Rules of
Department of Insurance
Division 400—Life, Annuities and Health
Chapter 7—Health Maintenance Organizations

Title 20—DEPARTMENT OF INSURANCE
Division 400—Life, Annuities and Health
Chapter 7—Health Maintenance Organizations

20 CSR 400-7.010 Forms Which Must be Approved Prior to Use

PURPOSE: This rule describes the forms which must be filed by a health maintenance organization with the Department of Insurance for approval prior to use. This rule is promulgated pursuant to sections 354.405 and 354.485, RSMo.

(1) The following forms shall not be delivered or issued for delivery in this state until they have been submitted to the Missouri Department of Insurance and approved by the director:

(A) Group and individual contracts;

(B) Evidence of coverage to be issued to the enrollees;

(C) Application forms;

(D) Enrollment forms;

(E) Riders;

(F) Amendments;

(G) Endorsements; and

(H) Any other forms which are intended to become part of a contract which is provided to an enrollee or group subscriber.

(2) Each filing shall be made in accordance with the procedures outlined in 20 CSR 400-8.200.

AUTHORITY: sections 354.405 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.075. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.405, RSMo 1983 and 354.485, RSMo 1983.*

20 CSR 400-7.020 Changes to Documents Submitted to Obtain Original Certificate of Authority

PURPOSE: This rule sets forth the documents which must be submitted to the Department of Insurance prior to any changes becoming effective. This rule is promulgated pursuant to sections 354.405, 354.410, 354.425 and 354.485, RSMo.

(1) Every health maintenance organization (HMO) shall file with the director notice of its intention to modify or change the documents and mechanisms approved in conjunction with the HMO's application for a certificate of authority pursuant to sections 354.400–354.550, RSMo. This notice shall be filed prior to the actual modification. These documents and mechanisms include, but are not limited to:

(A) Articles of incorporation, articles of association, partnership agreement or trust agreement;

(B) Bylaws, rules or similar documents regulating the HMO's internal affairs;

(C) Grievance procedure and complaint mechanisms;

(D) Enrollee participation mechanism;

(E) Reinsurance contracts; and

(F) Bonds (surety and fidelity).

(2) The documents and mechanisms, as modified, shall be promptly filed with the director for approval. If the modification is not disapproved by the director within thirty (30) days after filing, the modification shall be deemed approved.

AUTHORITY: sections 354.405, 354.410, 354.425 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.080. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.405, RSMo 1983; 354.410, RSMo 1983; 354.425, RSMo, 1983; and 354.485, RSMo 1983.*

20 CSR 400-7.030 Mandatory Provisions—All Contracts

PURPOSE: This rule sets forth the provisions which must be present in an evidence of coverage. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) All group and individual contracts and all evidences of coverage must contain in substance the following provisions, or provisions which in the opinion of the director of insurance are more favorable to the enrollee or at least as favorable to the enrollee and more favorable to the contract holder: name, address and telephone number of the administrative offices of the health maintenance organization (HMO) must appear on the face page; the face page is the first page that contains any written material; and if in booklet form, the first page inside the cover is the face page.

(2) Benefits. A description of all health care services available to an enrollee under the health care plan, including any copayments or other charges for which the member may be responsible.

(3) Cancellation. A statement that the HMO must give the group contract holder, in the case of group coverage, or the enrollee, in the case of individual coverage, at least thirty-one (31) days' prior notice of any cancellation or termination except termination for nonpayment of premium. In the case of group coverage, the HMO may not terminate the contract prior to the first anniversary date except for nonpayment of the required premium or the failure to meet continued underwriting standards.

(4) Claim Filing Procedure. A provision setting forth the procedure for filing claims, including:

(A) How, when and where to obtain claim forms, if required; and

(B) The requirements for providing proper notice of claim and proof of loss. Failure to furnish the notice or proof within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to give notice or proof within this time.

(5) Definitions. A provision defining any words in the evidence of coverage which have other than the usual meaning.

(6) Effective Date. A statement of the effective date requirements for various classes of enrollees.

(7) Eligibility. A statement of the eligibility requirements for coverage including:

(A) The condition under which dependent enrollees may be added to those originally covered;

(B) Any limiting age for enrollees and dependents, including effects of Medicare eligibility; and

(C) A clear statement regarding the coverage of newborn children. All evidences of coverage which provide coverage for a family member of the enrollee, as to this family member's coverage, also shall provide that the benefits applicable for children also shall be applicable with respect to a newly born child of the enrollee from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The HMO may require that the enrollee notify the HMO during the initial thirty-one (31) days after the birth of the child and pay any additional premium required to provide coverage for the newborn child from the date of birth.

(8) Emergency Services. A description of how to obtain services in an emergency situation, including:

(A) Any requirements that the HMO be contacted before the enrollee obtains care; and

(B) What to do in case of a life-threatening emergency.

(9) Out-of-Area Benefits and Services. The contract and evidence of coverage shall contain a specific description of benefits and services available out of the service area. Medically necessary emergency benefits must be available when the enrollee is temporarily outside the service area and—

(A) Medically necessary health services are immediately required;

(B) The condition for which the services are required could not have been foreseen;

(C) The enrollee's medical condition does not permit his/her return to the service area for treatment;

(D) The reason for being outside the service area must be for some purpose other than the receipt of treatment for a medically-related condition;

(E) The HMO may require notification from or on behalf of the enrollee as soon as possible; and

(F) Services received by the enrollee outside the service area will be covered until the enrollee's medical condition permits travel or transport to the HMO's service area.

(10) Entire Contract, Amendments. A provision stating that the contract and any attachments constitute the entire contract between the parties and that, to be valid, any change in the contract must be approved by an officer of the HMO and attached to the affected contract and that no insurance producer or representative has the authority to change the contract or waive any of the provisions.

(11) Exclusions and Limitations. A provision setting forth any exclusions and limitations on health care services.

(12) Time Limit on Certain Defenses. A provision that, in the absence of fraud, all statements made by an enrollee are considered representations and not warranties and that no statement voids the coverage or reduces the benefits after the coverage has been in force for two (2) years from its effective date, unless the statement was material to the risk assumed and contained in a written application. A copy of the written application or enrollment form must have been furnished to the enrollee if the terms of the application or enrollment form are to be applied.

(13) Schedule of Rates. A provision that discloses the HMO's right to change the rates charged and indicates the amount of prior notice which must be given.

(14) Service Area. A map or clear description of the service area indicating major primary and emergency care delivery sites.

(15) Termination Due to Attaining Limiting Age.

(A) Medicare. A provision describing the effect of becoming eligible for Medicare on the part of an enrollee or dependent.

(B) Handicapped Child. A provision that a child's attainment of a limiting age does not operate to terminate coverage of the child while that child is incapable of self-sustaining employment due to mental or physical handicap and chiefly dependent upon the enrollee for support and maintenance. The enrollee may be required to furnish proof of incapacity and dependency within thirty-one (31) days before the child's attainment of the limiting age and subsequently, as required, but not more frequently than annually following the child's attainment of the limiting age.

(16) Where to Obtain Services. A statement explaining where and in what manner information is available as to how services may be obtained.

(17) Every HMO that has a plan which will affect the choice of physician, hospital or other health care provider, such as by refusing to cover services rendered by a provider not affiliated with the HMO, shall set forth conspicuously the following statement, or other wording which has been approved by the director to the same effect, on the following materials when given to current and prospective enrollees: certificates and evidences of coverage, member handbooks, provider directories and any materials which make a direct offer to an individual prospective enrollee to become a member of the HMO.

NOTICE

THIS HMO MAY HAVE RESTRICTIONS REGARDING WHICH PHYSICIANS OR OTHER HEALTH CARE PROVIDERS AN HMO MEMBER MAY USE. PLEASE CONSULT YOUR MEMBER HANDBOOK OR PROVIDER DIRECTORY FOR MORE DETAILS. IF YOU HAVE ANY ADDITIONAL QUESTIONS, PLEASE WRITE OR CALL US AT:

_____
(HMO's Name)

_____
(HMO's Address)

_____
(HMO's Telephone Number)

(A) The HMO shall not be required to place such a statement in materials that constitute or represent supplemental benefit riders, copayment schedules or marketing or promotional material including, but not limited to, posters or print or media advertisements, which are not directed to specific individual enrollees but which may be directed toward a group(s) of enrollees.

(B) Every HMO shall include such a statement at the time promotional and descriptive materials, disclosure forms and certificates and evidences of coverage are issued or revised for distribution, but in no case later than the effective date of section (17) of this rule (January 1, 1994).

AUTHORITY: sections 354.430, 354.485, and 374.045, RSMo 2000. This rule was previously filed as 4 CSR 190-15.090. Original rule filed Nov. 2, 1987, effective April 11, 1988. Amended: Filed Nov. 3, 1992, effective Jan. 1, 1994. Amended: Filed July 12, 2002, effective Jan. 30, 2003.*

**Original authority: 354.430, RSMo 1983, amended 1997; 354.485, RSMo 1983; and 374.045, RSMo 1967, amended 1993, 1995.*

20 CSR 400-7.040 Additional Mandatory Provisions—Group Contracts and Evidences of Coverage

PURPOSE: This rule sets forth provisions which must be included in group contracts and evidences of coverage in addition to the provisions set forth in 20 CSR 400-7.030. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) Group contracts and evidences of coverage must contain in substance the following provision(s) which, in the opinion of the director of insurance, are more favorable to the enrollee or at least as favorable to the enrollee and more favorable to the contract holder in addition to those set out in 20 CSR 400-7.030.

(2) Evidence of Coverage. Provisions that the group contract holder must be provided with evidence of coverage to be delivered to each enrollee, that the evidence of coverage is a part of the group contract as if fully incorporated in the contract; and that any direct conflict between the group contract and the evidence of coverage will be resolved according to the terms which are most favorable to the enrollee. Note: This section does not apply if the same form is used for both the group contract and the evidence of coverage.

(3) New Employees. A provision specifying the conditions under which new enrollees

may be added to those originally covered, including the terms under which coverage will be effective.

(4) Grace Period. A provision for a grace period of at least thirty-one (31) days for the payment of any premium falling due after the first premium, during which time the coverage remains in effect. Coverage may be terminated at the end of the grace period and, if services are rendered during the grace period, the group will be responsible for either the premium due or the value of services received.

AUTHORITY: sections 354.430 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.110. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.430, RSMo 1983, and 354.485, RSMo 1983.*

20 CSR 400-7.050 Additional Mandatory Provisions—Individual Contracts and Evidences of Coverage

PURPOSE: This rule sets forth provisions which must be included in individual contracts and evidences of coverage in addition to the provisions set forth in 20 CSR 400-7.030. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) Individual contracts and evidences of coverage must contain in substance the following provision(s) which, in the opinion of the director of insurance, are at least as or more favorable to the enrollee, in addition to those set out in 20 CSR 400-7.030.

(2) Reinstatement. A provision that clearly sets forth the requirements for reinstatement and discloses how reinstatement changes or affects the rights and coverages originally provided. New evidence on insurability may be required.

