVE, AND GENERAL GOVERNMENT, EXCEPT FINANCE	0
92	JUSTICE, PUBLIC ORDER AND SAFETY	3
93	PUBLIC FINANCE, TAXATION & MONETARY	0
94	ADMINISTRATION OF HUMAN RESOURCE PERSONNEL	0
95	ADMINISTRATION OF ENVIRONMENTAL QUALITY AND HOUSING PROGRAMS	0

SIC Code	SIC Description	Number of Facilities
96	ADMINISTRATION OF ECONOMIC PROGRAMS	1
97	NATIONAL SECURITY AND INTERNATIONAL AFFAIRS	1
99	UNKNOWN	36
	Total Facilities	2,340

IV. ASSUMPTIONS

1. For the convenience of calculating this fiscal note over a reasonable time frame, the life of the rule is assumed to be ten (10) years although the duration of the rule is indefinite. If the life of the rule extends beyond ten years, the annual costs for additional years will be consistent with the assumptions used to calculate annual costs as identified in this fiscal note.

2. The private entity costs are fee collection estimates. The costs are based on the most recent data available to the department and are expected to be more accurate than previous fiscal notes for the same fiscal years.

3. The fees for emissions produced during the previous calendar year shall be due April 1 each year for all United States Department of Labor Standard Industrial Classifications except for Standard Industrial Classification 4911 Electric Services which shall be due June 1 each year. For example, costs for all calendar year 2005 emission fees are received by the Missouri Department of Natural Resources between January 1, 2006 and June 30, 2006.

4. Cost and affected entity estimates are based on data presently entered in the tracking systems of the Missouri Department of Natural Resources' Air Pollution Control Program. This data is subject to change as additional information is reviewed, updated, and entered.

5. Fees for private entities are based on $35.50 per ton of regulated air pollutant for calendar 2005. This fee represents an $2.50 dollar increase from the emissions fee of $33.00 per ton of regulated air pollutant for calendar year 2004.

6. The emission fees paid by private entities may vary depending on their current information and their chargeable emissions with fees remaining relatively constant. However, new controls decrease the amount of their emission fees.

7. The percent difference between the two most recent years of actual facility emissions is used to project future year facility emissions.

8. Compliance and EIQ preparation costs reported on EIQs are not included in this fiscal note because these costs are not a result of this rulemaking. Compliance and preparation costs have been included in fiscal notes for the rulemakings that implemented these requirements.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 107—Sales/Use Tax—Exemption Certificates

PROPOSED AMENDMENT

12 CSR 10-107.100 Use of and Reliance on Exemption Certificates. The director proposes to delete section (5).

PURPOSE: This amendment is necessary to have the annotations removed from the body of the rule. The annotations will be placed in the ***Code of State Regulations*** *following the rule.*

[(5) Annotations.

(A) All Star Amusement, Inc. v. Director of Revenue, 873 S.W.2d 843 (Mo. banc 1994). A seller that accepts an exemption certificate in good faith is not required to collect and remit tax on the sale. There is no requirement that a seller accept an exemption certificate contemporaneously with the sale or that the certificate be dated to fulfill the good faith requirement. However, the fact that an exemption certificate is received after the sale or is not dated may influence a factual finding on the issue of the seller's good faith.

(B) Conagra Poultry Co. v. Director of Revenue, 862 S.W.2d 915 (Mo. banc 1993). In order to accept an exemption certificate in good faith, a seller must act with honesty of intention and freedom from knowledge that ought to put the seller on notice. When seller prepared the exemption certificates two (2) years after the transaction and obtained the buyer's signatures, the seller did not act in good faith.

(C) Director of Revenue v. Armco, Inc., 787 S.W.2d 722 (Mo. banc 1993). Failure by seller to provide exemption certificates at time of department audit forfeited the right to claim the sales were exempt.

(D) Cadwell Supermarket, Inc. v. Director of Revenue (AHC 1997). When seller's employees personally knew the buyers were purchasing for exempt purposes, failure to obtain exemption certificates did not defeat the exemption claim.]

AUTHORITY: section 144.270, RSMo 2000. Original rule filed Oct. 25, 2004, effective May 30, 2005. Amended: Filed May 10, 2005.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Revenue, Office of Legislation and Regulations, PO Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

PROPOSED AMENDMENT

13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services. The division is adding a new section (1), amending and renumbering old sections (1) and (2) and renumbering the remaining sections.

PURPOSE: This amendment clarifies what documentation a provider of a Medicaid service must keep in order to avoid violating this section and therefore receiving a sanction.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The Missouri Medicaid program shall be administered by the Department of Social Services, Division of Medical Services. The services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the division and shall be included in the Medicaid provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website www.dss.mo.gov/dms, June 15, 2005. This rule does not incorporate any subsequent amendments or additions. The division reserves the right to affect changes in services, limitations, and fees with notification to providers.

[(1)] **(2)** The following definitions will be used in administering this rule:

(A) Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered. **An adequate and complete patient record is a record which is legible, which is made contemporaneously with the delivery of the service, which addresses the patient/client specifics, which include, at a minimum, individualized statements that support the assessment or treatment encounter, and shall include documentation of the following information:**

1. First name, and last name, and either middle initial or date of birth of the Medicaid recipient;

2. An accurate, complete, and legible description of each service(s) provided;

3. Name, title, and signature of the Missouri Medicaid enrolled provider delivering the service. Inpatient hospital services must have signed and dated physician or psychologist orders within the patient's medical record for the admission and for services billed to Missouri Medicaid. For patients registered on hospital records as outpatient, the patient's medical record must contain signed and dated physician orders for services billed to Missouri Medicaid. Services provided by an individual under the direction or supervision are not reimbursed by Missouri Medicaid. Services provided by a person not enrolled with Missouri Medicaid are not reimbursed by Missouri Medicaid;

4. The name of the referring entity, when applicable;

5. The date of service (month/day/year);

6. For those Medicaid programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services as specified under 13

CSR 70-91.010 Personal Care Program (4)(A)) the actual begin and end time taken to deliver the service (for example, 4:00–4:30 p.m.) must be documented;

7. The setting in which the service was rendered;

8. The plan of treatment, evaluation(s), test(s), findings, results, and prescription(s) as necessary. Where a hospital acts as an independent laboratory or independent radiology service for persons considered by the hospital as "nonhospital" patients, the hospital must have a written request or requisition slip ordering the tests or procedures;

9. The need for the service(s) in relationship to the Medicaid recipient's treatment plan;

10. The Medicaid recipient's progress toward the goals stated in the treatment plan (progress notes); and

11. For applicable programs it is necessary to have adequate invoices, trip tickets/reports, activity log sheets, employee records (excluding health records), and training records of staff;

(B) Affiliates means persons having an overt, covert or conspiratorial relationship so that any one (1) of them directly or indirectly controls or has the power to control another;

(C) Closed-end provider agreement means an agreement that is for a specified period of time, not to exceed twelve (12) months, and that must be renewed in order for the provider to continue to participate in the Medicaid program;

(D) Contemporaneous means at the time the service was performed or within seventy-two (72) hours of the time the service was provided;

(E) Federal health care program means a program as defined in section 1128B(f) of the Social Security Act;

*[(D)]***(F)** Fiscal agent means an organization under contract to the state Medicaid agency for providing any services in the administration of the Medicaid program;

*[(E)]***(G)** Medicaid agency or the agency means the single state agency administering or supervising the administration of a state Medicaid plan;

*[(F)]***(H)** Open-end provider agreement means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties;

*[(G)]***(I)** Participation means the ability and authority to provide services or merchandise to eligible Medicaid recipients and to receive payment from the Medicaid program or those services or merchandise;

*[(H)]***(J)** Person means any natural person, company, firm, partnership, unincorporated association, corporation or other legal entity;

*[(I)]***(K)** Provider means an individual, firm, corporation, pharmacy, hospital, long-term care facility, association or institution which has a provider agreement to provide services to a recipient pursuant to Chapter 208, RSMo;

*[(J)]***(L)** Record*[s]* means any books, papers, journals, charts, treatment histories, medical histories, tests and laboratory results, photographs, X rays and any other recordings of data or information made by or caused to be made by a provider relating in any way to services provided to Medicaid recipients and payments charged or received. Medicaid claim for payment information**,** appointment books, financial ledgers, financial journals or any other kind of patient charge without corresponding adequate medical records do not constitute adequate documentation;

*[(K)]***(M)** Supervision means *[the service was performed while the provider was physically present during the service or the provider was on the premises and readily available to give direction to the person actually performing the service]* **to direct an employee of the provider in the performance of a covered and allowable service such as under the Missouri Medicaid dental and nurse midwife programs or a covered and allowable nonpsychiatric service under the Missouri Medicaid physician program. In order to direct the performance of such service, the provider must be in the office where the service is being provided and must be immediately available to give directions in person to the employee actually rendering the service and the adequately documented service must be cosigned by the enrolled billing provider**;

*[(L)]***(N)** Suspension from participation means an exclusion from participation for a specified period of time;

*[(M)]***(O)** Suspension of payments means placement of payments due a provider in an escrow account;

*[(N)]***(P)** Termination from participation means the ending of participation in the Medicaid program; and

*[(O)]***(Q)** Withholding of payments means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the providers.

[(2)] **(3)** Program Violations.