(3) Ten (10) Days to Examine Agreement. A provision stating that the enrollee to whom the evidence of coverage is issued shall be permitted to return the evidence of coverage within ten (10) days of receiving it and have the premium paid refunded to them if, after examination of the agreement, the enrollee is not satisfied with it for any reason. If the enrollee, pursuant to provision, returns the evidence of coverage to the issuing health maintenance organization (HMO) or to the insurance producer or representative through whom it was purchased, it is considered void from the beginning and the parties are in the same position as if no evidence of coverage had been issued. If services are rendered or claims paid by the HMO during the ten (10) days, the person shall not be permitted to return the contract and receive a refund of the premium paid.

(4) Original Premium. The original premium for coverage must be stated in the evidence of coverage or in the application.

(5) Grace Period. A provision for a grace period of at least ten (10) days, for payment of any premium falling due after the first premium, during which time the coverage remains in effect. If payment is not received within ten (10) days, coverage may be cancelled after the tenth day. The terminated enrollee will be responsible for the cost of services received during the grace period if this requirement is disclosed in the evidence of coverage.

AUTHORITY: sections 354.430, 354.485 and 374.045, RSMo 2000. This rule was previously filed as 4 CSR 190-15.100. Original rule filed Nov. 2, 1987, effective April 11, 1988. Amended: Filed July 12, 2002, efective Jan. 30, 2003.*

**Original authority: 354.430, RSMo 1983, amended 1997; 354.485, RSMo 1983; and 374.045, RSMo 1967, amended 1993, 1995.*

120 CSR 400-7.060 Integration With Other Benefits

PURPOSE: This rule provides that a health maintenance organization integration provision must be consistent with the Coordination of Benefit Provisions in Group Health Plans set forth in 20 CSR 400-2.030. This rule is promulgated pursuant to section 354.485, RSMo.

Those provisions of a health maintenance organization (HMO) contract which are designed to coordinate with the benefits of other health plans must be consistent with the corresponding provisions of 20 CSR 400-2.030, Coordination of Benefit Provisions in Group Health Plans.

AUTHORITY: section 374.045, RSMo 2000. This rule was previously filed as 4 CSR 190-15.130 Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 374.045, RSMo 1983.*

20 CSR 400-7.070 Bonding Requirements

PURPOSE: This rule sets forth the health maintenance organization bond requirements and when those requirements will be deemed satisfied. This rule is promulgated pursuant to sections 354.425 and 354.485, RSMo.

(1) The requirement of section 354.425, RSMo that every health maintenance organization (HMO) shall maintain in force a surety bond on any director, officer or partner who receives, collects, disburses or invests funds in connection with the activities of the HMO will be deemed to be satisfied by a fidelity bond or contract of equal purpose. This bond or contract shall—

(A) Be in an amount of not less than one hundred thousand dollars ($100,000) or other sum as may be prescribed by the director;

(B) Be written with at least a one (1)-year discovery period. If written with less than a three (3)-year discovery period, the bond or contract shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of ninety (90) days after written notice of the cancellation or termination has been filed with the director of the Department of Insurance, unless an earlier date is approved by the director; and

(C) Specify on the declaration page of the bond or contract the length of the discovery period and, if less than three (3) years, that the bond or contract complies with the ninety (90)-day notification of cancellation or termination provision of section 354.425, RSMo.

AUTHORITY: sections 354.425 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.140. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.425, RSMo 1983 and 354.485, RSMo 1983.*

20 CSR 400-7.080 Enrollee Protection Provisions

PURPOSE: This rule sets forth enrollee protection provisions. This rule is promulgated pursuant to section 354.485, RSMo.

(1) Providers who provide health care services to health maintenance organization (HMO)-covered enrollees pursuant to a provider contract between themselves and the HMO, under no circumstances (including, but not limited to, nonpayment by an HMO for medical services rendered to an enrollee by a provider, insolvency of an HMO or an HMO's breach of any term or condition of its agreement with a provider), shall bill, charge, collect a deposit, seek compensation, remuneration or reimbursement from or have any recourse against an enrollee or person acting on behalf of an enrollee for fees, charges or expenses relating to medical services which the HMO is obligated to provide

and pay for under the terms of the enrollee's subscriber agreement with the HMO.

(2) In order to ensure compliance with this provision, no contract between an HMO and provider will be valid or enforceable by the provider unless the contract specifically establishes an independent contractor relationship between the HMO and the provider and further provides that under no circumstances (including, but not limited to, those sets of circumstances previously described) shall the provider bill, charge or in any way seek to hold an enrollee legally liable for the payment of any fees which are the legal obligation of the HMO as provided in this rule.

(3) The contract must further provide that the provision referred to in this rule will survive the termination of the provider's agreement with the HMO regardless of the cause of the termination and that the terms are applicable to, and binding upon, all individuals with whom a provider may subcontract to provide services to HMO enrollees. Nothing in this provision, however, shall in any way affect or limit a provider's right or obligation to collect from enrollees copayments, deductibles or fees assessed for noncovered services in accordance with the agreement governing the enrollee's enrollment with the HMO.

AUTHORITY: section 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.160. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.485, RSMo 1983.*

20 CSR 400-7.090 Service Area Expansion

PURPOSE: This rule sets forth the information to be provided to the director by a health maintenance organization seeking to expand its service area. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) For a contiguous service area expansion request to be approved, the health maintenance organization (HMO) must provide the director with the following information in support of the request:

(A) If prior action of the HMO's board is required, minutes of the board meeting at which expansion was authorized and any related amendments to the basic organization document or bylaws;

(B) A map of the new service area showing locations of primary care physicians, hospitals and emergency care facilities;

(C) Any *pro forma* contracts or agreements with physicians and other providers in the new area; and

(D) A list of all physicians and other providers who have agreed to provide services in the new area.

(2) If the new area is not contiguous with the previously approved area, the following additional information must be provided:

(A) A brief narrative description of the administrative arrangements and other pertinent information;

(B) Biographical data sheets for the management staff assigned to the new area;

(C) Enrollee participation plan for the new area;

(D) Marketing information about the new area, including demographic material, enrollment projections for the period from the beginning of operations until operations in the new service area have produced a net income for twelve (12) consecutive months and proposed advertising and sales materials;

(E) Evidence of coverage to be used in the new area;

(F) Rates to be charged and appropriate actuarial certifications;

(G) Copies of leases, loans and contracts to be used in the proposed new area; and

(H) Sources of financing and financial projections for the period from the beginning of operations until operations in the new area will have produced a net income for twelve (12) consecutive months.

(3) The HMO shall provide other information as the director may consider necessary to adequately describe the proposal.

AUTHORITY: section 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.170. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority: 354.485, RSMo 1983.*

20 CSR 400-7.095 HMO Access Plans

PURPOSE: This rule clarifies the information required to be submitted as part of an access plan for a health maintenance organization's managed care plans pursuant to section 354.603, RSMo Supp. 2001, and the process for approval or disapproval of the access plans filed.

(1) Definitions.

(A) Access plan—The plan required to be filed with the Department of Insurance pursuant to section 354.603, RSMo, and in accordance with the requirements of this regulation.

(B) Categories of counties—

1. Urban access counties—Counties with a population of two hundred thousand (200,000) or more persons.

2. Basic access counties—Counties with a population between fifty thousand (50,000) persons and one hundred ninety-nine thousand, nine hundred ninety-nine (199,999) persons.

3. Rural access counties—Counties with a population of fewer than fifty thousand (50,000) persons.

4. Population figures shall be based on census data as reported in the latest edition of the *Official Manual of the State of Missouri*.

(C) Closed practice provider—A health care provider who does not accept new or additional patients from the health maintenance organization (HMO) that is reporting the provider as part of the managed care plan's network.

(D) Distance standard—The travel distance standards set forth in Exhibit A, which is included herein. Each distance standard represents the maximum number of miles an enrollee may be required to travel in order to access participating providers of the managed care plan. The standards set forth in Exhibit A apply for members living or working within an HMO's approved service area.

(E) Employer specific network—A network created for a specific employer group that differs from the networks of all other managed care plans customarily offered by the HMO in either the identity or number of providers included within the network. An employer specific network constitutes a different or reduced network for the purposes of section 354.603.1(4), RSMo, and is a distinct managed care plan for access plan filing purposes.

(F) Enrollee access rate—The percentage of a managed care plan's enrollees living or working within a county who are able to access a participating provider within the travel distance standards set forth in Exhibit A.

(G) Health benefit plan—A policy, contract, certificate or agreement entered into, offered or issued by an HMO to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, and identified by the form number or numbers used by the HMO when the health benefit plan was filed for approval pursuant to 20 CSR 400-7.010 and 20 CSR 400-8.200.

(H) Hospitals—

1. Basic—Hospitals with central services, dietary services, emergency services, medical records, nursing services, pathology

and medical laboratory services, pharmaceutical services, radiology services, social work services and an inpatient care unit.

2. Secondary—Hospitals with all of the facilities listed under "Basic," plus one (1) or more operating rooms, obstetrics unit, and intensive care unit.

(I) Managed Care Plan—A health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use an identified set of health care providers managed, owned, under contract with or employed by the HMO. A managed care plan is a type of health benefit plan. For purposes of this rule, a managed care plan consists of a health benefit plan and a network. If an HMO offers managed care plans where the health benefit plan, the network or both differ, the HMO is offering more than one (1) managed care plan. For example:

1. If the HMO offers the same health benefit plan with two (2) different networks, the HMO is offering two (2) managed care plans.

2. If the HMO offers two (2) different health benefit plans with the same network, the HMO is offering two (2) managed care plans.

3. If the HMO offers two (2) different health benefit plans each with a different network, the HMO is offering two (2) managed care plans.

(J) Network—The group of participating providers providing services to a managed care plan or pursuant to a health benefit plan established by an HMO. The meaning of the term network is further clarified for purposes of this rule: A network is one (1) component of a managed care plan. A network is the identified set of health care providers managed, owned, under contract with or employed by the HMO, either directly or indirectly, for purposes of rendering medical services to all enrollees of a managed care plan.

(K) Offer—An HMO is offering a managed care plan when it is presenting that managed care plan for sale in Missouri.

(L) Participating provider—A provider who, under a contract with the HMO or with the HMO's contractors or subcontractors, has agreed to provide health care services to all enrollees of a managed care plan with an expectation of receiving payment directly or indirectly from the HMO. The following types of providers are not participating providers:

1. Providers to which an enrollee may not go for covered services, with or without a referral from a primary care provider, are not participating providers;

2. Providers that are only available in the event that an enrollee has a point-of-service benefit level, or other option attached to the HMO level of benefits, are not participating providers for purposes of complying with this rule; and

3. A provider that has agreed to render services to an enrolled person in an isolated instance for purposes of treating a medical need that cannot otherwise be met within the network is not a participating provider.

(M) Pharmacy—Any pharmacy, drug store, chemical store or apothecary shop possessing a valid and current permit issued by the State of Missouri Board of Pharmacy and doing business for the purposes of compounding, dispensing and retailing any drug, medicine, chemical or poison to be used for filling a physician's prescription.

(N) Primary care provider (PCP)—A participating health care professional designated by the HMO to supervise, coordinate, or provide initial care or continuing care to an enrollee, and who may be required by the HMO to initiate a referral for specialty care and maintain supervision of health care services rendered to the enrollee. A PCP may be a professional who practices general medicine, family medicine, general internal medicine or general pediatrics. A PCP may be a professional who practices obstetrics and/or gynecology, in accordance with the provider contracts and health benefit plans of the HMO.

(O) Specialist—A licensed health care provider whose area of specialization is in an area other than general medicine, family medicine or general internal medicine. A professional whose area of specialization is pediatrics, obstetrics and/or gynecology may be either a PCP or a specialist within the meaning of this rule.

(P) Tertiary services—

1. Level I or Level II trauma unit—a secondary hospital with a Level I or Level II trauma unit according to the most recent *Hospital Profiles*. A trauma unit that is designated as pediatric only by the Bureau of Emergency Medical Services does not satisfy the requirements of this rule.

2. Neonatal intensive care unit—any hospital offering a neonatal intensive care unit according to the most recent *Hospital Profiles*.

3. Perinatology services—a secondary hospital with active perinatologists on staff and offering perinatal items according to the most recent *Hospital Profiles*.

4. Comprehensive cancer services—any hospital with active board certified oncologists on staff, according to the most recent *Hospital Profiles*, and offering all cancer services listed in the most recent *Hospital Profiles*.

5. Cardiac catheterization—a secondary hospital with active cardiovascular disease physicians on staff and offering a cardiac catheterization lab and adult cardiac catheterizations according to the most recent *Hospital Profiles*.

6. Cardiac surgery—a secondary hospital with active cardiovascular disease physicians on staff and offering open heart surgery according to the most recent *Hospital Profiles*.

7. Pediatric subspecialty care—any hospital with active pediatricians and pediatric specialists on staff and offering staffed pediatric beds according to the most recent *Hospital Profiles*.

(2) Requirements for Filing Access Plans.

(A) Annual filing—By March 1 of each year, an HMO must file an access plan for each managed care plan it was offering in this state on January 1 of that same year. An HMO may file separate access plans for each managed care plan it offers, or it may file a consolidated access plan incorporating information for multiple managed care plans that it offers, so long as the information submitted with the consolidated access plan clearly identifies the managed care plan or plans to which it applies. The access plan must contain the following information for each managed care plan to which it applies:

1. Pursuant to section 354.603.2(1), RSMo, either:

A. Information regarding the participating providers in each managed care plan's network and the enrollees covered by each managed care plan in a format to be determined by the Department of Insurance including, but not limited to, the following:

(I) The name, address where medical care is provided, zip code, professional license number or other unique identifier as assigned by the appropriate licensing or oversight agency, and specialty, degree or type of each provider;

(II) Whether or not the provider is a closed practice provider, as defined in subsection (1)(C) of this regulation, above; and

(III) The number of enrollees by either work or residence zip code in each managed care plan to which the access plan applies; or

B. An affidavit in the form contained in Exhibit B, which is included herein, certifying that the managed care plan to which the affidavit applies has met one (1) or more of the following standards:

(I) The managed care plan is a Medicare+Choice coordinated care plan

operated by the HMO pursuant to a contract with the federal Centers for Medicare and Medicaid Services;

(II) The managed care plan is accredited by the National Committee for Quality Assurance (NCQA) at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed;

(III) The managed care plan's network is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) at a level of "accreditation without type I recommendations" or better, and such accreditation is in effect at the time the access plan is filed;

(IV) The managed care plan is accredited by the American Accreditation Healthcare Commission (URAC) at a level of full URAC Health Plan accreditation, and such accreditation is in effect at the time the access plan is filed; or

(V) The managed care plan or its network is accredited by any other nationally recognized managed care accrediting organization, similar to those above, that is approved by the Department of Insurance prior to the filing of the access plan, and such accreditation is in effect at the time the access plan is filed. Requests for approval of another nationally recognized managed care accrediting organization must be submitted to the department no later than October 15 of the year prior to the year the access plan is filed.

2. Pursuant to section 354.603.2(2) through (8), RSMo, a written description with any relevant supporting documentation addressing each of the requirements set forth in the statute.

3. Pursuant to section 354.603.2(9), RSMo, the following information:

A. For all managed care plans, information demonstrating that:

(I) Emergency medical services—A written triage, treatment and transfer protocol for all ambulance services and hospitals is in place;

(II) Home health providers—Home health providers are contracted to serve enrollees in each county where enrollment is reported. A home health provider need not be physically located or headquartered in each county. However, there must be at least one (1) home health provider under contract to serve enrollees in each county if the need arose; and

(III) Administrative measures are in place which ensure enrollees timely access to appointments with the medical providers listed in Exhibit A, based on the following guidelines:

(a) Routine care, without symptoms—within thirty (30) days from the time the enrollee contacts the provider;

(b) Routine care, with symptoms—within one (1) week or five (5) business days from the time the enrollee contacts the provider;

(c) Urgent care for illnesses/injuries which require care immediately, but which do not constitute emergencies as defined by section 354.600, RSMo — within twenty-four (24) hours from the time the enrollee contacts the provider;

(d) Emergency care—a provider or emergency care facility shall be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency care as defined by section 354.600, RSMo;

(e) Obstetrical care—within one (1) week for enrollees in the first or second trimester of pregnancy; within three (3) days for enrollees in the third trimester. Emergency obstetrical care is subject to the same standards as emergency care, except that an obstetrician must be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency obstetrical care; and

(f) Mental health care—Telephone access to a licensed therapist shall be available twenty-four (24) hours per day, seven (7) days per week.

B. For all managed care plans, a section demonstrating that the entire network is available to all enrollees of a managed care plan, including reference to contracts or evidences of coverage that clearly state the entire network is available and describing any network management practices that affect enrollees' access to all participating providers;

C. For employer specific networks, a section demonstrating that the group contract holder agreed in writing to the different or reduced network. An employer specific network is subject to the standards in this rule;

D. For all managed care plans, a listing of the product names used to market those plans; and

E. Any other information the director may require.

(B) Updates to annual filing—An HMO must file an updated access plan for a managed care plan if, at any time between the time annual access plan filings are due, one (1) of the following occurs:

1. If an affidavit was submitted for a managed care plan pursuant to the provisions of (2)(A)1.B., above, and the accreditation specified in the affidavit is no longer in effect, the HMO must file within thirty (30) days of the date such accreditation is no longer in effect either:

A. Network and enrollee information for the managed care plan as required by the provisions of (2)(A)1.A., above; or

B. If the accreditation has been replaced by alternative acceptable accreditation, an affidavit as required by the provisions of (2)(A)1.B., above.

2. If network and enrollee information was submitted for a managed care plan pursuant to the provisions of (2)(A)1.A., above, and changes in the network or number of enrollees may cause the managed care plan not to meet any of the distance standards set forth in Exhibit A, the HMO must file within thirty (30) days of such changes updated network and enrollee information as required by the provisions of (2)(A)1.A., above.

(C) Prior to offering a new managed care plan—If at any time between the time annual access plan filings are due an HMO proposes to begin offering a new managed care plan in this state, the HMO must file an access plan for the new managed care plan prior to offering the new managed care plan, including a managed care plan with an employer specific network.

(D) Waiver for the filing of the annual access plan—

1. An HMO may request a waiver of the filing of the annual access plan for a managed care plan if it certifies to the department that:

A. The HMO has notified enrollees of the managed care plan and producers with whom the HMO does business that the managed care plan is no longer being marketed, and the HMO has ceased writing any new contracts for the managed care plan; and

B. The HMO has informed enrollees of the managed care plan that they may access any provider at no greater cost than if that provider was a participating provider in the event the managed care plan cannot provide access to providers as required under this rule.

2. A request to waive the filing of the annual access plan for a managed care plan must be received by the department no later than January 15 of the year in which an access plan would otherwise be required.

(3) Evaluation of Access Plans.

(A) For the information submitted pursuant to section 354.603.2(1), RSMo, the information will be evaluated as follows:

1. If information regarding a managed care plan's network and enrollees is submitted, the department will calculate the enrollee access rate for each type of provider in each county in the HMO's approved service area to determine if the average enrollee access

rate for each county and the average enrollee access rate for all counties is greater than or equal to ninety percent (90%). In calculating the enrollee access rate for a managed care plan, the department will give consideration to the following:

A. Tertiary services may be contracted at one (1) hospital, or among multiple hospitals; and

B. With the department's approval, a managed care plan's network may receive an exception for one (1) or more of the distance standards set forth in Exhibit A under the following circumstances:

(I) Quality of care exception—An exception may be granted if the managed care plan's access plan is designed to significantly enhance the quality of care to enrollees, demonstrates that it does in fact enhance the quality of care, and imposes no greater cost on enrollees than would be incurred if they had access to contracted, participating providers as otherwise required under this rule;

(II) Noncompetitive market exception for PCPs and pharmacies—In the event an HMO can demonstrate to the department that there is not a competitive market among PCPs and/or pharmacies who meet the HMO's credentialing standards, and who are qualified within the scope of their professional license to provide appropriate care and services to enrollees, the department may grant an exception for the managed care plan's network that doubles the distance standard indicated in Exhibit A for PCPs or pharmacies;

(III) Noncompetitive market exception for other provider types—If no provider (exclusive of PCPs and pharmacies) of the appropriate type provides services to enrollees of a managed care plan in a county within the distance standards indicated in Exhibit A, an exception may be granted if the HMO can demonstrate that no fewer than ninety percent (90%) of the population of that county (or, at the HMO's discretion, ninety percent (90%) of the enrollees residing or working in the county) have access to a participating provider of the appropriate type, which provider is located no more than twenty-five (25) miles further than the provider closest to that county;

(IV) Staff or Independent Practice Association (IPA) Model exception—An exception may be granted for those health care services provided to enrollees of the managed care plan if substantially all of those services are provided by the HMO to its enrollees through qualified full-time employees of the HMO or qualified full-time employees of a medical group that does not provide substantial health care services other than on behalf of such HMO. In order to qualify for the exception provided for in this section, an HMO must demonstrate that all or substantially all of the type of health care services in question are provided by full-time employees, that enrollees have adequate access to such health care services as described in the provisions of (2)(A)3.A., above, and that the contract holder was made aware of the circumstances under which such services were to be provided prior to the decision to contract with the HMO for that managed care plan; or

(V) Use of physician extenders—If there is insufficient availability of physicians of the appropriate type providing services to enrollees of a managed care plan in a county within the distance standards indicated in Exhibit A, an exception may be granted for the use of physician extenders. The HMO must demonstrate that enrollees residing or working in the county may access a participating provider who may be either a physician or an advanced practice nurse rendering care under a collaborative agreement pursuant to 4 CSR 200-4.200, and in accordance with the provider contracts and health benefit plans of the HMO. An exception may be granted for other types of physician extenders in addition to advanced practice nurses if information is submitted justifying, to the satisfaction of the department, that the other types of physician extenders are able to provide the appropriate services within the scope of their license, and in accordance with the provider contracts and health benefit plans of the HMO.