(A) Sanctions may be imposed by the Medicaid agency against a provider for any one (1) or more of the following reasons:

1. Presenting, or causing to be presented, for payment any false or fraudulent claim for services or merchandise in the course of business related to Medicaid;

2. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable Medicaid program policies or rules, including, but not limited to, the billing or coding of services which results in payments in excess of the fee schedule for the service actually provided or billing or coding of services which results in payments in excess of the provider's charges to the general public for the same services **or billing for higher level of service or increased number of units from those actually ordered or performed or both**, or altering or falsifying medical records to obtain or verify a greater payment than authorized by a fee schedule or reimbursement plan;

3. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements or for the purpose of obtaining payments in order to avoid the effect of those changes;

4. *[Making]* **Failing to make** available, and disclosing to the Medicaid agency or its authorized agents, all records relating to services provided to Medicaid recipients *[and]* **or records relating to** Medicaid payments, whether or not the records are commingled with non-Title XIX **(Medicaid)** records *[is mandatory for all providers]*. **All records must be kept a minimum of five (5) years from the date of service unless a more specific provider regulation applies. The minimum five (5)-year retention of records requirement continues to apply in the event of a change of ownership or discontinuing enrollment in Medicaid. Services billed to the Medicaid agency that are not adequately documented in the patient's medical records or for which there is no record that services were performed shall be considered a violation of this section.** Copies of records must be provided upon request of the Medicaid agency or its authorized agents**, regardless of the media in which they are kept**. Failure to make these records available on a timely basis at the same site at which the services were rendered **or at the provider's address of record with the Medicaid agency**, or failure to provide copies as requested, or failure to keep and make available adequate records which adequately document the services and payments shall constitute a violation of this section and shall be a reason for sanction**. Failure to send records, which have been requested via mail, within the specified time frame shall constitute a violation of this section and shall be a reason for sanction**;

5. Failing to provide and maintain quality, necessary and appropriate services, including adequate staffing for long-term care facility Medicaid recipients, within accepted medical community standards as adjudged by a body of peers, as set forth in both federal and state statutes or regulations. Failure shall be documented by repeat discrepancies. The discrepancies may be determined by a peer review committee, medical review teams, independent professional review

teams, utilization review committees or by Professional Standards Review Organizations (PSRO). The medical review may be conducted by qualified peers employed by the single state agency;

6. Engaging in conduct or performing an act deemed improper or abusive of the Medicaid program or continuing the conduct following notification that the conduct should cease. This will include inappropriate or improper actions relating to the management of recipients' personal funds or other funds;

7. Breaching of the terms of the Medicaid provider agreement of any current written and published policies and procedures of the Medicaid program (such as are contained in provider manuals or bulletins **which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website www.dss.mo.gov/dms, June 15, 2005. This rule does not incorporate any subsequent amendments or additions. The division reserves the right to affect changes in services, limitations, and fees with notification to providers.)** or failing to comply with the terms of the provider certification on the Medicaid claim form;

8. Utilizing or abusing the Medicaid program as evidenced by a documented pattern of inducing, furnishing or otherwise causing a recipient to receive services or merchandise not otherwise required or requested by the recipient, attending physician or appropriate utilization review team; a documented pattern of performing and billing tests, examinations, patient visits, surgeries, drugs or merchandise that exceed limits or frequencies determined by the department for like practitioners for which there is no demonstrable need, or for which the provider has created the need through ineffective services or merchandise previously rendered;

9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral; or collecting a portion of the service fee from the recipient, except this shall not apply to Title XIX services for which recipients are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.051 and 13 CSR 70-55.010;

10. Violating any provision of the State Medical Assistance Act or any corresponding rule;

11. Submitting a false or fraudulent application for provider status which misrepresents material facts. This shall include concealment or misrepresentation of material facts required on any provider agreements or questionnaires submitted by affiliates when the provider knew or should have known the contents of the submitted documents;

12. Violating any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries. In addition to all other laws which would commonly be understood to govern or regulate the conduct of occupations, professions or regulated industries, this provision shall include any violations of the civil or criminal laws of the United States, of Missouri or any other state or territory, where the violation is reasonably related to the provider's qualifications, functions or duties in any licensed or regulated profession or where an element of the violation is fraud, dishonesty, moral turpitude or an act of violence;

13. Failing to meet standards required by state or federal law for participation (for example licensure);

14. *[Excluding]* **Exclusion** from *[Medicare for any reason arising out of improper conduct related to]* the Medicare program **or any other federal health care program**;

15. Failing to accept Medicaid payment as payment in full for covered services or collecting additional payment from a recipient or responsible person, except this shall not apply to Title XIX services for which recipients are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.051 and 13 CSR 70-55.010;

16. Refusing to execute a new provider agreement when requested to do so by the single state agency in order to preserve the single state agency's compliance with federal and state requirements; or failure to execute an agreement within twenty (20) days for compliance purposes;

17. Failing to correct deficiencies in provider operations within ten (10) days **or date specified** after receiving written notice *[established by a signed receipt of delivery]* of these deficiencies from the single state agency or within the time frame provided from any other agency having licensing or certification authority;

18. Being formally reprimanded or censured by a board of licensure or an association of the provider's peers for unethical, unlawful or unprofessional conduct; any termination, removal, suspension, revocation, denial, probation, consented surrender or other disqualification of all or part of any license, permit, certificate or registration related to the provider's business or profession in Missouri or any other state or territory of the United States;

19. Being suspended or terminated from participation in another governmental medical program such as Workers' Compensation, Crippled Children's Services, Rehabilitation Services**,** *[and]* **Title XX Social Service Block Grant or** Medicare;

20. Using fraudulent billing practices arising from billings to third parties for costs of services or merchandise or for negligent practice resulting in death or injury or substandard care to persons including, but not limited to, the provider's patients;

21. Failing to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments prior to the allowed forty-five (45) days which the provider has to refund the requested amount;

22. Billing the Medicaid program *[twice]* **more than once** for the same service when the billings were not caused by the single state agency or its agents;

23. Billing the state Medicaid program for services not provided prior to the date of billing (prebilling), except in the case of prepaid health plans or pharmacy claims submitted by point-of-service technology; whether or not the prebilling causes loss or harm to the Medicaid program;

24. Failing to reverse **or credit back to the medical assistance program (Medicaid) within thirty (30) days** any pharmacy claims submitted *[by point-to-service technology while representing]* **to the agency that represent products or** services not received by the recipient*[, by the time established by pharmacy manual on the Friday evening following the date the claim was submitted by point-of-service technology.]***; for example, prescriptions that were returned to stock because they were not picked up;**

25. Conducting any action resulting in a reduction or depletion of a long-term care facility Medicaid recipient's personal funds or reserve account, unless specifically authorized in writing by the recipient, relative or responsible person;

26. *[Providing services by a nonenrolled person without the direct supervision of a provider and billed by the provider as having performed those services, or services billed by a provider but performed by a similarly licensed practitioner, nonenrolled due to Medicaid sanction, whether or not the performing practitioner was under supervision of the billing provider]* **Submitting claims for services not personally rendered by the individually enrolled provider, except for the provisions specified in the Missouri Medicaid dental, physician, or nurse midwife programs where such claims may be submitted only if the individually enrolled provider directly supervised the person who actually performed the service and the person was employed by the enrolled provider at the time the service was rendered. All claims for psychiatric, psychological counseling, speech therapy, physical therapy, and occupational therapy services may only be billed by the individually enrolled provider who actually performs the service, as supervision is noncovered for these services. Services performed by a nonenrolled person due to Medicaid sanction, whether or not the person was under supervision of the enrolled provider, is a noncovered service**;

27. Making any payment to any person in return for referring an individual to the provider for the delivery of any goods or services for which payment may be made in whole or in part under Medicaid. Soliciting or receiving any payment from any person in return for referring an individual to another supplier of goods or services regardless of whether the supplier is a Medicaid provider for the delivery of any goods or services for which payment may be made in whole or in part under Medicaid is also prohibited. Payment includes, without limitation, any kickback, bribe or rebate made, either directly or indirectly, in cash or in-kind;

28. *[Having]* **Billing for** services *[billed and rendered],* **through an agent,** which were upgraded from those actually ordered**, performed;** or billing or coding services**, either directly or through an agent,** in a manner that services are paid for as separate procedures when, in fact, the services were performed concurrently or sequentially and should have been billed or coded as integral components of a total service as prescribed in Medicaid policy for payment in a total payment less than the aggregate of the improperly separated services; **or billing a higher level of service than is documented in the patient/client record; or unbundling procedure codes;**

29. Conducting civil or criminal fraud against the Missouri Medicaid program or any other state Medicaid (medical assistance) program, or any criminal fraud related to the conduct of the provider's profession or business;

30. Having sanctions or any other adverse action invoked by another state Medicaid program;

31. Failing to take reasonable measures to review claims for payment for accuracy, duplication or other errors caused or committed by employees when the failure allows material errors in billing to occur. This includes failure to review remittance advice statements provided *[with the payment document]* which results in payments which do not correspond with the actual services rendered;

32. Submitting improper or false claims to the state or its fiscal agent by an agent or employee of the provider;

33. **For providers other than long-term care facilities,** *[F]***f**ailing to retain **in legible form for at least five (5) years from the date of service,** worksheets *[or]***, financial records, appointment books, appointment calendars (for those providers who schedule patient/client appointments), adequate documentation of the service, and** other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. *[The documentation must be retained for five (5) years. Long-term care providers are required to retain financial records for seven (7) years]* **For long-term care providers, failing to retain in legible form, for at least seven (7) years from the date of service, worksheets, financial records, adequate documentation for the service(s), and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. The documentation must be maintained so as to protect it from damage or loss by fire, water, computer failure, theft, or any other cause**;

34. Removing or coercing from the possession or control of a recipient any item of durable medical equipment which has reached Medicaid-defined purchase price through Medicaid rental payments or otherwise become the property of the recipient without paying fair market value to the recipient;

35. Failing to timely submit civil rights compliance data or information or failure to timely take corrective action for civil rights compliance deficiencies within thirty (30) days after notification of these deficiencies or failure to cooperate or supply information required or requested by civil rights compliance officers of the single state agency; *[and]*

36. Billing the Medicaid program for services rendered to a recipient in a long-term care facility when the resident resided in a portion of the facility which was not Medicaid-certified or properly licensed or was placed in a nonlicensed or Medicaid-noncertified bed*[.]***;**

37. Failure to comply with the provisions of the state contract or agreement relating to health care services;

38. Failure to maintain documentation which is to be made contemporaneously to the date of service;

39. Failure to maintain records for services provided and all billing done under his/her provider number regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the Medicaid claim or both;

40. Failure to submit proper diagnosis codes, procedure codes, billing codes regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the Medicaid claim;

41. Failure to submit and document, as defined in subsection (2)(A) the length of time (begin and end clock time) actually spent providing a service, except for services as specified under 13 CSR 70-91.010(4)(A) Personal Care Program, regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the Medicaid claim or both; and

42. Billing for the same service as another provider when the service is performed or attended by more than one (1) enrolled provider. Missouri Medicaid will reimburse only one (1) provider for the exact same service.