2. If an affidavit is submitted, the department will review it to make sure that it meets all the requirements of Exhibit B. If the access plan is a consolidated access plan including information for more than one (1) managed care plan, the department will also review the affidavit for the following:

A. An affidavit that relies upon a managed care plan being a Medicare+Choice plan will only apply to the specific managed care plan that is a Medicare+Choice plan. All other managed care plans included in the access plan must be accompanied by either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating they are otherwise accredited pursuant to the provisions of (2)(B)1.B., above;

B. An affidavit that relies upon a managed care plan being accredited by the NCQA will only apply to the specific managed care plan included with the accreditation. All other managed care plans included in the access plan must be accompanied by either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating they are otherwise accredited pursuant to the provisions of (2)(B)1.B., above;

C. An affidavit that relies upon a managed care plan's network being accredited by the JCAHO will only apply to that portion of the managed care plan's network that is included within the accreditation. For the remainder of the network, either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating the remaining network is otherwise accredited pursuant to the provisions of (2)(B)1.B., above, must be submitted. All other managed care plans included in the access plan must be accompanied by either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating they are otherwise accredited pursuant to the provisions of (2)(B)1.B., above;

D. An affidavit that relies upon a managed care plan being accredited by URAC will only apply to the specific managed care plan included with the accreditation. All other managed care plans included in the access plan must be accompanied by either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating they are otherwise accredited pursuant to the provisions of (2)(B)1.B., above;

E. An affidavit that relies upon a managed care plan being accredited by any other nationally recognized managed care accrediting organization, similar to those above, will only apply to the specific managed care plan included with the accreditation. All other managed care plans included in the access plan must be accompanied by either network information pursuant to the provisions of (2)(A)1.A., above, or an affidavit indicating they are otherwise accredited pursuant to the provisions of (2)(B)1.B., above.

(4) Approval or Disapproval of Access Plans.

(A) For a managed care plan for which network and enrollee information is submitted pursuant to the provisions of (2)(A)1.A. above, the department will:

1. Approve the access plan or portion of a consolidated access plan that applies to that managed care plan when the enrollee access rate across the entire network (all counties, all provider types) for that managed care plan is ninety percent (90%) or better, and the average enrollee access rate in each county in an HMO's approved service area for that managed care plan is ninety percent (90%) or better, and the information submitted pursuant to the provisions of (2)(A)2. and 3., above, is satisfactory;

2. Conditionally approve the access plan or portion of a consolidated access plan that applies to that managed care plan when the enrollee access rate across the entire network (all counties, all provider types) for that managed care plan is ninety percent (90%) or better, but the average enrollee access rate in any county for that managed care plan is less than ninety percent (90%), and the information submitted pursuant to the provisions of (2)(A)2. and 3., above, is satisfactory. If an access plan or portion of an access plan is conditionally approved, the department will require the HMO to present an action plan for increasing the enrollee access rate for that managed care plan's network to ninety percent (90%) or better in those counties where this standard is not met; or

3. Disapprove the access plan or portion of a consolidated access plan that applies to that managed care plan when the enrollee access rate across the entire network (all counties, all provider types) for that managed care plan is less than ninety percent (90%) and/or the information submitted pursuant to the provisions of (2)(A)2. and 3., above, is unsatisfactory. Disapproval of the access plan or portion of the access plan will subject the HMO and its managed care plan to the enforcement mechanisms described in section (5), below, of this regulation.

(B) For a managed care plan for which an affidavit is submitted pursuant to (2)(A)1.B. above, the department will:

1. Approve the access plan or portion of a consolidated access plan that applies to that managed care plan when both the managed care plan's affidavit and the information submitted pursuant to (2)(A)2. and 3., above, are satisfactory; or

2. Disapprove the access plan or portion of a consolidated access plan that applies to that managed care plan when the managed care plan's affidavit and/or the information submitted pursuant to (2)(A)2. and 3., above, are unsatisfactory. Disapproval of the access plan or portion of the access plan will subject the HMO and its managed care plan to the enforcement mechanisms described in section (5), below, of this regulation.

(C) Approval of an access plan or portion of an access plan is subject to the following:

1. Approval of an access plan shall not remove any HMO's obligations to provide adequate access to care as expressed in this regulation or in Exhibit A. In any case where a managed care plan's network has an insufficient number or type of participating providers to provide a covered benefit, the HMO shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director. This may include, but is not limited to, the following:

A. With regard to the types of providers listed in Exhibit A and only those types of providers, allowing an enrollee access to a nonparticipating provider at no additional cost when no participating provider of that same type is within the distance standard prescribed by Exhibit A; and

B. With regard to the services listed in (2)(A)3.A.(III), above, allowing an enrollee access to a nonparticipating provider at no additional cost when no participating provider is available to provide the service within the time prescribed for timely access to appointments;

2. If there is no participating provider in a managed care plan's network with the appropriate training and experience to meet the particular health care needs of an enrollee, the HMO shall make arrangements with an appropriate nonparticipating provider, pursuant to a treatment plan developed in consultation with the primary care provider, the nonparticipating provider and the enrollee or enrollee's designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

(5) Enforcement Process for Disapproved Access Plans.

(A) If a managed care plan's access plan has been disapproved pursuant to (4)(A)3., above, it is subject to the following:

1. The managed care plan may be placed on probationary status by the department for a period not to exceed ninety (90) days to allow the HMO time to bring the managed care plan's distance standard rate across the entire network up to ninety percent (90%) and/or submit satisfactory information pursuant to (2)(A)2. and 3., above. If information sufficient to allow the department to "approve" or "conditionally approve" the managed care plan's access plan is submitted prior to the expiration of the probationary period, the managed care plan will be removed from probationary status;

2. If the HMO fails to submit information sufficient to allow the department to "approve" or "conditionally approve" the managed care plan's access plan by the end of the probationary period, the department may, after notice and hearing pursuant to sections 354.470 and 354.490, RSMo, order the HMO to refrain from offering that managed care plan in part or all of the HMO's service area until such time as the HMO can demonstrate to the department's satisfaction that the managed care plan fully meets the requirements of this rule.

(B) If the managed care plan's access plan has been disapproved pursuant to (4)(B)2., above, it is subject to the following:

1. The managed care plan may be placed on probationary status for a period not to exceed ninety (90) days to allow the HMO time to remedy any problems with the affidavit submitted pursuant to (2)(A)1.B., above, and/or submit satisfactory information pursuant to (2)(A)2. and 3., above. If information sufficient to allow the department to "approve" or "conditionally approve" the managed care plan's access plan is submitted prior to the expiration of the probationary period, the managed care plan will be removed from probationary status;

2. If the HMO fails to submit information sufficient to allow the department to "approve" or "conditionally approve" the managed care plan's access plan by the end of the probationary period, the department may, after notice and hearing pursuant to sections 354.470 and 354.490, RSMo, order the HMO to refrain from offering that managed care plan in part or all of the HMO's service area until such time as the HMO can demonstrate to the department's satisfaction that the managed care plan fully meets the requirements of this rule.

(C) If all of an HMO's managed care plans are disapproved at the time of renewal of the HMO's certificate of authority, the department may, after notice and hearing pursuant to section 354.490, RSMo, deny renewal of the HMO's certificate of authority until such time as the HMO demonstrates to the satisfaction of the department that one or more of its managed care plans meet the requirements of this regulation.

Exhibit A

Provider/Service Type	Distance Standards		
	Urban County	Basic County	Rural County
Physicians			
PCPs	10	20	30
Obstetrics/Gynecology	15	30	60
Neurology	25	50	100
Dermatology	25	50	100
Physical Medicine/Rehab	25	50	100
Podiatry	25	50	100
Vision Care/Primary Eye Care	15	30	60
Allergy	25	50	100
Cardiology	25	50	100
Endocrinology	25	50	100
Gastroenterology	25	50	100
Hematology/Oncology	25	50	100
Infectious Disease	25	50	100
Nephrology	25	50	100
Ophthalmology	25	50	100
Orthopedics	25	50	100
Otolaryngology	25	50	100
Pediatric	25	50	100
Pulmonary Disease	25	50	100
Rheumatology	25	50	100
Urology	25	50	100
General surgery	15	30	60
Psychiatrist-Adult/General	15	30	60
Psychiatrist-Child/Adolescent	15	30	60
Psychologists/Other Therapists	10	20	40
Chiropractor	15	30	60
Hospitals			
Basic Hospital	30	30	30
Secondary Hospital	50	50	50
Tertiary Services			
Level I or Level II trauma unit	100	100	100
Neonatal intensive care unit	100	100	100
Perinatology services	100	100	100
Comprehensive cancer services	100	100	100
Cardiac catheterization	100	100	100
Cardiac surgery	100	100	100
Pediatric subspecialty care	100	100	100
Mental Health Facilities			
Outpatient-Adult	15	30	60
Outpatient-Child/Adolescent	15	30	60
Outpatient-Geriatric	15	30	60
Inpatient/Intensive Treatment-Adult	25	50	100
Inpatient/Intensive Treatment-Child/Adolescent	25	50	100
Inpatient/Intensive Treatment-Geriatric	38	75	100
Inpatient/Intensive Treatment-Alcohol/Chemical Dependency	38	75	100
Ancillary Services			
Physical Therapy	30	30	30
Occupational Therapy	30	30	30
Speech Therapy	50	50	50
Audiology	50	50	50
Pharmacy			
Pharmacy	10	20	30

Exhibit B

AFFIDAVIT PURSUANT TO 20 CSR 400-7.095(2)(A)1.B.

State of _____)
) ss.
County of _____)

_____, first being duly sworn, on his/her oath states:
(Insert Name)

He/she is the _____ of _____,
(Insert Title of Individual) (Insert Name of HMO)

a(n) _____ corporation, and as such officer is duly authorized to make this affidavit
(Insert State of Incorporation)

on behalf of said corporation;

The managed care plan to which this affidavit applies is known by the product name(s):

_____
_____;
(Insert Product Name(s) used by the HMO for this Managed Care Plan; if none, so state)

The form number(s) of the health benefit plan for this managed care plan are:

_____
_____
_____;
(Insert Form Numbers as Filed for Approval with the Department of Insurance)

This managed care plan meets the following criteria:
(insert an "X" in one or more of the following, as applicable.)

____ The managed care plan is a Medicare+Choice coordinated care plan offered pursuant to a contract with the federal Centers for Medicare and Medicaid Services, and the contract is currently in effect;

____ The managed care plan is accredited by the National Committee for Quality Assurance (NCQA) at a level of "accredited" or better, and the accreditation is currently in effect;

____ All/some (circle one) of the managed care plan's network is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) at a level of "accreditation without type I recommendations" or better, and the accreditation is currently in effect. (If "some" is circled, additional information for that portion of the Network not covered by the JCAHO accreditation must be submitted pursuant to 20 CSR 400-7.095(2)(A)1.A. or B.)

____ The managed care plan is accredited by the American Accreditation Healthcare Commission (URAC) for full URAC Health Plan accreditation, and the accreditation is currently in effect;

____ The managed care plan or its network is accredited by _____, this accreditation was approved by the department prior to the date of this affidavit, and this accreditation is currently in effect.

_____
(Signature of Affiant Corporate Officer)

Subscribed and sworn to before me this _____ day of _____, 20_____.

My commission expires _____, 20___.

_____
Notary Public

AUTHORITY: sections 354.405, 354.615 and 374.045, RSMo 2000; and 354.603, RSMo Supp. 2001. Original rule filed Nov. 3, 1997, effective May 30, 1998. Rescinded and readopted: Filed Oct. 1, 2002, effective April 30, 2003.

**Original authority: 354.405, RSMo 1983, amended 1997; 354.603, RSMo 1997. amended 2001; 354.615, RSMo 1997; and 374.045, RSMo 1967.*

20 CSR 400-7.100 Copayments

PURPOSE: This rule states that an health maintenance organization may require copayments of its enrollees as a condition for the receipt of health care services. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

A health maintenance organization (HMO) may require copayments of its enrollees as a condition of the receipt of specific health care services. An HMO may not impose copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty percent (20%) of the total cost of providing all basic health services. An HMO may not impose copayment charges for basic health care services on any enrollee in any calendar year after the copayments made by the enrollee in that calendar year for basic health care services total two hundred percent (200%) of the total annual premium which is required to be paid by, or on behalf of, that enrollee and shall be stated as a dollar amount in the group contracts. Copayments shall be the only allowable charge, other than premiums, assessed to enrollees for basic and supplemental health care services. Single service copayment amounts shall be disclosed either as a percentage or as a stated dollar amount in the evidence of coverage. For group contracts the copayment amount may be changed only on the anniversary date of the group contract except by mutual agreement of the parties to the contract.

AUTHORITY: sections 354.430 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.190. Original rule filed Nov. 2, 1987, effective April 11, 1988. Amended: Filed Aug. 16, 1989, effective Dec. 15, 1989.*

**Original authority: 354.430, RSMo 1983 and 354.485, RSMo, 1983.*

20 CSR 400-7.110 Health Maintenance Organizations—Resolution of Enrollee Grievances

PURPOSE: This rule sets forth the guidelines and procedures to be used by a health maintenance organization to resolve enrollee grievances. This rule is promulgated pursuant to section 354.485, RSMo and implements sections 354.430.3(2)(e) and 354.445, RSMo.

(1) Definitions.

(A) Grievance means a complaint submitted in writing in accordance with the health maintenance organization's (HMO) formal grievance procedure by or on behalf of the enrollee regarding the interpretation of the certificate of coverage or dissatisfaction with the quality of health care provided by an HMO employee or a contracted provider.

(B) Grievance advisory panel means a panel established by the HMO which may review the HMO's decision regarding grievances which have not been resolved to the satisfaction of the enrollee and which an enrollee has requested the panel to review. This panel must be comprised, at least in part, of enrollees and also may include representatives from the HMO, but shall not include anyone involved in the circumstances giving rise to the grievance, or in any subsequent investigation or determination of the grievance placed before it.

(2) An HMO shall set forth in its certificate of coverage the procedures for resolving enrollee grievances. At a minimum, the certificate of coverage shall include the following provisions:

(A) The definition of a grievance;

(B) How, where and to whom the enrollee should file his/her grievance; and

(C) That upon receiving notification of a grievance related to payment of a bill for medical services, the HMO will—

1. Acknowledge receipt of the grievance in writing within ten (10) working days unless it is resolved within that period of time;

2. Conduct a complete investigation of the grievance within twenty (20) working days after receipt of a grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty (20) working days after receipt of a grievance, the enrollee shall be notified in writing within thirty (30) working days time, and every thirty (30) working days after that, until the investigation is completed. The notice shall set forth the reasons for which additional time is needed for the investigation;

3. Have within five (5) working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the HMO's decision regarding the grievance and of any right to appeal. The notice shall explain the resolution of the grievance and any right to appeal. The notice shall explain the resolution of the grievance in terms which are clear and specific; and

4. Notify, if the HMO has established a grievance advisory panel, the enrollee of his/her right to request the grievance advisory panel to review the HMO's decision. This notice shall indicate that the grievance advisory panel is not obligated to conduct the review. This provision shall also state how, where and when the enrollee should make his/her request for this review.

(3) An HMO shall keep a record or report of the total number, type, nature and result of all grievances. Upon request by the director of the Department of Insurance or his/her appointee, the HMO shall provide, promptly, all those records or reports.

(4) An HMO, upon receipt of any inquiry from the Department of Insurance regarding a grievance, within fifteen (15) working days of receipt of the inquiry, shall furnish the department with a written response to the information requested.

(5) All written grievances shall be date stamped when received by the HMO. The date shall be legible and easily identified.

(6) The director of the Department of Insurance may institute disciplinary action for a violation of this rule in accordance with the provisions of section 354.550, RSMo and any other applicable law.

AUTHORITY: sections 354.430, 354.445 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority: 354.430, RSMo 1983; 354.445, RSMo 1983; and 354.485, RSMo 1983.*

20 CSR 400-7.120 Health Maintenance Organization—Enrollee Participation

PURPOSE: This rule sets forth the health maintenance organization's method for enrollees to participate in matters of policy and operation. This rule is promulgated pursuant to section 354.485, RSMo and implements section 354.420, RSMo.

(1) Definitions.

(A) Enrollee means an individual who is covered by a health maintenance organization (HMO).

(B) Evidence of coverage means any certificate, agreement or contract issued to an enrollee which sets out the coverage to which the enrollee is entitled under the HMO contract which covers the enrollee.

(2) Enrollee Participation. Every HMO shall establish a mechanism which affords enrollees an opportunity to participate in matters of the HMO's policy and operation. The HMO in its evidence of coverage shall clearly advise the member that a mechanism which affords enrollees an opportunity to participate in matters of the HMO's policy and operation, and which has been approved by the Missouri Department of Insurance, will be made available to this member upon request. At a minimum, the mechanism used must both afford enrollees an opportunity to offer appropriate suggestions to the policymaking body of the HMO and ensure that the policymaking body gives these suggestions due consideration, and either approves or disapproves them. For purposes of this section, suggestions deemed appropriate for presentation to the policymaking body shall be those selected by either an enrollee advisory committee, the composition of which is set forth in the HMO's organizational documents or such other means as have been approved by the director.

(3) Discipline. The director of the Department of Insurance may institute disciplinary action for a violation of this rule in accordance with the provisions of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.420 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority: 354.420, RSMo 1983 and 354.485, RSMo 1983.*

20 CSR 400-7.130 Authorization for Emergency Medical Services

PURPOSE: This rule sets forth the requirements of a health maintenance organization when prior authorization for emergency medical services is required. This rule is promulgated pursuant to section 354.485, RSMo and implements sections 354.410.1(2) and 354.470.1(3), RSMo.

(1) A health maintenance organization (HMO) that requires prior authorization before making payment for the treatment of medical emergency conditions, as defined by the HMO, shall provide enrollees with a toll-free telephone number answered twenty-four (24) hours per day, seven (7) days a week. At least one (1) person with medical training who is authorized to determine whether an emergency condition exists shall be available twenty-four (24) hours per day, seven (7) days a week to make these determinations.

(2) An HMO shall not base its denial of payment for emergency medical services solely on the enrollee's failure to receive authorization prior to receiving the emergency medical service. The enrollee must notify the HMO of receipt of medical services for emergency conditions within twenty-four (24) hours or as soon after that as is reasonably possible. Nothing shall require the HMO to authorize payment for any services provided during that twenty-four (24)-hour period, regardless of medical necessity, if those services do not otherwise constitute benefits under the certificate of coverage approved by the department.

(3) If the participating provider is responsible for seeking prior authorization from the HMO before receiving payment for the treatment of emergency medical conditions and the enrollee is eligible at the time when covered services are provided, then the enrollee will not be held financially responsible for payment for covered services if the prior authorization for emergency medical services has not been sought and received, other than for what s/he would otherwise be responsible, such as copayments and deductibles.

(4) All disputes between an enrollee and an HMO arising under the provisions of this regulation shall be resolved by means of the HMO's grievance procedure.

(5) Discipline. The director of the Department of Insurance may institute disciplinary action for violation of this rule in accordance with the provisions of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.410, 354.470 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority: 354.410, RSMo 1983; 354.470, RSMo 1983; and 354.485, RSMo 1983.*

20 CSR 400-7.140 Health Maintenance Organizations—Reinsurance Agreements

PURPOSE: This rule sets forth the requirements that relate to the filing of reinsurance agreements with the Department of Insurance. This rule is promulgated pursuant to section 354.485, RSMo and implements sections 354.405.5. and 354.410.1(3)(c) and (6), RSMo.

(1) Definition. As used in this rule, a contract of reinsurance means the entire contract, including the signatures of the representatives of the health maintenance organization (HMO) and the reinsurer, and any binders, certificates, attachments, amendments or modifications to the contract.

(2) Filing. A contract of reinsurance shall be submitted to the Department of Insurance for filing and approval no later than ten (10) working days after receipt by the HMO. If it appears there will be a substantial delay between the issuance of a binder and all other documents connected with the contract of reinsurance, or difficulty in obtaining a contract of reinsurance as evidenced by the negotiation process, the HMO shall file a copy of the binder or a letter signed by an officer of the reinsurer explaining the circumstances pertaining to the delay. After filing this binder or letter, the HMO shall file its contract of reinsurance ten (10) working days after receipt of the contract. Proof of coverage shall be filed no later than ten (10) working days after its effective date.

(3) Provisions. A contract of reinsurance shall not contain a provision stating that the contract of reinsurance will not apply or will become ineffective in the event the HMO is unable to meet its financial obligations or is insolvent.

(4) Requests. Upon request by the director of the Department of Insurance or his/her appointee, the HMO shall provide promptly to the Department of Insurance all contracts of reinsurance required by this section and available to the HMO.

(5) Discipline. The director of the Department of Insurance may institute disciplinary action for violation of this rule in accordance with the provisions of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.405, 354.410 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority: 354.405, RSMo 1983; 354.410, RSMo 1983; and 354.458, RSMo 1983. 1983.*

20 CSR 400-7.150 Health Maintenance Organizations—Disenrollments

PURPOSE: This rule specifies when a health maintenance organization may disenroll an enrollee for nonpayment of a copayment when his/her premium has been paid. This rule is promulgated pursuant to section 354.485, RSMo and implements section 354.462, RSMo.

(1) Definitions.

(A) Copayment means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

(B) Copayment maximum means the total amount of copayments an enrollee is obligated to pay during the calendar year as defined by the contract.

(C) Disenrollment means a health maintenance organization's (HMO) termination of an enrollee's eligibility for service.

(D) Enrollee means an individual who is properly enrolled in an HMO.

(2) Disenrollment. An enrollee for whom premium has been paid may not be disenrolled nor denied renewal for nonpayment of a copayment except when the HMO or provider to whom the copayment is due has initiated collection efforts within sixty (60) days after the HMO is notified that copayment is due. The enrollee also must receive written notice from the HMO stating the disenrollment will occur unless arrangements for payment of the copayment are made within ten (10) working days after receipt of the notice.

(3) Refunds. An HMO shall refund any premium payment, net of copayments due, made to cover the period after disenrollment.

(4) Copayment Notification. Upon request, an HMO shall inform an enrollee if s/he has reached his/her copayment maximum.

(5) Discipline. The director of the Department of Insurance may institute disciplinary action for a violation of this rule in accordance with the provision of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.462 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority: 354.462, RSMo 1983 and 354.485, RSMo 1983.*

20 CSR 400-7.160 Multiple Names Prohibited

PURPOSE: This rule implements the provisions of sections 354.405, 354.460, 375.934 and 375.936(4), RSMo regarding the name of a health maintenance organization and misleading information and advertising. This rule prohibits an health maintenance organization from using any name other than its true name on its certificate of authority and sets forth specific requirements for the use of multiple names on its other documents and publications.

(1) A health maintenance organization (HMO) must use its true name for its certificate of authority to conduct business as an HMO in this state.