*[(3)]***(4)** Any one (1) or more of the following sanctions may be invoked against providers for any one (1) or more of the program violations specified in section (2) of this rule:

(A) Failure to respond to notice of overpayments or notice of deficiencies in provider operations within the specified forty-five (45)-day time limit shall be considered cause to withhold future provider payments until the situation in question is resolved;

(B) Termination from participation in the Medicaid program for a period of not less than sixty (60) days nor more than ten (10) years;

(C) Suspension of participation in the Medicaid program for a specified period of time;

(D) Suspension or withholding of payments to a provider;

(E) Referral to peer review committees including PSROs or utilization review committees;

(F) Recoupment from future provider payments;

(G) Transfer to a closed-end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed-end provider agreement;

(H) Attendance at provider education sessions;

(I) Prior authorization of services;

(J) One hundred percent (100%) review of the provider's claims prior to payment;

(K) Referral to the state licensing board for investigation;

(L) Referral to appropriate federal or state legal agency for investigation, prosecution, or both, under applicable federal and state laws;

(M) Retroactive denial of payments; and

(N) Denial of payment for any new admission to a skilled nursing facility (SNF), intermediate care facility (ICF) or ICF/mentally retarded (MR) that no longer meets the applicable conditions of participation (for SNFs) or standards (for ICFs and ICF/MRs) if the facility's deficiencies do not pose immediate jeopardy to patients' health and safety. Imposition of this sanction must be in accordance with all applicable federal statutes and regulations.

*[(4)]***(5)** Imposition of a Sanction.

(A) The decision as to the sanction to be imposed shall be at the discretion of the Medicaid agency. The following factors shall be considered in determining the sanction(s) to be imposed:

1. Seriousness of the offense(s)—The state agency shall consider the seriousness of the offense(s) including, but not limited to, whether or not an overpayment (that is, financial harm) occurred to the program, whether substandard services were rendered to Medicaid recipients, or circumstances were such that the provider's behavior could have caused or contributed to inadequate or dangerous medical care for any patient(s), or a combination of these. Violation of pharmacy laws or rules, practices potentially dangerous to patients and fraud are to be considered particularly serious;

2. Extent of violations—The state Medicaid agency shall consider the extent of the violations as measured by, but not limited to, the number of patients involved, the number of Medicaid claims involved, the number of dollars identified in any overpayment and the length of time over which the violations occurred. The Medicaid agency may calculate an overpayment or impose sanctions under this rule by reviewing records pertaining to all or part of a provider's Medicaid claims. When records are examined pertaining to part of a provider's Medicaid claims, no random selection process in choosing the claims for review as set forth in 13 CSR 70-3.130 need be utilized by the Medicaid agency. But, if the random selection process is not used, the Medicaid agency may not construe violations found in the partial review to be an indication that the extent of the violations in any unreviewed claims would exist to the same or greater extent;

3. History of prior violations—The state agency shall consider whether or not the provider has been given notice of prior violations of this rule or other program policies. If the provider has received notice and has failed to correct the deficiencies or has resumed the deficient performance, a history shall be given substantial weight supporting the agency's decision to invoke sanctions. If the history includes a prior imposition of sanction, the agency should not apply a lesser sanction in the second case, even if the subsequent violations are of a different nature;

4. Prior imposition of sanctions—The Medicaid agency shall consider more severe sanctions in cases where a provider has been subject to sanctions by the Missouri Medicaid program, any other governmental medical program, Medicare or exclusion by any private medical insurance carriers for misconduct in billing or professional practice. Restricted or limited participation in compromise after being notified or a more severe sanction should be considered as a prior imposition of a sanction for the purpose of this subsection;

5. Prior provision of provider education—In cases where sanctions are being considered for billing deficiencies only, the Medicaid agency may mitigate its sanction if it determines that prior provider education was not provided. In cases where sanctions are being considered for billing deficiencies only and prior provider education has been given, prior provider education followed by a repetition of the same billing deficiencies shall weigh heavily in support of the medical agency's decision to invoke severe sanctions; and

6. Actions taken or recommended by peer review groups, licensing boards or Professional Review Organizations (PRO) or utilization review committees—Actions or recommendations by a provider's peers shall be considered as serious if they involve a determination that the provider has kept or allowed to be kept, substandard medical records, negligently or carelessly performed treatment or services, or, in the case of licensing boards, placed the provider under restrictions or on probation.

(B) Where a provider has been convicted of defrauding any Medicaid program, has been previously sanctioned due to program abuse, has been terminated from the Medicare program, the Medicaid agency shall terminate the provider from participation in the Medicaid program.

(C) When a sanction involving the collection, recoupment or withholding of Medicaid payments from a provider is imposed on a provider, it shall become effective ten (10) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction. When any other sanction is imposed on a provider it shall become effective thirty (30) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction. If, in the judgment of the single state agency, the surrounding facts and circumstances clearly show that serious abuse or harm may result from delaying the imposition of a sanction, any sanction may be made effective immediately upon receipt of notice by the provider.

(D) A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure or inadequacy of performance may be imputed to an affiliate when the affiliate knew or should have known of the provider's actions.

(E) Suspension or termination of any provider shall preclude the provider from participation in the Medicaid program, either personally or through claims submitted by any clinic, group, corporation or other association to the single state agency or its fiscal agents for any services or supplies provided under the Medicaid program except for those services or supplies provided prior to the suspension or termination.

(F) No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the single state agency or its fiscal agents for any services or supplies provided by, or under the supervision of, a person within the organization who has been suspended or terminated from participation in the Medicaid program except for those services or supplies provided prior to the suspension or termination.

(G) When the provisions of the previously mentioned are violated by a provider of services which is a clinic, group, corporation or other association, the single state agency may suspend or terminate the organization, the individual person, or both, within the organization who knew or should have known of the violation.

(H) When a provider has been sanctioned, the single state agency shall notify, as appropriate, the applicable professional society, board of registration or licensure, federal and state agencies of the finding made and the sanctions imposed.

(I) Where a provider's participation in the Medicaid program has been suspended or terminated, the single state agency shall notify the county offices of the suspensions or terminations.

(J) Except where termination has been imposed, a provider who has been sanctioned may be required to participate in a provider education program as a condition of continued participation. Provider education programs may include:

1. Telephone and written instructions;
2. Provider manuals and workshops;
3. Instruction in claim form completion;
4. Instruction on the use and format of provider manuals;
5. Instruction on the use of procedure codes;
6. Key provisions of the Medicaid program;
7. Instruction on reimbursement rates; and
8. Instruction on how to inquire about coding or billing problems.

(K) Providers that have been suspended from the Missouri Medicaid program under subsections *[(3)]***(4)**(B) and (C) may be reenrolled in the Medicaid program upon expiration of the period of suspension from the program after making satisfactory assurances of future compliance. Providers that have been terminated from the Missouri Medicaid program under subsection *[(3)]***(4)**(B) may be reenrolled in the program at the sole discretion of the single state agency and only after providing satisfactory evidence that the past cause for termination has ceased and that future participation is warranted.

*[(5)]***(6)** Amounts Due the Department of Social Services From a Provider.

(A) If there exists an amount due the Department of Social Services from a provider, the single state agency shall notify the provider or the provider's representative of the amount of the overpayment. If the amount due is not sooner paid to the Department of Social Services by or on behalf of the provider, the single state agency, forty-five (45) days from the date the provider receives the notice, established by a signed receipt of delivery, may take appropriate action to collect the overpayment. The single state agency may recover the overpayment by withholding from current Medicaid reimbursement. The withholding may be taken from one (1) or more payments until the funds withheld in the aggregate equal the amount due as stated in the notice.

(B) When a provider receives notice, established by a signed receipt of delivery, of an overpayment and the amount due is in excess of one thousand dollars ($1,000), the provider, within ten (10) days of the notice, may submit to the single state agency a plan for repayment of forty percent (40%) of the overpayment amount and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. No repayment plans will be considered for the first sixty percent (60%) of the overpayment amount. If this repayment plan is timely received from a provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case and reject, accept or offer to accept a modified version of the provider's plan for repayment. The single state agency shall notify the provider of its decision within ten (10) days after the proposal is received. If no plan for repayment is agreed upon within thirty (30) days after the provider receives notice of the overpayment, the Medicaid agency may take appropriate action to collect the balance of the amount due.

(C) If a plan agreed to and implemented under provisions of subsection *[(5)]***(6)**(B) for repayment of amounts due the Department of Social Services from a provider is breached, discontinued or otherwise violated by a provider, the single state agency, immediately upon the next payment to the provider, may begin to withhold payments or portions of payments until the entire amount due has been collected.

(D) Repayment or an agreement to repay amounts due the Department of Social Services by a provider shall not prevent the imposition of any sanction by the single state agency upon the provider.

AUTHORITY: section 208.201, RSMo [Supp. 1987] ***2000****. This rule was previously filed as 13 CSR 40-81.160. Original rule filed Sept. 22, 1979, effective Feb. 11, 1980. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed May 16, 2005.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 4—Conditions of Recipient Participation, Rights and Responsibilities

PROPOSED AMENDMENT

13 CSR 70-4.050 Copayment and Coinsurance for Certain Medicaid-Covered Services. The division is amending sections (1), (3), (6), (8), (9), (10), (11), (12) and deleting section (7) and adding four (4) new sections (13), (14), (15) and (16).

PURPOSE: This proposed amendment changes the copayment due from Medicaid recipients for physician-related services and hospital outpatient clinic or emergency room services.

(1) Recipients eligible to receive Missouri Medicaid services under certain program areas shall be required to pay a small portion of the costs of the services. The services to be affected by the copayment or coinsurance requirements are—

(F) **Hospital** *[O]***o**utpatient *[hospital]* clinic/emergency room services; and

(G) **All** *[P]***p**hysician**-related** services *[rendered in a hospital outpatient clinic or emergency room]*.

(3) Copayment charged shall be in accordance with 42 CFR 447.54 and, applicable to the services described in subsections (1)(A), (B) (excepting dentures), (C) *[and]***,** (D), **and (G),** based on the following schedule:

Medicaid Payment for Each Item of Service	Recipient Copayment Amount
$*[10.99]* **10** or less	$0.50
$*[11.00]* **10.01**–$25*[.99]*	$1.00
$*[26.00]* **25.01**–$50*[.99]*	$2.00
$*[51.00]* **50.01** or more	$3.00

(6) Copayment to be charged for hospital outpatient clinic or emergency room services shall be *[two dollars ($2)]* **three dollars ($3)** for each date of service on which the recipient receives, either one (1) or both, outpatient clinic or emergency room services.