(2) An HMO will be permitted to use a fictitious name, an acronym or a portion of its true name, in its advertising, agreements, contracts, policies, evidences of coverage, filings with the director or any other publication of its name, provided that the HMO uses its true name at least once in each advertisement, agreement, contract, policy, evidence of coverage, filing with the director, or any other publication of its name.

(3) Any HMO which does business as an HMO in this state under a fictitious name shall file with the director a copy of all documents, including the authorization from the Missouri secretary of state, which shows the legal authority for the HMO to use such other name. Any acronym or portion of the true name must be registered with the director.

(4) Any HMO which prior to the effective date of this rule used or employed more than one (1) name shall cease using more than one (1) name, except as permitted by this rule, and take all steps necessary to comply with this rule within sixty (60) days after the effective date of this rule (June 6, 1994), including but not limited to, the filing of an application for an amended certificate of authority to reflect the true name of the HMO and the payment of fees in accordance with section 354.495, RSMo.

(5) The director may institute disciplinary action for violations of this rule in accordance with the provisions of sections 354.490, 354.500, 374.046 and 375.942, RSMo and any other applicable law.

AUTHORITY: section 374.045, RSMo Supp. 1993. Original rule filed Oct. 1, 1993, effective June 6, 1994.*

**Original authority: 374.045, RSMo 1967, amended 1993.*

20 CSR 400-7.170 Distribution of Written Disclosure Information

PURPOSE: This rule sets forth with greater specificity the enrollees who are entitled to written disclosure information. This rule is promulgated pursuant to section 354.485, RSMo, and implements section 354.442.1, RSMo.

(1) Definition. As used in this rule, a household means those persons who dwell under the same roof and are covered by the same policy.

(2) If a household includes more than one (1) enrollee, a health maintenance organization is only required to provide one (1) written disclosure to that household.

AUTHORITY: sections 354.442.1, RSMo Supp. 1997 and 354.485, RSMo 1994. Original rule filed Nov. 3, 1997, effective June 30, 1998.

**Original authority: 354.442, RSMo 1997 and 354.485, RSMo 1983.*

20 CSR 400-7.180 Standard Form To Establish Credentials

PURPOSE: This rule sets forth the standard form which shall be used by all health carriers when soliciting the credentials of a health care professional in a managed care plan. This rule is promulgated pursuant to section 354.485, RSMo, and implements section 354.442.1(15), RSMo.

(1) Definitions.

(A) Health care professional means a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law.

(B) Health carrier means a health maintenance organization as organized pursuant to sections 354.400 through 354.636, RSMo.

(C) Managed care plan means a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with or employed by the health carrier.

(2) The form provided in Exhibit A shall be used by all health carriers and their agents when credentialing or recredentialing health

care professionals in a managed care plan. Use of another state's standardized credentialing form is permissible so long as the director determines prior to its use that it is substantially similar to the form in Exhibit A. Carriers shall accept any form approved by the director for credentialing purposes, and shall not require a Missouri health care professional to use any particular approved form to the exclusion of any other approved form, so long as the form submitted by the Missouri health care professional is Missouri's Standardized Credentialing Form or any other form approved pursuant to this rule. Requests for the director's approval of the use of another state's standardized credentialing form should be submitted to the following address: Missouri Department of Insurance, Managed Care Section, P.O. Box 690, Jefferson City, MO 65102-0690. A request must include a complete copy of the form to be approved and the name, address and telephone number of the person requesting approval. The director will provide written notice to all Missouri licensed health maintenance organizations of the approval of the use of another state's standardized credentialing form. The director also will provide on the department's Internet home page a copy of Missouri's Standardized Credentialing Form with a list of other state standardized credentialing forms that have been approved.

(3) Health carriers may request additional information to explain or provide details regarding responses obtained on the standard form. Health carriers are prohibited from routinely requiring additional information from health care professionals.

(4) An on-site examination by the health carrier or their agent of the health care professional's place of business shall not, in itself, be considered a routine request for additional information.

(5) A health carrier may require a health care professional to sign an affirmation and release of the health carrier's own design.

AUTHORITY: sections 354.442.1(15), RSMo Supp. 1999 and 354.485, RSMo 1994. Original rule filed Nov. 3, 1997, effective June 30, 1998. Amended: Filed June 6, 2000, effective Feb. 28, 2001.

**Original authority: 354.442, RSMo 1997 and 354.485, RSMo 1983.*

Exhibit A

Standardized Credentialing Form To Be Used By Health Maintenance Organizations Licensed in the State of Missouri

COMPLETE EACH SECTION AS THOROUGHLY AS POSSIBLE. PLEASE TYPE OR PRINT.

I. GENERAL INFORMATION

1. _____
Name (Last, First, MI, Degree/Prof. Designation-M.D./D.O./Ph.D./M.S.W./D.C./D.P.M./D.D.S./D.M.D./ A.P.N./P.A./Other)

2. _____
Home Address/Street

3. _____ 4. _____
City/State/ZIP E-Mail Address

5. _____ 6. _____
Other Names You May Have Used (i.e. Maiden, etc.) Date of Birth (Month/Day/Year)

7. _____ 8. _____
Place of Birth Social Security Number

9. Are You a U.S. Citizen? Yes_____ No _____ 10. Sex: Male_____ Female_____

If Not a Citizen of the U.S., Indicate the Current Status of Your VISA:

_____

_____

Form Authorized by the Missouri Department of Insurance 1998

DO NOT SUBMIT COMPLETED FORM TO THE DEPARTMENT OF INSURANCE

Page 1

II. OFFICE/PRACTICE INFORMATION

If More Than Two Offices, Check Here ____ and Attach a Copy of Page 3, Completing Questions 22 - 40 for Each Office.

1. Participation Status For Which You Are Applying: (Indicate Specialty)

   Primary Care Specialty: _____ Subspecialty: _____ Patient Ages: _____

2. _____ From: _____
   PRIMARY OFFICE ADDRESS/STREET/BUILDING/SUITE (month/year)
3. _____
   City/State/ZIP
4. _____
   Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name)
5. _____
   Business Name or Name By Which the Provider Group is Generally Known
6. _____ 7. _____
   Office Phone Number After Hours/Emergency Number or Procedure
8. _____ 9. _____
   Office Fax Number Office E-Mail Address
10. _____ 11. _____
    Office Manager Federal Tax ID#
12. _____
    BILLING ADDRESS/STREET (If Different From Above)
13. _____
    Billing City/State/ZIP
14. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

15. Evening Hours: Yes_____ No_____ If Yes, List Hours After 5:00 P.M.

Monday	Tuesday	Wednesday	Thursday	Friday

16. Weekend Hours: Yes_____ No_____

Saturday	Sunday

17(a) Lab Service in Your Office:
Yes_____ No_____

17(b) _____
If Yes, specify Waived, Physician Performed Microscopy, Moderately Complex, Highly Complex

18. Please check all of the following that you perform IN THIS OFFICE:

EKG ____ Office gynecology (Routine Pelvic/PAP) _____ Drawing Blood _____ Age appropriate immunizations _____
X-Rays ____ Minor Surgery ____ Tympanometry/audiometry screening _____ Flexible sigmoidoscopy _____
Laceration Repair ____ Pulmonary Function Studies _____ Asthma Treatment _____ Allergy Skin Testing _____
Osteopathic manipulation _____ IV hydration/treatment _____ Other (please specify) _____

19. (a) Languages Spoken (other than English): (b) Are Interpreters Available? Yes_____ No_____

_____ _____
Health Care Provider Staff

20. Does Your Office: *(CIRCLE ONE)*

(a) Have 24-Hr. Phone Coverage Service?	Y	N	(b) Qualify as a Minority Business Enterprise?	Y	N
(c) Have Capability for Electronic Billing?	Y	N	(d) Provide Child Care Services?	Y	N
(e) Meet ADA Accessibility Standards?	Y	N	(f) Have Public Transportation Accessibility?	Y	N
(g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)?				Y	N

If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the Name(s) of the Individual(s).

(h) Type of Practice: Solo Single Specialty Group Multispecialty Group Other
If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.

21. Do You Currently: *(CIRCLE ONE)*

(a) Accept New Patients Into Practice?	Y	N	(b) Accept New Patients By Physician Referral Only?	Y	N
(c) Have Medicare Certification?	Y	N	(d) Accept Medicare Assignment?	Y	N
(e) Provide Inpatient Care?	Y	N	(f) Accept Medicaid Assignment?	Y	N

Page 2

II. OFFICE/PRACTICE INFORMATION

If More Than Two Offices, Check Here ____ and Attach a Copy of Page 3, Completing Questions 22 - 40 for Each Office.

22. Participation Status For Which You Are Applying: (Indicate Specialty)

Primary Care Specialty: _____ Subspecialty: _____ Patient Ages: _____

23. _____
PRIMARY OFFICE ADDRESS/STREET/BUILDING/SUITE

24. _____
City/State/ZIP

25. _____
Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name)

26. _____
Business Name or Name By Which the Provider Group is Generally Known

27. _____
Office Phone Number

28. _____
After Hours/Emergency Number or Procedure

29. _____
Office Fax Number

30. _____
Office E-Mail Address

31. _____
Office Manager

32. _____
Federal Tax ID#

33. _____
BILLING ADDRESS/STREET (If Different From Above)

34. _____
Billing City/State/ZIP

35. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

36. Evening Hours: Yes_____ No_____ If Yes, List Hours After 5:00 P.M.

Monday	Tuesday	Wednesday	Thursday	Friday

37. Weekend Hours: Yes_____ No_____

Saturday	Sunday

38.(a) Lab Service in Your Office
Yes_____ No_____

38.(b) _____
If Yes, specify Waived, Physician Performed Microscopy, Moderately Complex, Highly Complex

39. Please check all of the following that you perform IN THIS OFFICE:

EKG ____ Office gynecology (Routine Pelvic/PAP) _____ Drawing Blood _____ Age appropriate immunizations _____
X-Rays ____ Minor Surgery ____ Tympanometry/audiometry screening _____ Flexible sigmoidoscopy _____
Laceration Repair ____ Pulmonary Function Studies _____ Asthma Treatment _____ Allergy Skin Testing _____
Osteopathic manipulation _____ IV hydration/treatment _____ Other (please specify) _____

40. (a) Languages Spoken (other than English):

_____
Health Care Provider

(b) Are Interpreters Available? Yes_____ No_____

_____
Staff

41. Does Your Office: *(CIRCLE ONE)*

(a) Have 24-Hr. Phone Coverage Service? Y N
(b) Qualify as a Minority Business Enterprise? Y N
(c) Have Capability for Electronic Billing? Y N
(d) Provide Child Care Services? Y N
(e) Meet ADA Accessibility Standards? Y N
(f) Have Public Transportation Accessibility? Y N
(g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)? Y N
If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the Name(s) of the Individual(s).
(h) Type of Practice: Solo Single Specialty Group Multispecialty Group Other
If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.

42. Do You Currently: *(CIRCLE ONE)*

(a) Accept New Patients Into Practice? Y N
(b) Accept New Patients By Physician Referral Only? Y N
(c) Have Medicare Certification? Y N
(d) Accept Medicare Assignment? Y N
(e) Provide Inpatient Care? Y N
(f) Accept Medicaid Assignment? Y N

Page 3

III A. PROFESSIONAL EDUCATION

List All Medical Schools/Institutions Attended.