[(7) Co-payment to be charged for physician services provided in a hospital outpatient clinic or emergency room shall be one dollar ($1) for each date of service on which the recipient receives these services.]

*[(8)]***(7)** *[With noted exceptions, t]***T**he following exemptions **apply** to the copayment requirement *[apply to the services]* **for services** described in subsections (1)(A)–(G):

(A) Services provided *[on or after December 1, 1984]* to recipients under *[eighteen (18)]* **nineteen (19)** years of age;

(B) Services to recipients residing within a skilled nursing home, an intermediate care nursing home, a residential care home, an adult boarding home or a psychiatric hospital;

(C) Services to recipients who have both Medicare and Medicaid entitlement if Medicare covers the service and provides payment for it;

(D) Emergency or transfer inpatient hospital admissions;

(E) Emergency services provided in an outpatient clinic or emergency room, *[such as—heart attack, hemorrhaging, poisoning, concussion, bone fractures or stroke]* **after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:**

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part;

(F) Certain therapy services (physical therapy, chemotherapy, radiation therapy, psychotherapy and chronic renal dialysis) except when provided as an inpatient hospital service;

(G) Family planning services;

(H) Services provided to pregnant women *[which are directly related to the pregnancy or a complication of the pregnancy]*;

(I) Services provided to foster care recipients; *[and]*

(J) **Services identified as medically necessary through an** Early Periodic Screening, Diagnosis and Treatment **(EPSDT) screen** *[services.]***; and**

(K) Services provided through MC+ Managed Care Contracts.

[(9)] **(8) Providers are responsible for collecting the copayment or coinsurance amounts from individuals. The medical assistance program shall not increase its reimbursement to a provider to offset an uncollected copayment from a recipient. A provider shall collect a copayment from a recipient at the time each service is provided or at a later date.** Providers of services as described in this rule and as subject to a copayment or coinsurance requirement may not deny or reduce services otherwise eligible for Medicaid benefits on the basis of the recipient's inability to pay the due copayment or coinsurance amount when charged.

[(10)] **(9)** A recipient's inability to pay a required coinsurance or copayment amount, as due and charged when a service is delivered, in no way shall extinguish the recipient liability to pay the due amount **or prevent a provider from attempting to collect a copayment**.

[(11)] **(10)** Participation privileges in the Medicaid program shall be limited to providers who accept, as payment in full, the amounts paid by the state agency plus any coinsurance or copayment amount required of the recipient.

[(12)] **(11)** Providers of services in the program areas named must charge copayment or coinsurance as specified at the time the service is provided to retain their participation privileges in the Missouri Medicaid program.

[(13)] **(12)** Providers must maintain records of copayment or coinsurance amounts for five (5) years and must make those records available to the Department of Social Services upon request.

(13) If it is the routine business practice of a provider to discontinue future services to an individual with uncollected debt, the provider may include uncollected copayments under this practice.

(14) A provider shall give a Medicaid recipient a reasonable opportunity to pay an uncollected copayment.

(15) A provider shall give a Medicaid recipient with uncollected debt advanced notice and a reasonable opportunity to arrange care with a different provider before services can be discontinued.

(16) If a provider is not willing to provide services to a recipient with uncollected copayments and the requirements of this regulation have been met, the provider may discontinue future services to an individual with uncollected copayments. In accordance with 42 *Code of Federal Regulations* (CFR) 431.51, a recipient may obtain services from any qualified provider who is willing to provide services to that particular recipient and accept their ability/inability to pay the required copayments.

AUTHORITY: sections [207.020] ***208.152, RSMo Supp. 2004, 208.201****, RSMo [1986]* ***2000 and 208.215 as enacted by the 93rd General Assembly****. This rule was previously filed as 13 CSR 40-81.054. Emergency rule filed Oct. 21, 1981, effective Nov. 1, 1981, expired Feb. 10, 1982. Original rule filed Oct. 21, 1981, effective Feb. 11, 1982. Emergency amendment filed Jan. 21, 1983, effective Feb. 1, 1983, expired May 11, 1983. Amended: Filed Jan. 21, 1983, effective May 12, 1983. Amended: Filed Aug. 14, 1984, effective Nov. 11, 1984. Amended: Filed May 16, 2005.*

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

PRIVATE COST: This proposed amendment will cost private entities approximately twenty-three (23) million dollars based on state fiscal year 2004 utilization.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-4.050 Copayment and Coinsurance for Certain Medicaid-Covered Services
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the count of compliance with the rule by the affected entities:
355,221	Medicaid recipients other than those noted exceptions listed in the assumptions	Unknown, no data is available on how many of the current Medicaid recipients required to pay co-payments actually pay
23,533	Medicaid enrolled hospitals and physician-related service providers	Providers will comply due to the systematic reduction of the co-payment from the provider's payment

III. WORKSHEET

The proposed amendment will provide for a standard, or fixed co-payment amount for any physician-related service and hospital outpatient clinic or emergency room service. This standard co-payment may be determined by applying the maximum co-payment amounts (specified below) to the agency's average or typical payment for that service. For example, if the agency's typical payment for a physician-related office visit is $20, the standard co-payment could be set at $1. The co-payments are charged on per encounter.

The co-payment to be charged for hospital outpatient clinic or emergency room services shall be $3 for each date of service on which the recipient receives, either one or both, outpatient clinic or emergency room services.

States Payment for the Service	Maximum Co-payment Chargeable to Recipient
$10 or less..............................	$0.50
$10.01 to $25	$1.00
$25.01 to $50	$2.00
$50.01 or more	$3.00

The private cost of this proposed amendment is $23,000,000 based on the state fiscal year 2004 utilization of physician-related services and hospital outpatient clinic or emergency room services.

IV. ASSUMPTIONS

The proposed amendment changes the co-payment due from Medicaid recipients for physician-related services and hospital outpatient clinic or emergency room services pursuant to Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly, 2005.

Cost sharing may be either a deductible, or a coinsurance, or a co-payment, but not a combination of these on any single service. For any service, Medicaid programs may not impose more than one type of cost sharing.

The state will impose a nominal co-payment (as capped above) for any physician-related or hospital outpatient clinic or emergency room service and require certain recipients to share some of the costs of Medicaid.

The following recipients are excluded from co-payments:
- Children
- Pregnant women
- Institutionalized individuals (long-term care facility or other medical institution)
- Emergency services if the patient's health is in serious jeopardy, if there is serious impairment to bodily functions, or if there is serious dysfunctions of any bodily organ or part (Prudent Layperson)
- Family planning
- Hospice

The co-payment will be systematically deducted from the provider's Medicaid payment. No provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing. The deduction of the co-payment, in many cases, would be a rate reduction for the provider and may cause access issues due to the potential for some providers to drop out of the Medicaid program or choose to not see some Medicaid clients.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 4—Conditions of Recipient Participation, Rights and Responsibilities

PROPOSED RULE

13 CSR 70-4.110 Placement of Liens on Property of Certain Institutionalized Medicaid Eligible Persons

PURPOSE: This rule implements the guidelines for placement of liens on the property of certain institutionalized Medicaid eligible persons, in accordance with the authority given to states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended.

(1) When an applicant for Medicaid or a Medicaid recipient is a patient, or will become a patient, in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, the Department of Social Services will determine if the placement of a lien against the property of the applicant or recipient is applicable. A lien is imposed on the property of an individual, in accordance with the authority given states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), when:

(A) The Medicaid recipient is or has made application to become a patient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution, to spend for costs of medical care all but a minimal amount of his income required for personal needs;

(B) The institutionalized Medicaid recipient owns property. Property includes the homestead and all other real property in which the person has a sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than fair market value within thirty-six (36) months prior to the person entering the nursing facility;

(C) The department has determined after notice and opportunity for hearing that there is no reasonable expectation that the person can be discharged from the facility within one hundred twenty (120) days and return home. The hearing, if requested, will proceed under the provision of Chapter 536, RSMo, before a hearing officer designated by the director of the Department of Social Services. The fact that there is no reasonable expectation that the person can be discharged from the facility within one hundred twenty (120) days and return home may be substantiated by one (1) of the following:

1. Applicant/recipient states in writing that he/she does not intend to return home within one hundred twenty (120) days;

2. Applicant/recipient has been in the institution for longer than one hundred twenty (120) days; and

3. A physician states in writing that the applicant/recipient cannot be expected to be discharged within one hundred twenty (120) days of admission; and

(D) A lien is imposed on the property unless one (1) of the following persons lawfully resides in the property:

1. The institutionalized person's spouse;

2. The institutionalized person's child who is under twenty-one (21) years of age or is blind or permanently and totally disabled;

3. The institutionalized person's sibling who has an equity interest in the property and who was residing in such individual's home for a period of at least one (1) year immediately before the date of the individual's admission to the institution.

(2) After determining the applicability of the lien, the Medicaid recipient is given an Explanation of TEFRA Lien. A person who objects to the imposition of a lien is ineligible for medical assistance. Ineligibility is based on the person's objection without good cause to the imposition of the lien, which impedes the department's ability to implement its lien requirements.

(3) The director of the department or the director's designee will file for record, with the recorder of deeds of the county in which any real property is situated, a written Certificate of TEFRA Lien. The lien will contain the name of the Medicaid recipient and a description of the property. The recorder will note the time of receiving such notice and will record and index the certificate of lien in the same manner as deeds of real estate are required to be recorded and indexed. The county recorder shall be reimbursed by presenting a statement showing the number of certificates and releases filed each calendar quarter to the Department of Social Services.

(4) The TEFRA lien will be for the debt due the state for medical assistance paid or to be paid on behalf of the Medicaid recipient. The amount of the lien will be for the full amount due the state at the time the lien is enforced. Fees paid to county records of deeds for filing of the lien will be included in the amount of the lien.

(5) The TEFRA lien does not affect ownership interest in a property until it is sold, transferred, or leased, or upon the death of the individual, at which time the lien must be satisfied.

(6) The lien will be dissolved in the event the individual is discharged from the institution and returns home. A Notice of TEFRA Lien Release will be filed within thirty (30) days with the recorder of deeds of the county in which the original Certificate of TEFRA Lien was filed.

AUTHORITY: sections 208.201, RSMo 2000 and 208.215 as enacted by the 93rd General Assembly. Original rule filed May 16, 2005.

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

PRIVATE COST: This proposed rule will cost private entities (medical assistance) less than one hundred thousand dollars ($100,000) in the aggregate over the first two (2) years of the life of the rule. In following years the medical assistance program will recover approximately one (1) million dollars a year from property with these liens.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	13 CSR 70-4.110 Placement of Liens on Property of Certain Institutionalized Medicaid Eligible Persons
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the entities which would likely be affected:	Estimate in the aggregate as to the count affected by the rule:
	Individuals who are eligible for medical assistance who will stay in a nursing facility more than 120 days	90% will be impacted 10% will be exempted under the rule

III. WORKSHEET

Average Monthly NH Population	24,694
20% Property Owners	5,539
10% Exemption	4,985
3% Death Rate of NH Estate Cases	82
Property Value	$12,195
Annual Recovery Projection	$1,000,000

IV. ASSUMPTIONS

This proposed rule will cost private entities (medical assistance recipients) less than $100,000 in the aggregate over the first two years of the rule because liens will be filed but not collected until the death of the medical assistance recipient. The average length of stay in a nursing facility is three years. In following years the medical assistance program will recover approximately $1,000,000 a year from property with these liens.

Based on FY04 Table 5 statistical data, there are an average of 24,694 nursing facility residents per month. Assuming 20% of the residents own property, which is 5,539. Assuming 10% of the residents will be exempt as specified in the rule leaves 4,985 potential liens to be filed in the first

year. Since 3% of the Medicaid population are residents in nursing facilities, assume that 3% of the number of decedents from FY04 Estate cases worked (2,734), 82 liens may be collected annually. Assuming the average value of the resident's property is $12,195, the potential recovery is $1,000,000.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 5—Nonemergency Medical Transportation Services

PROPOSED RULE

13 CSR 70-5.010 Nonemergency Medical Transportation (NEMT) Services

PURPOSE: This rule establishes the criteria by which the medical assistance program (Medicaid) reimburses expenses for nonemergency medically necessary transportation if a recipient does not have access to transportation services that are available free of charge.

(1) The Missouri Medical Assistance program (Medicaid) or its contractor reimburses eligible recipients or nonemergency medical transportation (NEMT) providers for medically necessary transportation only if a recipient does not have access to transportation services that are available free of charge.

(A) The recipient must have an appointment for any medical treatment that is approved by the Division of Medical Services.

(B) Alternative transportation services that may be provided free of charge include volunteers, relatives, designated legal representative, individual involved in the resident's care, or transportation services provided by nursing facilities or other residential centers. Recipients must certify in writing that they do not have access to free transportation.

(2) Medicaid eligible residents of a nursing facility are not provided nonemergency transportation services by the Medicaid Nonemergency Transportation Program. Nursing facilities must provide nonemergency transportation to meet the medical needs of the resident, for example, visits to physicians or other medical providers.

(3) Nonemergency medical transportation is not available to a pharmacy.

(4) Medicaid reimburses the most appropriate and least costly transportation alternative suitable for the recipient's medical condition. If a recipient can use private vehicles or less costly public transportation, those alternatives must be used before recipients can use more expensive transportation alternatives.

AUTHORITY: section 208.201, RSMo 2000. Original rule filed May 16, 2005.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 73—Board of Nursing Home Administrators
Chapter 2—General Rules

PROPOSED AMENDMENT

19 CSR 73-2.050 Renewal of Licenses. The board proposes to amend sections (2) and (3), add a new section (4), and renumber sections (4) and (5).

PURPOSE: This proposed amendment revises the license renewal auditing process, removes the requirement for prior approval on programs held in another state, and increases the number of clock hours awarded for serving as a preceptor.

(2) Licensees seeking renewal shall, during the month of May of each year, file an application for renewal on a form furnished by the board, and shall submit a renewal fee of fifty dollars ($50) made payable to the Department of Health and Senior Services. **Information provided in the application shall be given under oath and include evidence that the licensee has completed, during the reporting period, twenty (20) clock hours of board-approved continuing education. A minimum of five (5) clock hours must be in patient-care related offerings, as defined in 19 CSR 73-2.031(2)(A)–(F). The reporting period will cover fifteen (15) months that begins on April 1, of the preceding licensure year and ends on June 30, of the current licensure year. Continuing education hours earned at a single program cannot be split or used to renew in two (2) different reporting periods.**

(3) *[As a requirement for renewal of license, a licensee shall provide the board, on the annual application form for license renewal, satisfactory evidence of twenty (20) clock hours of board-approved continuing education obtained during the current licensure year or carried from the preceding year. A minimum of five (5) clock hours must be in patient-care related offerings, as defined in 19 CSR 73-2.031(2)(A)–(F) and must be obtained during the current licensure year.]* **Licensees must maintain proof of having completed the number of continuing education hours claimed at the time of renewal and shall, upon request of the board, make that proof available for audit to verify completion of the number and validity of hours claimed. Documentation to prove completion of continuing education hours must be maintained by each licensee for four (4) years from the last day of the licensure year in which the hours were earned.**

(A) A minimum of fifteen (15) clock hours toward the twenty (20) required shall be obtained through attendance at board-approved continuing education programs or academic courses, as defined in 19 CSR 73-2.031(2)(A)–(K), and must meet the following criteria:

1. Be *[prior]* approved by the board. In the case of academic courses, the licensee must submit a course description from the college for board review. A maximum of five (5) clock hours per semester hour may be approved by the board. Upon successful completion of the course (grade of "C" or above), an official *[copy of the]* **transcript or** grade report must be submitted to the board office**, upon request,** as verification of course completion;

2. Be offered by a registered training agency approved by the board or a single offering provider (as outlined in 19 CSR 73-2.060);

3. *[Programs held out-of-state, may be considered for prior approval by the board upon submission of the following information:*

A. Evidence that the program has been] **Be** approved by another state licensure board for nursing home administrators or by the National Continuing Education Review Service (NCERS) under the National Association of Boards (NAB); *[and*

B. A brochure or other detailed information from the program which must include: offering title, date and location; program objectives; speaker credentials; and a detailed agenda.]

(B) A maximum of five (5) clock hours toward the twenty (20) required may be obtained as follows:

1. For the purposes of this subsection, the following definitions shall apply:

A. Referred publication—a publication that undergoes an anonymous review process that determines whether or not the article will be published; and

B. National health-care publication—a publication that is—

(I) Published by a health-care association whose mission statement/bylaws indicate its scope is national;

(II) Mailed nationwide; and

(III) Addressing content contained within the long-term care core of knowledge outlined in 19 CSR 73-2.031(2)(A)–(K);

2. Publishing health-care related articles of at least fifteen hundred (1,500) words shall be granted—

A. Five (5) clock hours if article appears in a national health-care referred publication;

B. Four (4) clock hours if article appears in a regional health-care referred publication;

C. Three (3) clock hours if article appears in a state health-care referred publication;

D. Two (2) clock hours if article appears in a national health-care publication; and

E. One (1) clock hour if article is published.

3. Serving as a registered preceptor for an applicant who has been required by the board to complete an internship as described in 19 CSR 73-2.031. One (1) clock hour per full month as a preceptor shall be granted with a maximum of *[five (5)]* **ten (10)** clock hours per internship; and

4. An administrator lecturing at a board-approved seminar may receive credit equal to each hour or quarter hour of presentation time with a maximum of three (3) hours credit earned per licensure year. This credit may be in addition to actual hours of attendance at the seminar but credit shall be granted for only one (1) presentation of the same seminar

[(E) Licensees making application for renewal of license shall be responsible for filing evidence of continuing education clock hours with the executive secretary BEFORE the renewal application is approved by the board. The evidence submitted may be subject to audit and review by the board and additional documentation may be requested. To facilitate submission of any additional evidence to the board prior to expiration of licenses June 30, all renewal forms must be completed and received by the executive secretary prior to May 30. Information provided in the application shall be given under oath.

(F) Up to a maximum of fifteen (15) excess clock hours from subsection (2)(A), of continuing education may be carried forward to apply toward the renewal of license in the following year. However, the five (5) clock hours required in patient-care related offerings described in section (2) of this rule MUST be applied in the current year. Any excess hours will NOT be used to meet the next year's requirement of five (5) clock hours in patient-care related offerings.]

(4) The board shall annually select on a random basis at least five percent (5%) of the licensees applying for renewal to have their claims of continuing education hours audited for compliance with board requirements. A licensee will be notified by mail when a renewal application has been selected for audit and will have up to thirty (30) days to provide copies of all certificates of attendance and other documentation supporting the continuing education clock hours claimed on the renewal application. Nothing in this section shall prevent the board from requiring any individual licensee to provide evidence satisfactory to the board of having completed the continuing education hours required for license renewal. Failure to provide proof of continuing education hours as reported on the renewal application or submission of falsified records can be cause for discipline pursuant to section 344.050.2., RSMo.

*[(4)]***(5)** If an incomplete application is received by the board prior to May 30, the board shall grant the licensee a thirty (30)-day extension if needed effective May 31. If an incomplete application is received by the board between May 31 and June 30, the board shall grant the licensee a thirty (30)-day extension, if needed, effective the date the incomplete application is received. An incomplete application shall not include an application that lacks completion of the continuing education requirements prior to June 30. The licensee shall submit a completed application within the thirty (30)-day period or the board may refuse to renew the license. The notarized renewal application, fee and supporting documentation must all be submitted to the board office prior to June 30 to avoid the late penalty fee of twenty-five dollars ($25).

[(5)] **(6)** When the required information, documentation and fee are received and approved by the board within the specified time period, the board shall issue the annual license.

AUTHORITY: section 344.070, RSMo 2000. This rule was previously filed as 13 CSR 73-2.050. Original rule filed May 13, 1980, effective Aug. 11, 1980. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed May 16, 2005.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Nursing Home Administrators, Diana Love, Executive Secretary, PO Box 570, 912 Wildwood, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE
Division 400—Life, Annuities and Health
Chapter 3—Medicare Supplement Insurance

PROPOSED AMENDMENT

20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act. The department is amending sections (1)–(10), (12)–(16), (18) and (19) of this rule. The department is also amending Appendix A, Appendix B and Appendix C of this rule. The department is deleting section (23) of this rule. This amendment also replaces a portion of the form referred to in paragraph (15)(C)4., which is found on pages 59–60 of 20 CSR 400-3 as published in the *Code of State Regulations*.