Please Explain Any 30 Day or Greater Gap In Your Training. Attach Additional Sheets if Necessary.

1. _____
   Medical/Professional School Name
2. _____
   Address/Street
3. _____
   City/State/Zip/Country
4. From: _____ To: _____ 5. _____
   Dates Attended (month/year) Degree(s) Awarded
5. If You Are a Graduate of a Foreign Medical School, Are You Certified by the Education Council for Foreign Medical Graduates (ECFMG)? If Yes, Please Enclose a Copy of Your Certificate With This Application.
   Yes_____ No_____

III B. POSTGRADUATE TRAINING: INTERNSHIP

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____ 5. _____
   Dates Attended (month/year) Department Chair/Program Director
5. _____
   Type of Internship (Rotating/Straight) - If Straight, Please List Specialty.

III C. POSTGRADUATE TRAINING: FIRST RESIDENCY

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____ 5. _____
   Dates Attended (month/year) Department Chair/Program Director
5. _____
   Type of Residency

III D. POSTGRADUATE TRAINING: SECOND RESIDENCY or FELLOWSHIP

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____ 5. _____
   Dates Attended (month/year) Department Chair/Program Director
5. _____
   Type of Residency/Fellowship

Page 4

III E. POSTGRADUATE TRAINING: FELLOWSHIP/OTHER

1. _____
Institution Name
2. _____
Address/Street
3. _____
City/State/Zip
4. From: _____ To: _____
Dates Attended (month/year)
5. _____
Department Chair/Program Director
5. _____
Type of Fellowship/Other Explanation

IV A. HOSPITAL AFFILIATIONS: PRIMARY

1. _____
CURRENT PRIMARY HOSPITAL NAME
2. _____
Address/Street
3. _____
City/State/Zip
4. _____
Status of Privileges *(INDICATE BY USING KEY)*
5. From: _____ To: _____
Dates Affiliated (month/year)

Status of Privileges Key

1 Active	4 Associate	7 Courtesy	10 Senior Staff	13 Consulting
2 Courtesy Provisional Staff	5 Visiting	8 Admitting	11 Provisional	14 Pending
3 Active Provisional Staff	6 Temporary	9 CO-Admitting	12 Suspended	15 Other: _____

If CO-Admitting Status, List Other Admitting Physician(s) _____

6. Any Past or Present Restriction of Privileges? Yes_____ No_____ *(IF YES, EXPLAIN)*
_____
_____

IV B. HOSPITAL AFFILIATIONS: OTHER

List All Other Hospitals At Which You Have Or Have Had Privileges. Attach Additional Pages If Necessary.

1a. _____
HOSPITAL NAME
2a. _____
Address/Street
3a. _____
City/State/Zip
4a. _____
Status of Privileges *(INDICATE BY USING KEY)*
5a. From: _____ To: _____
Dates Affiliated (month/year)
If CO-Admitting Status, List Other Admitting Physician(s) _____
6a. Any Past or Present Restriction of Privileges? Yes_____ No_____ *(IF YES, EXPLAIN)*
_____
_____

1b. _____
HOSPITAL NAME
2b. _____
Address/Street
3b. _____
City/State/Zip
4b. _____
Status of Privileges *(INDICATE BY USING KEY)*
5b. From: _____ To: _____
Dates Affiliated (month/year)
If CO-Admitting Status, List Other Admitting Physician(s) _____
6b. Any Past or Present Restriction of Privileges? Yes_____ No_____ *(IF YES, EXPLAIN)*
_____
_____
_____

Page 5

1c. _____
HOSPITAL NAME
2c. _____
Address/Street
3c. _____
City/State/Zip
4c. _____ 5c. From: _____ To: _____
Status of Privileges *(INDICATE BY USING KEY)* Dates Affiliated (month/year)
If CO-Admitting Status, List Other Admitting Physician(s) _____
6c. Any Past or Present Restriction of Privileges? Yes_____ No_____ *(IF YES, EXPLAIN)*
_____
_____

IV C. OTHER PRACTICE AFFILIATIONS (e.g. HMOs, PPOs, IPAs, PHOs, etc.)

Attach Additional Pages If Necessary.

1a. _____
Institution/Organization Name
2a. _____
Address/Street
3a. _____
City/State/Zip
4a. _____ 5a. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1b. _____
Institution/Organization Name
2b. _____
Address/Street
3b. _____
City/State/Zip
4b. _____ 5b. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1c. _____
Institution/Organization Name
2c. _____
Address/Street
3c. _____
City/State/Zip
4c. _____ 5c. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1d. _____
Institution/Organization Name
2d. _____
Address/Street
3d. _____
City/State/Zip
4d. _____ 5d. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1e. _____
Institution/Organization Name
2e. _____
Address/Street
3e. _____
City/State/Zip
4e. _____ 5e. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

Page 6

V. PRACTICE SPECIALTY

Attach Copy of Certificate(s). If Not Applicable to Your Profession/Specialty, Complete With N/A.

1. _____ **PRIMARY SPECIALTY / BOARD CERTIFICATION**
2. _____ Certification Number
3. _____ Name of Board
4. _____ Date of Certification
5. _____ Expiration Date
6. _____ Date of Recertification (If Applicable)
7. _____ If Not Certified, Indicate Current Status and/or Date Intending to Sit For Boards.
8. _____ **SECONDARY SPECIALTY / BOARD CERTIFICATION**
9. _____ Certification Number
10. _____ Name of Board
11. _____ Date of Certification
12. _____ Expiration Date
13. _____ Date of Recertification (If Applicable)
14. _____ If Not Certified, Indicate Current Status and/or Date Intending to Sit For Boards.

VI. WORK /PRACTICE HISTORY

List Chronologically All Employment, Including Self Employment, For the Last Ten (10) Years. For Any Gap in Chronology, Explain On a Separate Sheet. Leave No Time Period Unaccounted For Within the Last Ten Years, Excluding Previously Stated Training. Attach Additional Sheets If Necessary.

1a. _____ **NAME of PREVIOUS PRACTICE**
2a. _____ Address/Street
3a. _____ City/State/Zip
4a. _____ Phone Number
5a. _____ Title or Professional Occupation
6a. From: _____ To: _____ Dates of Employment (month/year)

1b. _____ **NAME of PREVIOUS PRACTICE**
2b. _____ Address/Street
3b. _____ City/State/Zip
4b. _____ Phone Number
5b. _____ Title or Professional Occupation
6b. From: _____ To: _____ Dates of Employment (month/year)

1c. _____ **NAME of PREVIOUS PRACTICE**
2c. _____ Address/Street
3c. _____ City/State/Zip
4c. _____ Phone Number
5c. _____ Title or Professional Occupation
6c. From: _____ To: _____ Dates of Employment (month/year)

1d. _____ **NAME of PREVIOUS PRACTICE**
2d. _____ Address/Street
3d. _____ City/State/Zip
4d. _____ Phone Number
5d. _____ Title or Professional Occupation
6d. From: _____ To: _____ Dates of Employment (month/year)

Page 7

VII. PROFESSIONAL CERTIFICATES / LICENSE NUMBERS

List All States In Which You Have Held, or Currently Hold a License to Practice Your Profession. Please Attach Copies.

1. _____ License/Certification/Registration Number; Licensing State
2. _____ Expiration Date
3. _____ Other License/Certification/Registration Number; Licensing State
4. _____ Expiration Date
5. _____ Other License/Certification/Registration Number; Licensing State
6. _____ Expiration Date
7. _____ Federal Drug Enforcement Agency (DEA) Number(s)
8. _____ Expiration Date(s)
9. _____ CDS Certification Number (BNDD Number for Missouri)
10. _____ Expiration Date
11. _____ Medicare/Unique Provide ID Number (UPIN)
12. _____ National Provider ID Number (NPI)
13. _____ State Medicaid Number(s); Licensing State(s)
14. _____ ECFMG Number

VIII. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please Attach a Copy of Your Current Certificate(s) or Declaration(s) of Insurance, Including HCSF for Kansas Practitioners.

1a. _____ **CURRENT CARRIER NAME**

2a. _____ Address/Street

3a. _____ City/State/Zip

4a. _____ Phone Number

5a. _____ Policy Number

6a. From: _____ To: _____ Dates of Coverage (month/year)

7. Indicate Coverage Type: Claims Based _____ Occurrence Based _____

8. Policy Limits: Per Occurrence $_____ Aggregate $_____

Prior Carriers Within the Last Ten (10) Years. Attach Additional Sheets if Necessary.

1b. _____ **PREVIOUS CARRIER NAME**

2b. _____ Address/Street

3b. _____ City/State/Zip

4b. _____ Phone Number

5b. _____ Policy Number

6b. From: _____ To: _____ Dates of Coverage (month/year)

1c. _____ **PREVIOUS CARRIER NAME**

2c. _____ Address/Street

3c. _____ City/State/Zip

4c. _____ Phone Number

5c. _____ Policy Number

6c. From: _____ To: _____ Dates of Coverage (month/year)

1d. _____ **PREVIOUS CARRIER NAME**

2d. _____ Address/Street

3d. _____ City/State/Zip

4d. _____ Phone Number

5d. _____ Policy Number

6d. From: _____ To: _____ Dates of Coverage (month/year)

Page 8

IX. MALPRACTICE CLAIMS HISTORY

***A SIGNATURE IS REQUIRED AT THE BOTTOM OF THIS PAGE, EVEN IF THERE IS NO HISTORY TO REPORT**

Are you currently or have you within the last ten (10) years been involved in a malpractice suit or other suit or claim in which your care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial, or settled to avoid a lawsuit? yes____ no____ if yes, answer the following questions for EACH such claim. Duplicate this page as necessary.

1. _____ Patient Name
2. _____ Plaintiff Name, If Other Than Patient
3. _____ Your Involvement in the Case (Attending, Consulting, Etc.)
4. _____ Date of Occurrence (month/day/year)
5. _____ Your Status in the Case (Primary Defendant, Co-Defendant, Other)
6. _____ Date Claim Was Filed (month/day/year)
7. _____ Professional Liability Insurance Carrier Involved
8. _____ Carrier's Phone Number
9. _____ Policy Number
10. _____ Additional Defendants
11. Describe the Allegations Against You: _____
12. Describe the Alleged Injury to the Patient: _____
13. Claimant/Plaintiff Filed Suit in Court? Yes_____ No_____
14. _____ State Court Case Number
15. _____ State
16. _____ County/Parish
17. _____ Federal Court (US District Court) Case Number
18. _____ District
19. Present Status of Claim: Open_____ Closed_____ Pending_____

If PENDING, DO NOT Complete the Rest of This Page *Except For Signature and Date*.

20. If Closed, Indicate the Method of Resolution:

_____	Dismissed	Date: _____
_____	Settled (With Prejudice)	Date: _____
_____	Settled (Without Prejudice)	Date: _____
_____	Judgment for Defendant(s)	Date: _____
_____	Judgment for Plaintiff(s)	Date: _____
_____	Other	Date: _____

21. _____ Settlement Amount Paid On Your Behalf (If Any)
22. Additional Information/Explanation:
(e.g. Patient condition and diagnosis at time of incident, description of treatment, subsequent patient outcome, etc.)

_____ **Signature**

_____ **Date (month/day/year)**

IF YOU HAVE NO HISTORY TO REPORT, PLEASE INDICATE THAT AND SIGN.