PURPOSE: This amendment changes the terms "agent" and "broker" to "insurance producer," and also implements changes necessary to remain consistent with minimum federal standards applicable to Medicare Supplement Insurance.

(1) Applicability and Scope.

(C) All forms printed with this rule are included herein.

(2) Definitions. For purposes of this rule—

(B) "Bankruptcy" means when a Medicare*[+Choice]***Advantage** organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state;

(J) "Insurance producer" means a person required to be licensed under section 375.012(6), *Revised Statutes of Missouri*, to sell, solicit or negotiate insurance;

*[(J)]***(K)** "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates;

*[(K)]***(L)** "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

*[(L)]***(M)** "Medicare*[+Choice]***Advantage** plan" means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare*[+Choice]***Advantage** medical savings account; and

3. Medicare*[+Choice]***Advantage** private fee-for-service plans;

*[(M)]***(N)** "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and health services corporations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act (42 U.S.C. section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare*[;]*. **"Medicare supplement policy" does not include MedicareAdvantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCCP) that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act;**

*[(N)]***(O)** "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer;

*[(O)]***(P)** "Pre-standardized Medicare supplement plan" means a Medicare supplement plan issued prior to July 30, 1992;

*[(P)]***(Q)** "Qualified actuary" means a member of the American Academy of Actuaries;

*[(Q)]***(R)** "Standardized Medicare Supplement Plan" means a Medicare supplement plan issued after July 30, 1992; and

*[(R)]***(S)** "Secretary" means the Secretary of the United States Department of Health and Human Services.

(3) Policy Definitions and Terms. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

(D) "Health care expenses" means**, for purposes of section (12),** expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. *[Expenses shall not include:*

1. Home office and overhead costs;

2. Advertising costs;

3. Commissions and other acquisition costs;

4. Taxes;

5. Capital costs;

6. Administrative costs; and

7. Claims processing costs.]

(G) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare **Parts A and B**, to the extent recognized as reasonable and medically necessary by Medicare.

(4) Policy Provisions.

(D)

1. Subject to paragraphs (5)(A)4., 5. and 7. and (6)(A)4. and 5., a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

2. A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

3. After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

A. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan and;

B. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

(5) Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 30, 1992. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" Medicare supplement policy shall not—

A. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

B. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

5.

A. Except as authorized by the director, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

B. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subparagraph D. of this paragraph, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(I) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(II) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection (6)(B) of this rule.

C. If membership in a group is terminated, the issuer shall—

(I) Offer the certificate holder the conversion opportunities described in subparagraph 5.B. of this subsection; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

D. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. **Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.**

7. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

(6) Benefit Standards for Policies or Certificates Issued or Delivered on or After July 30, 1992. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

A. The issuer shall not cancel or nonrenew the policy solely on the grounds of health status of the individual.

B. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (6)(A)5.E., the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

(I) Provides for continuation of the benefits contained in the group policy; or

(II) Provides for benefits that otherwise meet the requirements of this subsection.

D. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall—

(I) Offer the certificate holder the conversion opportunity described in subparagraph (6)(A)5.C.; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

E. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

F. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. **Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.**

7.

A. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four (24) months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

B. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

C. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal rule) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

*[C.]***D.** Reinstitution of coverages*[—]***as described in subparagraphs (6)(A)7.B. and (6)(A)7.C.:**

(I) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(II) Shall provide for **resumption of** coverage which is substantially equivalent to coverage in effect before the date of suspension*[;]***. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension;** and

(III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(B) Standards for Basic (Core) Benefits Common to *[All Benefit Plans]* **Benefit Plans A–J**. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of **one hundred percent (100%) of** the Medicare Part A eligible expenses for hospitalization paid at the *[diagnostic related group (DRG) day outlier per diem]* **applicable prospective payment system (PPS) rate,** or other appropriate **Medicare** standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. **The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.**

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by section (7) of this rule.

1. Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4. Eighty Percent (80%) of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Basic Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar*[s]* ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. **The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.**

7. Extended Outpatient Prescription Drug Benefit*[:]***.** Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar*[s]* ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. **The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.**

8. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

9. Preventive Medical Care Benefit. Coverage for the following preventive health services*[:]* **not covered by Medicare:**

A. An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph B. and patient education to address preventive health care measures;

[B. Any one (1) or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(I) Fecal occult blood test or digital rectal examination, or both;

(II) Mammogram;

(III) Dipstick urinalysis for hematuria, bacteriuria and proteinuria;

(IV) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(V) Serum cholesterol screening (every five (5) years);

(VI) Thyroid function test;

(VII) Diabetes screening;]

B. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician;

C. Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster as medically appropriate; **and**

[D. Any other tests or preventive measures determined appropriate by the attending physician; and]

*[E.]***D.** Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

10. At-Home Recovery Benefit. Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

A. For purposes of this benefit, the following definitions shall apply:

(I) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(II) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(III) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence; and

(IV) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24)-hour period of services provided by a care provider is one (1) visit.

B. Coverage Requirements and Limitations.

(I) At-home recovery services provided must be primarily services which assist in activities of daily living.

(II) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(III) Coverage is limited to—

(a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(b) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit;

(c) One thousand six hundred dollars ($1,600) per calendar year;

(d) Seven (7) visits in any one (1) week;

(e) Care furnished on a visiting basis in the insured's home;

(f) Services provided by a care provider as defined in this section;

(g) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(h) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight (8) weeks after the service date of the last Medicare-approved home health care visit.

C. Coverage is excluded for—

(I) Home care visits paid for by Medicare or other government programs; and

(II) Care provided by family members, unpaid volunteers or providers who are not care providers.

11. New or Innovative Benefits. An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. **After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.**

(D) Standards for Plans K and L.

1. Standardized Medicare supplement benefit plan "K" shall consist of the following:

A. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

B. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

D. Medicare Part A deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

E. Skilled nursing facility care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

F. Hospice care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

G. Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal rules) unless replaced in accordance with federal rules until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

H. Except for coverage provided in subparagraph (6)(D)1.I. below, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J. below;

I. Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

J. Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustments specified by the secretary of the U.S. Department of Health and Human Services.

2. Standardized Medicare supplement benefit plan "L" shall consist of the following:

A. The benefits described in subparagraphs (6)(D)1.A., B., C., and I;

B. The benefit described in subparagraphs (6)(D)1.D., E., F., G., and H., but substituting seventy-five percent (75%) for fifty percent (50%); and

C. The benefit described in subparagraph (6)(D)1.J., but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000).

(7) Standard Medicare Supplement Benefit Plans.

(A) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in subsections (6)(B) **and (6)(C)** of this rule.

(C) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through *["J"]* **"L"** listed in this section and conform to the definitions in section (3) of this rule. Each benefit shall be structured in accordance with the format provided in subsections (6)(B)*[and]*, (6)(C)**, and (6)(D)** and list the benefits in the order shown in this section. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(E) Make-Up of Benefit Plans.

1. Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in subsection (6)(B) of this rule.

2. Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible as defined in paragraph (6)(C)1.

3. Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3. and 8. respectively.

4. Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit (as defined in subsection (6)(B) of this rule), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in foreign country and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 8. and 10. respectively.

5. Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in paragraphs (6)(C)1., 2., 8. and 9. respectively.

6. Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., 5. and 8. respectively.

7. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., 5., and 8., respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

8. Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 4., 8. and 10. respectively.

9. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 6. and 8. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

10. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in paragraphs (6)*[(B)]***(C)**1., 2., 5., 6., 8. and 10. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

11. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9. and 10. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9. and 10. respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be fifteen hundred dollars ($1,500) for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

(F) Make-up of two (2) Medicare supplement plans mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

1. Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in paragraph (6)(D)1.

2. Standardized Medicare supplement plan "L" shall consist only of those benefits described in paragraph (6)(D)2.

(8) Medicare Select Policies and Certificates. This section shall apply to Medicare Select policies and certificates, as defined in this section.

(I) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with—

A. Other Medicare supplement policies or certificates offered by the issuer; and

B. Other Medicare Select policies or certificates;

2. A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized*[;]***. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L";**

4. A description of coverage for emergency and urgently needed care and other out-of-service area coverage;

5. A description of limitations on referrals to restricted network providers and to other providers;

6. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

7. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(M)

1. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, *[coverage for prescription drugs,]* coverage for at-home recovery services or coverage for Part B excess charges.

(N) Medicare Select policies and certificates shall provide for continuation of coverage in the event the secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, *[coverage for prescription drugs,]* coverage for at-home recovery services or coverage for Part B excess charges.

(9) Open Enrollment.

(A) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6)-month period beginning with the first day of the first month in which the applicant is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B.

1. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(E) No issuer required by subsection (B) of this section to issue policies or certificates of Medicare supplement insurance shall discriminate as to rates, between the rates charged to persons enrolled under subsection (B) of this section and the average rates charged for participation in that policy form number or certificate form number by persons enrolled in Medicare Part B by reason of age, or discriminate between persons entitled to enroll in the policy form number or certificate form number under subsection (B) of this section and other enrollees in the policy form number or certificate form number in other terms or conditions of the plan, policy form number, or certificate form number.

1. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)** by either—

A. Charging a premium rate for disabled persons that does not exceed the lowest available aged premium rate for that plan, type, and form level; or

B. Charging a premium rate for disabled persons that does not exceed the "weighted average aged premium rate" for that plan, type, and form level, and providing, at the time of each rate filing, its calculation of the "weighted average aged premium rate" for each plan, type, and form level.

2. The "weighted average aged premium rate" is determined by—

A. First multiplying the premium rate (calculated prior to modal, area, and other factors) for each age band, age sixty-five (65) and over, by the number of Missouri insureds in-force in that age band to arrive at the total Missouri premium for each age band age sixty-five (65) and over; and

B. Then calculating the sum of the Missouri premium for all age bands age sixty-five (65) and over to arrive at the total Missouri premium for all age bands age sixty-five (65) and over; and

C. Then calculating the sum of the Missouri insureds*[-]*in-force for all age bands age sixty-five (65) and over to arrive at the total number of Missouri insureds in-force for all age bands age sixty-five (65) and over; and

D. Then dividing the total Missouri premium for all age bands age sixty-five (65) and over by the total number of Missouri insureds in-force for all age bands, age sixty-five (65) and over to determine the weighted average aged premium rate.

3. Modal, area, and other factors may be added to the disabled premium.

(H) No Medicare supplement carrier shall, directly or indirectly enter into any contract, agreement or arrangement with an *[agent or broker]* **insurance producer** that provides for or results in the compensation paid to an *[agent or broker]* **insurance producer** for the sale of a Medicare supplement policy or certificate to be varied because of the age, health status, claims experience, receipt of health care or medical condition of an applicant eligible by reason of subsection (B) of this section for Medicare supplement insurance.

(I) A Medicare supplement carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an *[agent or broker]* **insurance producer**, if any, for the sale, during the open enrollment periods described in subsection (B) of this section, of a Medicare supplement insurance policy or certificate.

(J) No Medicare supplement insurance carrier shall terminate, fail to renew or limit its contract or agreement of representation with an *[agent or broker]* **insurance producer** for any reason related to the age, health status, claims experience, receipt of health care or medical condition of an applicant, eligible by reason of subsection (B) of this section for Medicare supplement insurance, placed by the *[agent or broker]* **insurance producer** with the Medicare supplement insurance carrier.

(10) Guaranteed Issue for Eligible Persons.
(A) Guaranteed Issue.
1. Eligible persons are those individuals described in subsection (B) of this section who *[apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (B) of this section,]* **seek to enroll under the policy during the period specified in subsection (C) of this section,** and who submit evidence*[, acceptable to the director,]* of the date of termination *[or disenrollment]***, disenrollment, or Medicare Part D enrollment** with the application for a Medicare supplement policy.
2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection *[(C)]***(E)** of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.
(B) Eligible Persons. An eligible person is an individual described in any of the following paragraphs:
1. The individual is enrolled under an employee welfare benefit plan **that provides health benefits that supplement the benefits under Medicare**; and the plan terminates, or the plan ceases to provide *[substantial health benefits to the individual either because the plan is modified or amended, or because the plan terminates, or because the individual leaves the plan]* **all such supplemental health benefits to the individual**;
2. The individual is enrolled with a Medicare*[+Choice]* **Advantage** organization under a Medicare*[+Choice]***Advantage** plan under Part C of Medicare, and any of the following circumstances apply, **or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a MedicareAdvantage plan**:
A. The organization's or plan's certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
B. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or because the plan is terminated for all individuals within a residence area or because of another change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856);
C. The individual demonstrates, in accordance with guidelines established by the secretary, that—
(I) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
(II) The organization, *[or agent]* **insurance producer,** or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
D. The individual meets such other exceptional conditions as the secretary may provide;
3.
A. The individual is enrolled with—
(I) An eligible organization under a contract under section 1876 (Medicare risk or cost);
(II) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
(III) An organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan); or
(IV) An organization under a Medicare Select Policy; and
B. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (10)(B)2.;
4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because—
A.
(I) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or
(II) Of other involuntary termination of coverage or enrollment under the policy;
B. The issuer of the policy substantially violated a material provision of the policy; or
C. The issuer, *[or an agent]* **insurance producer,** or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;
5.
A. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare*[+Choice]***Advantage** organization under a Medicare*[+Choice]***Advantage** plan under Part C of Medicare, any eligible organization under a contract under section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, **any PACE provider under section 1894 of the Social Security Act,** an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and
B. The subsequent enrollment under subparagraph (10)(B)5.A. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or
6. The individual, upon first becoming eligible for benefits under Part A of Medicare *[and enrolling in Medicare Part B]*, enrolls in a Medicare*[+Choice]***Advantage** plan under Part C of Medicare, **or with a PACE provider under section 1894 of the Social Security Act,** and disenrolls from the plan **or program** by not later than twelve (12) months after the effective date of enrollment; and
7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (E)4. of this section; and
*[7.]***8.** Any individual who terminates Medicare supplement coverage within thirty (30) days of the annual policy anniversary.
(C) Guarantee Issue Time Periods.
1. In the case of an individual described in paragraph (B)1. of this section, the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;
2. In the case of an individual described in paragraph (B)2., (B)3., (B)5. or (B)6. of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends

sixty-three (63) days after the date the applicable coverage was terminated;

3. In the case of an individual described in subparagraph (B)4.A. of this section, the guarantee issue period begins on the earlier of: (i) the date that individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage was terminated;

4. In the case of an individual described in paragraph (B)2., subparagraph (B)4.B., (B)4.C., paragraph (B)5. or (B)6., of this section who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

5. In the case of an individual described in paragraph (B)7. of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty (60)-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

6. In the case of an individual described in subsection (B) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment or the effective date of the loss of coverage under the group health plan and ends on the date that is sixty-three (63) days after the effective date.

(D) Extended Medigap Access for Interrupted Trial Periods.

1. In the case of an individual described in paragraph (B)5. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subparagraph (B)5.A. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (10)(B)6.; and

2. In the case of an individual described in paragraph (B)6. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in paragraph (B)6. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (10)(B)6.; and

3. For purposes of paragraphs (B)5. and (B)6. of this section, no enrollment of an individual with an organization or provider described in subparagraph (B)5.A. of this section, or with a plan or in a program described in paragraph (B)6. of this section, may be deemed to be an initial enrollment under this paragraph after the two (2)-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

*[(C)]***(E)** Products to Which Eligible Persons Are Entitled. The Medicare supplement policy to which eligible persons are entitled under—

1. Paragraphs (10)(B)1., 2., 3. and 4. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F **(including F with a high deductible), K or L** offered by any issuer;

[2. Paragraph (10)(B)5. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (C)1. of this section;]

A. Subject to subparagraph B., paragraph (10)(B)5. is the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph 1. of this subsection;

B. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is:

(I) The policy available from the same issuer but modified to remove the outpatient prescription drug coverage; or

(II) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

*[3.]***2.** Paragraph(10)(B)6. shall include any Medicare supplement policy offered by any issuer; *[and]*

3. Paragraph (10)(B)7. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage; and

4. Paragraph (10)(B)*[7.]***8.** shall include any Medicare supplement policy offered by any issuer but only a policy of the same plan as the coverage in which the individual was most recently enrolled.

*[(D)]***(F)** Notification Provisions.

1. At the time of an event described in subsection (B) of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A). Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in subsection (B) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A) of this section. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

(12) Loss Ratio Standards and Refund or Credit of Premium.

(A) Loss Ratio Standards.

1.

A. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form the higher of the originally filed anticipated loss ratio or—

(I) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(II) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies.

B. The ratios specified in this subsection shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. **Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:**

(I) Home office and overhead costs;
(II) Advertising costs;
(III) Commissions and other acquisition costs;
(IV) Taxes;
(V) Capital costs;
(VI) Administrative costs; and
(VII) Claims processing costs.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards (future loss ratio).

3. For purposes of applying paragraph (A)1. of this section and paragraph *[(C)]***(D)**3. of section (13) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet—

A. The originally filed anticipated loss ratio when combined with the actual experience since inception (the lifetime loss ratio);

B. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section when combined with actual experience beginning with *[either April 28, 1996, or January 1, 1996]* **January 1, 2006** to date; and

C. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section over the entire future period for which the rates are computed to provide coverage.

(B) Refund or Credit Calculation.

1. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

2. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this section, policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after *[April 28, 1996]* **January 1, 2006**. The first report shall be due by May 31, *[1998]* **2008**.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen (13)-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(13) Filing and Approval of Policies and Certificates and Premium Rates.

(B) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

*[(B)]***(C)** An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

*[(C)]***(D)**

1. Except as provided in paragraph 2. of this subsection, an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

2. An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

A. The inclusion of new or innovative benefits;

B. The addition of either direct response or *[agent]* **insurance producer** marketing methods;

C. The addition of either guaranteed issue or underwritten coverage; and

D. The offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

*[(D)]***(E)**

1. Except as provided in subparagraph 1.A. of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after April 8, 1993, that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

A. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state.

B. An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph 1.A. of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

3. Effect of change in rating structure or methodology.

A. A change in the rating structure or methodology includes, but is not limited to:

(I) A change between community rating, issue-age rating, and attained-age rating;

(II) A change in class structure (e.g., one class v. smoker/non-smoker class, unisex v. male/female classes); and

(III) A change between rating for each age v. age-banded rates.

B. A change in the rating structure or methodology shall be considered a discontinuance under paragraph 1. of this subsection unless the issuer complies with the following requirements:

(I) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

(II) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. Such actuarially equivalent policies or certificates shall be combined for filing purposes under

paragraph (13)*[(G)]***(H)**11. The director may approve a change to the differential which is in the public interest.

C. Notwithstanding subparagraph B. of this paragraph, where an issuer changes a rating structure or methodology and rates calculated under the new methodology are not actuarially equivalent to the old rates, the change in rating structure or methodology will be considered a discontinuance under subparagraph (13)*[(D)]***(E)**1.A. The actuarial equivalency of rates must be determined by a comparison of weighted average premium rate under the old and the new methodology, except in the case of a change between attained-age and issue-age rating where the actuarial equivalency of the rates will be determined from a comparison of actuarial present value of lifetime premiums by age or age-band.

*[(E)]***(F)**

1. Except as provided in paragraph *[(E)]***(F)**2. of this section, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section (12) of this rule.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

*[(F)]***(G)**

1. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after January 1, 2000, based upon attained-age rating as a structure or methodology. Notwithstanding, an issuer may continue in-force policies and certificates issued prior to January 1, 2000.

2. Where an issuer files for approval of a rate structure for policy forms or certificate forms which reflects a change in methodology from attained age to issue age, the issuer must demonstrate the actuarial equivalency of the rates proposed with the previously approved attained-age rates as required by paragraph (13)*[(D)]***(E)**3. If the policy forms or certificate forms were at any time approved by the director under an issue age methodology, the issuer must use the most recently approved issue age rate schedule as its proposed rate schedule for the policy forms or certificate forms and need make no further showing of actuarial equivalency under (13)*[(D)]***(E)**3.