Page 9

X. ADDITIONAL INFORMATION

Please Answer the Following Questions By Circling "Y" (Yes), "N" (No), or "N/A" (Not Applicable).

Please Provide an Explanation For Any "Yes" Responses on a Separate Page.

1. Have any of your board certifications ever been suspended, revoked, not renewed, denied renewal, voluntarily or involuntarily surrendered?	Y	N	N/A
2. Have you ever been named as a defendant in any criminal case?	Y	N	N/A
3. Have you ever been convicted, pled guilty, or pled nolo contendere to any felony, any offense reasonably related to your qualifications, functions, or duties as a medical professional, or any offense an essential element of which is fraud, dishonesty, or an act of violence?	Y	N	N/A
4. Has your malpractice insurance ever been canceled, suspended, not renewed, special rated, or restricted by the exclusion of any specific procedures from coverage?	Y	N	N/A
5. Have you ever been denied participation, suspended from, or denied renewal from the Medicare or Medicaid program, or had participation status modified?	Y	N	N/A
6. Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent or stipulation order, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
7. Has your federal or state controlled substance license ever been suspended, revoked, voluntarily or involuntarily surrendered, restricted, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
8. Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
9. Within the last five years, have you ever been a participating provider of another HMO, PPO, PHO, or MSO, etc. with which you are not affiliated at this time?	Y	N	N/A
10. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)?	Y	N	N/A
11. Has any information on you ever been reported to the National Practitioner Data Bank?	Y	N	N/A
12. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)	Y	N	N/A
13. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug?	Y	N	N/A
14. Have you discontinued practice for any reason (other than for routine vacation) for one month (30 days) or more?	Y	N	N/A

Page 10

X. ADDITIONAL INFORMATION (continued)

15. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? Y N N/A
If so, please provide the following information, attaching additional copies as necessary.

(a) _____ Organization Name

(b) _____ Type of Organization

(c) _____ Address/Street

(d) _____ City/State/Zip

(e) _____ Phone Number

(f) _____ Federal Tax ID#

(g) _____ Percent of Business Owned/Invested by Applicant

(h) _____ Nature of Business Interest (owner, partner, investor)

XI. ADDITIONAL DOCUMENTATION / ATTACHMENTS

Please Attach Copies of the Following Documents (If Applicable):

1. W9 Form For Each Entity the Applicant Expects Will Receive Payments or Reimbursements.
2. Collaborative Practice and/or Physician Assistant Verification of Supervision Agreement(s).
3. A List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.
4. Education Council for Foreign Medical Graduates (ECFMG) Certificate.
5. Board Certification Certificate(s).
6. Copies of Professional Diplomas, Internship, Residency, and Fellowship Certificates, As Applicable.
7. Current State Licenses (For All States Practicing).
8. Federal DEA Certificate.
9. State Controlled Substance Certificate(s) For All States Practicing (i.e. BNDD for Missouri).
10. Current Certificate(s) or Declaration(s) of Insurance, Including HCSF for Kansas Practitioners.
11. Curriculum Vitae (If Required By Health Carrier).
12. Professional References (If Required By Health Carrier).
13. Signed Copy of an Affirmation and Release of Information Document (Attestation Page) As Stipulated By the Health Carrier to Which the Applicant is Seeking to Become a Participating Provider.
14. Attach a copy of all postgraduate (CME) activities which you have attended and for which you have received credit in the past 2 years.
15. Include a list of societies of which you are currently a member.
16. Include copies of United States Military discharge papers/DD214 if discharged from U.S. Military, or status if currently serving.
17. Include a copy of certificate showing CLIA waiver number and identification number.
18. Provide a statement regarding the reasons for any inability to perform the essential functions, with or without accommodations, for the practice in which you are seeking to become a participating provider.

Page 11

20 CSR 400-7.200 Provider Selection Standards

PURPOSE: This rule sets forth the reporting requirements of each health carrier found in section 354.606, RSMo, H.B. 335, 1997, to file its selection standards for all participating providers.

(1) Every health carrier, including its intermediaries and any provider networks with which it contracts, shall file with the director annually, on or before March 1, a complete copy of all selection standards and any modifications thereto, for the selection of participating providers, participating primary care professionals and participating health care professional specialties.

(2) Every health carrier shall make the information required to be reported by this rule available directly to all licensed health care providers upon request. The information required to be filed by this rule shall be deemed a public record.

AUTHORITY: sections 354.485 and 354.510, RSMo 1994 and 374.045 and 354.606, RSMo Supp. 1997. Original rule filed Nov. 3, 1997, effective May 30, 1998.*

**Original authority: 654.485, RSMo 1983; 354.510, RSMo 1983; 354.606, RSMo 1997; and 374.045, RSMo 1967, 1993, 1995.*

20 CSR 400-7.300 Evidence Required to Prove Criteria for Designation as Community-Based Health Maintenance Organization

PURPOSE: This rule describes the evidence the department will require of a health maintenance organization to prove the health maintenance organization meets the criteria set out in sections 354.400(2)(d), 354.400(2)(e) and 354.400(2)(f), RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997), to be designated as a community-based health maintenance organization and other information which the department may take into account in determining whether or not a health maintenance organization meets the aforementioned criteria.

(1) In order to evidence that a health maintenance organization has met the requirements of sections 354.400(2)(d), 354.400(2)(e) and 354.400(2)(f), RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997), to be designated as a community-based health maintenance organization, a health maintenance organization must file with the department a Community Benefits Mission Statement adopted by resolution of its board of directors (or trustees) containing a board-approved Community Benefits Plan (Plan) which shall be available to the public and which—

(A) Demonstrates the health maintenance organization's active and ongoing involvement in attempting to improve performance on indicators of health status in the communities it serves, including the health status of those not enrolled in the health maintenance organization; and

(B) Demonstrates its accountability to the public for the cost of, quality of, and access to health care treatment services and for the effect such services have on the health of the community or communities served by the health maintenance organization.

(2) The Plan shall, at a minimum—

(A) Identify health care indicators in the communities served by the health maintenance organization and rate each community served by the health maintenance organization as to each indicator;

(B) Describe the means by which the health maintenance organization will be actively involved in attempting to improve performance on the identified indicators of health status in the community or communities in which the health maintenance organization is operating, including the health status of those not enrolled in the health maintenance organization;

(C) Describe the means by which the health maintenance organization will be accountable for the cost, quality, and access to health care treatment services and for the effect such services have on the health of the communities served by the health maintenance organization. Community-based health maintenance organizations shall at a minimum be required to hold an annual public hearing at which time they will seek public comment on their proposed budget for the coming year. The proposed budget should be made publicly available at least ten (10) days prior to the hearing. This budget should include, but not be limited to, a description of the community-based health maintenance organization's cost of providing health care services on a per-member, per-month basis for the past year and their projections for the coming year including their proposed premium structure. The information disclosed in the proposed budget should be of sufficient detail to help the public understand the components of health care costs in their proposed premium, which components are changing most rapidly, and what proportion of cost each component comprises. The public hearing should allow for ample time for public comment as well as a requirement on the part of the community-based health maintenance organization to publicly respond to the input that it received at the public hearing;

(D) Set out a timetable for the development and implementation of the Plan;

(E) Identify the members of the governing body and the senior management of the health maintenance organization responsible for the oversight, development, and implementation of the Plan;

(F) Identify the resources to be allocated to the Plan;

(G) Identify the administrative mechanisms for the Plan's regular evaluation; and

(H) Establish an advisory group comprised of enrollees and representatives of community interests to make recommendations to the health maintenance organization regarding the policies and procedures of the health maintenance organization.

(3) The department will utilize public resources and participation, including, but not limited to, plans or written comments from Community Health Resource Team programs established through the Department of Health in evaluating whether or not Plans submitted prove the submitting health maintenance organization meets the criteria of sections 354.400(2)(d), 354.400(2)(e) and 354.400(2)(f), RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997), for designation as a community-based health maintenance organization. The department will also consider priorities set by the health maintenance organization to improve community performance on the indicators of health status it identified in the Plan, including, but not limited to, those which concern—

(A) Promoting and marketing products to attract segments of the population of the communities which have not historically been served by the health maintenance organization;

(B) Avoiding marketing and advertising practices designed to discourage older, poorer, and less healthy persons from applying for membership;

(C) Allowing direct enrollment for non-group coverage;

(D) Promoting translator and telecommunications device for the deaf (TDD) services at all key points of patient contact;

(E) Providing subsidized coverage to those who are uninsured and unable to pay for health care services; and

(F) Providing assistance to consumers in obtaining and maintaining health care coverage, at least for limited periods of time at reduced rates.

(4) Any information which a community-based health maintenance organization deems to be proprietary, shall be handled in accordance with 20 CSR 10-2.400.

(5) A community-based health maintenance organization which has a grievance procedure established which is in compliance with Health Care Financing Administration guidelines for grievance procedures for Medicare recipients, may use that procedure for non-Medicare enrollees, provided that such enrollees may appeal an adverse determination to the Missouri Department of Insurance grievance procedure as set out in 20 CSR 100-5.020 Grievance Review Procedures, and the enrollee is notified of that procedure in a manner consistent with 20 CSR 100-5.010 Notice Requirements of an Adverse Determination.

AUTHORITY: section 354.485, RSMo 1994. Original rule filed Nov. 3, 1997, effective June 30, 1998.*

**Original authority: 354.485, RSMo 1983.*

20 CSR 400-7.400 Pharmacies and Prescription Drugs

PURPOSE: This rule carries out the provisions of section 354.535, RSMo H.B. 335 (89th General Assembly, First Regular Session, 1997).

(1) Except as otherwise indicated in this rule, the terms used in this rule shall have the same meaning as those terms defined in section 354.400 and as used in section 354.535.

(2) A health maintenance organization (HMO) offering enrollees a particular package of coinsurance, copayment, and deductible factors must offer to allow any pharmacy to sell prescriptions with that package of factors, if and only if the pharmacy—

(A) Is in the HMO's network; and

(B) Is willing to meet the explicit product cost determination set by the HMO; and

(C) Has been granted a permit or license from the Missouri Board of Pharmacy to operate in this state.

(3) If a pharmacy provider rejects a contract offered by the HMO containing the HMO's explicit product cost determination and the participation of that provider in the network is necessary for the HMO to comply with network adequacy provisions of section 354.400 to 354.636 or a rule adopted to implement those sections, the HMO may offer such other contracts as may be necessary to secure the pharmacy provider's participation in the network, but no such other contract need be offered to other pharmacy providers.

(4) No HMO may establish a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription, unless such limit is uniformly applied to all pharmacy providers in the HMO's network. A "limit on the quantity of drugs" means any limitation of the length of a prescription or quantity of drugs. If an enrollee may have filled a prescription of a given length or quantity by any pharmacy provider in the HMO's network, the HMO must ensure that the enrollee may have such prescription filled by all pharmacy providers in the HMO's network.

(5) An explicit product cost determination means and must be stated as a percentage of average wholesale price (AWP), maximum allowable cost (MAC) or similar measure plus a dispensing fee.

AUTHORITY: section 354.485, RSMo 1994. Original rule filed Nov. 3, 1997, effective June 30, 1998.*

**Original authority: 354.485, RSMo 1983.*