*[(G)]***(H)** Filing requirements and procedures for change of Medicare supplement insurance premium rate and for annual filing of premium rates.

1. When an issuer files for approval of annual premium rates for a plan under subsection (12)(C) or a change of premium rates for a plan under subsection (13)*[(B)]***(C)**, the following documentation must be provided to the director as part of the rate filing in addition to any other documentation required by law or regulation:

A. A completed Medicare Supplement Rate Filing Document (Missouri Form 375-0065, revised 10/98), which *[is incorporated herein by reference]* **can be accessed at the department's website at www.insurance.mo.gov**;

B. An actuarial memorandum supporting the rating schedule;

C. A report of durational experience (for standardized Medicare supplement plans only);

D. A projection correctly derived from reasonable assumptions;

E. A clear statement of all of the assumptions used to prepare the rate filing, including the source of trend;

F. All formulas used to prepare the projection except for formulas which can be ascertained from a cursory inspection of the projection itself; and

G. The issuer's current rate schedule and the proposed rate schedule for this state, including rates for disabled persons, if any, and all rating factors, including, but not limited to: area; smoker/non-smoker; standard/substandard.

2. The report of durational experience must contain for each calendar year of issue the following data by duration: incurred claims and earned premium; resultant loss ratio; and life-years. The durational split may be either by policy or certificate duration, calendar duration or calendar year of experience within each calendar year of issue.

3. The projection must—

A. State the incurred claims and earned premium, resultant loss ratio and corresponding life-years for each of the preceding calendar years beginning with the year in which the policy or certificate was first issued and must include the total for each category (incurred claims and earned premium, resultant loss ratio, and corresponding life-years) for all preceding calendar years;

B. State the projected incurred claims and projected earned premium, resultant loss ratios and corresponding life-years for at least each of the ten (10) calendar years subsequent to the rate filing and must include the total for each category (projected incurred claims and projected earned premium, resultant loss ratio, and corresponding life-years) for all projected calendar years;

C. Include a calculation of the sums of the combined total figures reported under subparagraph A. of this paragraph and those reported under subparagraph B. of this paragraph; and

D. Include, for pre-standardized Medicare supplement plans, the respective totals of the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for the period beginning April 28, 1996, or alternatively, January 1, 1996, through the end of the projection period described in subparagraph B. of this paragraph.

4. Where assumptions include interest, the totals for incurred claims accumulated/discounted with interest, earned premium accumulated/discounted with interest, and the resultant loss ratio must also be shown in all parts of the projection described in paragraph *[(G)]***(H)**3. of this section.

5. Both the report of durational experience and the projection must report Missouri and national data with respect to incurred claims, earned premium, loss ratio, and life-years. The projection must also report this information both with and without the rate change requested.

6. The issuer must specify whether the figures reported as incurred claims were determined by adding claims paid to unpaid claims reserves or by the actual runoff of claims. The method of determining the incurred claims must be consistent throughout the filing and supporting documentation.

7. Changes in active life reserves or claims expenses may not be included in incurred claims in the rate filing or any supplemental documentation.

8. For purposes of this section, "incurred claims" means the dollar amount of incurred claims.

9. Earned premium reported in the rate filing or any supporting documentation must include modal loadings and policy fees. An adjustment for premium refunds, if any, must also be made to earned premium and the details of the adjustment must be provided to the director with the filing. Changes in active life reserves may not be included in earned premium.

10. Life-years reported in a rate filing or supplemental documentation must be calculated in the same manner as for refund calculations.

11. Rate filings for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)** for standardized Medicare supplement plans marketed after June 30, 1998, must demonstrate compliance with the requirements of subsection (9)(E). The "weighted average aged premium," must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph (9)(E)1.A. The figure used in the calculation for the total number of insureds in-force for all age bands, age sixty-five (65) and over, must be the same as the figure reported on Missouri Form 375-0065 for the "Number of Missouri Aged Insureds."

12. For standardized Medicare supplement plans, the Medicare Supplement Rate Filing Document, the report of durational experience, and the projection must be provided separately for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)**.

13. For pre-standardized Medicare supplement rate plans, the information contained in the Medicare Supplement Rate Filing Document and projection may be pooled within a type.

14. The rates, rating schedule and supporting documentation required to be filed under subsection *[(G)]***(H)** of this section as part of a rate filing and all supplementary documentation in connection with the rate filing must be accompanied by the certification of a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the documentation submitted:

A. The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing;

B. The anticipated lifetime, future, and third-year loss ratios for the policy form or certificate form for which the rates are filed comply with the loss ratio requirements of subsection (12)(A) for policy forms or certificate forms of its type delivered or issued for delivery in this state;

C. With respect to rate filings concerning pre-standardized plans, the loss ratio for year 1996 (from April 28 or from January 1) through the end of the projection period complies with the loss ratio requirements of subsection (12)(A) for policies or certificates issued prior to July 30, 1992, and delivered or issued for delivery in this state;

D. Where the rate filing concerns a policy or certificate as to which rating methodologies have changed or are presented for approval based on a change in methodology, the percentage differential between the discontinued and subsequent (or new) rates has not changed;

E. All components of the filing, including rates, rating schedules, and supporting documentation, were prepared based on the current standards of practice promulgated by the Actuarial Standards Board;

F. The rate filing, including rates, rating schedule, and supporting documentation, is in compliance with the applicable laws and regulations of this state; and

G. The rates requested are reasonable in relationship to the benefits provided by the policy or certificate.

(14) Permitted Compensation Arrangements.

(A) An issuer or other entity may provide commission or other compensation to an *[agent]* **insurance producer** or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(C) No issuer or other entity shall provide compensation to its *[agents or other producers]* **insurance producers** and no *[agent or]* producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(15) Required Disclosure Provisions.

(A) General Rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6.

A. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the *[Health Care Financing Administration]* **Centers for Medicare and Medicaid Services (CMS)** and in a type size no smaller than twelve (12)-point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

B. For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(C) MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

*[(C)]***(D)** Outline of Coverage Requirements for Medicare Supplement Policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12)-point type, immediately above the company name: **"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."**

3. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in

the language and format prescribed below in no less than twelve (12)-point type. All plans A–*[J]***L** shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The following items shall be included in the outline of coverage in the order prescribed below.

*PUBLISHER'S NOTE: The forms included with this proposed amendment are printed with the emergency amendment on pages 1231–1271 of this issue of the **Missouri Register**.*

*[(D)]***(E)** Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy**,** a policy issued pursuant to a contract under section 1876 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; or other policy identified in subsection (1)(B) of this rule, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12)-point type and shall contain the following language: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in paragraph *[(D)]***(E)**1. of this section shall disclose, using the applicable statement in Appendix C, **included herein,** the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

(16) Requirements for Application Forms and Replacement Coverage.

(A) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant **currently** has *[another]* Medicare supplement, **MedicareAdvantage, Medicaid coverage,** or *[other]* **another** health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and *[agent]* **insurance producer** containing such questions and statements may be used.

Statements:

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. **If, after purchasing this policy, you become eligible for Medicaid,** *[T]***t**he benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your **suspended Medicare supplement** policy **(or, if that is no longer available, a substantially equivalent policy)** will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility. **If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.**

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

*[5.]***6.** Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Questions:

[To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force?

A. If so, with which company?

B. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

A. If so, with which company?

B. What kind of policy?

3. Are you covered for medical assistance through the state Medicaid program:

A. As a Specified Low-Income Medicare Beneficiary (SLMB)?

B. As a Qualified Medicare Beneficiary (QMB)?

C. For other Medicaid medical benefits?]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X")

To the best of your knowledge,

(1)

(a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? ______________

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3)

(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

(4)

(a) Do you have another Medicare supplement policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

____
____
____
____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

START __/__/__ END __/__/__

(B) *[Agents]* **Insurance producers** shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five (5) years which are no longer in force.

(D) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its *[agent]* **insurance producer**, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the *[agent]* **insurance producer**, except where the coverage is sold without an *[agent]* **insurance producer**, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(E) The notice required by subsection (D) above for an issuer shall be provided in substantially the following form in no less than twelve (12)-point type:(18) Standards for Marketing.

PUBLISHER'S NOTE: The forms included with this proposed amendment are printed with the emergency amendment on pages 1274–1275 of this issue of the ***Missouri Register****.*

(18) Standards for Marketing.

(A) An issuer, directly or through its producers, shall—

1. Establish marketing procedures to assure that any comparison of policies by its *[agents or other producers]* **insurance producers** will be fair and accurate;

2. Establish marketing procedures to assure excessive insurance is not sold or issued;

3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following: **"Notice to buyer: This policy may not cover all of your medical expenses."**;

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

5. Establish auditable procedures for verifying compliance with this subsection (A).

(B) In addition to the practices prohibited in the Unfair Trade Practices Act (sections 375.930 to 375.948, RSMo) and the Unfair Claim Settlement Practices Act (sections 375.1000 to 375.1018, RSMo), the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer;

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance *[agent]* **producer** or insurance company.

(19) Appropriateness of Recommended Purchase and Excessive Insurance.

(A) In recommending the purchase or replacement of any Medicare supplement policy or certificate an *[agent]* **insurance producer** shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(C) *[Any sale of Medicare supplement insurance to a person enrolled in a Medicare+Choice plan is prohibited.]* **An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.**

[(23) Effective Date. This rule shall be effective thirty days after publication in the Missouri Code of State Regulations.]

PUBLISHER'S NOTE: Appendix A, Appendix B and Appendix C that are included in this proposed amendment are printed with the emergency amendment on pages 1277–1297 of this issue of the ***Missouri Register****.*

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

AUTHORITY: section[s] 374.045, [376.864.3, 376.864.4, 376.864.5, 376.879 and 376.886, RSMo Supp. 1998 and 376.874, RSMo 1994] ***RSMo 2000****. Original rule filed Oct. 15, 1998, effective June 30, 1999. Emergency amendment filed May 16, 2005, effective June 1, 2005, expires Feb. 2, 2006. Amended: Filed May 16, 2005.*

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 10 a.m. on July 20, 2005. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or not heard, may submit a written statement in support of or in opposition to the proposed amendment, until 5:00 p.m. on July 20, 2005. Written statements shall be sent to Stephen R. Gleason, Department of Insurance, PO Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 751-2619 at least five (5) working days prior to the hearing.