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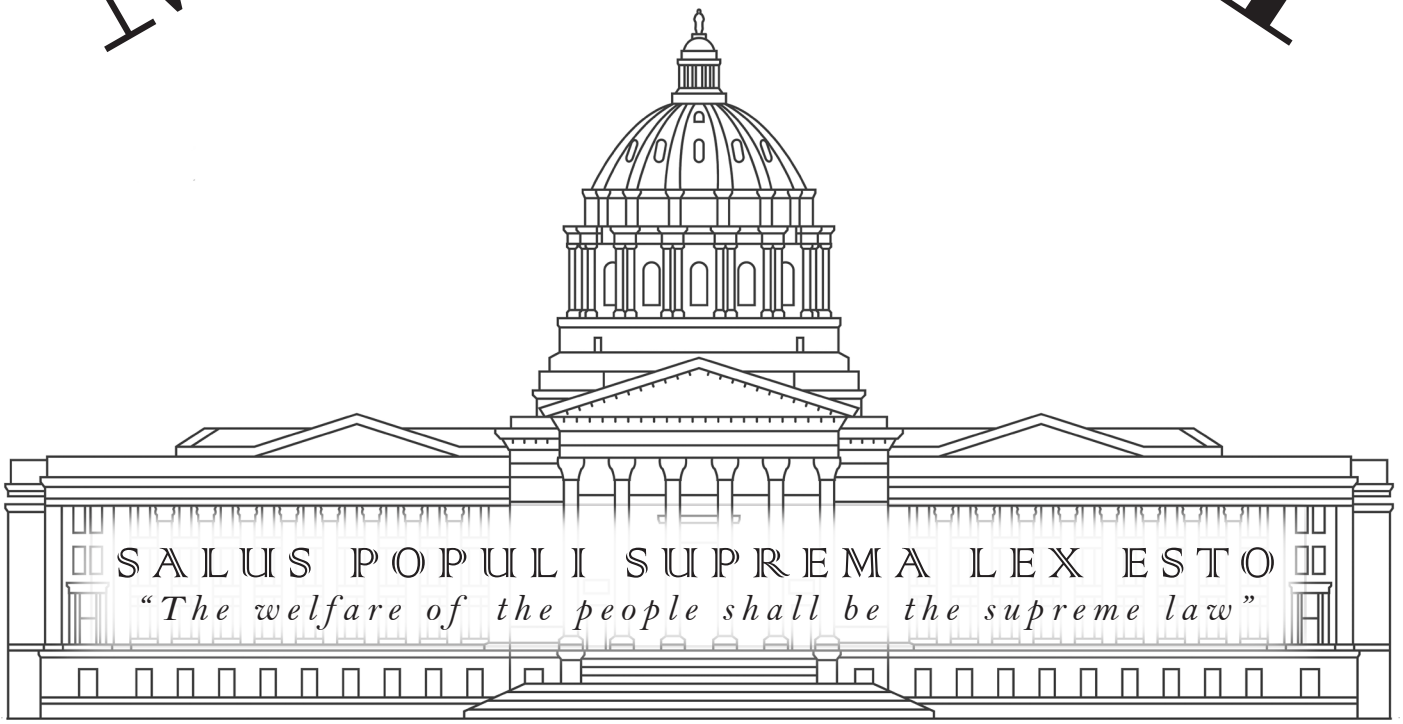

REGISTER

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MISSOURI REGISTER

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Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
October 1, 2024	**November 1, 2024**	November 30, 2024	December 30, 2024
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August 1, 2025	**September 2, 2025**	September 30, 2025	October 30, 2025
August 15, 2025	**September 16, 2025**	September 30, 2025	October 30, 2025

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

HOW TO CITE RULES AND RSMO

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

Title	CSR	Division	Chapter	Rule
3	*Code of*	10-	4	115
Department	*State*	Agency	General area	Specific area
	Regulations	division	regulated	regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation; for example, 3 CSR 10-4.115, NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

Code and *Register* on the Internet

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

The *Code* address is sos.mo.gov/adrules/csr/csr

The *Register* address is sos.mo.gov/adrules/moreg/moreg

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

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

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

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

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 35 – Children's Division
Chapter 71 – Rules for Residential Treatment Agencies for Children and Youth

EMERGENCY AMENDMENT

13 CSR 35-71.015 Background Checks for Personnel of Residential Care Facilities and Child Placing Agencies. The division is amending section (12).

PURPOSE: This emergency amendment provides an administrative review process for Children's Division to make preliminary and provisional eligibility determinations for applicants to commence employment at Licensed Residential Care Facilities (LRCFs), License-Exempt Residential Care Facilities (LERCFs), and Child Placing Agencies (CPAs) while the Division completes the background check required by section 210.493 RSMo.

*EMERGENCY STATEMENT: This emergency amendment is necessary to protect the health, safety, and welfare of Missouri children who are presently placed in LRCFs, LERCFs, and CPAs and who are at risk of harm due to insufficient staffing by correcting the inadvertent removal of the administrative review process for applicants determined ineligible through the background check process to be present at a LRCF, LERCF, or CPA. The emergency amendment will also protect the health, safety and welfare of Missouri children who are in need of residential treatment but who cannot be placed in Missouri residential care facilities due to insufficient staffing. The division has a compelling governmental interest ensuring the adequate staffing of residential care facilities and child placing agencies and protecting to protect the health, safety, and welfare of Missouri children whose emotional and behavioral needs require placement in such settings. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 24, 2024, becomes effective November 7, 2024, and expires May 5, 2025.*

(12) Administrative **Review and** Appeal Procedure.

(A) The decision of the division shall be final unless the applicant or person who is aggrieved by a decision of the division under this regulation files a request for administrative *[appeal]* **review** of the decision within fourteen (14) days of the mailing of the decision. Any request for administrative *[appeal]* **review** that the division receives after the deadline is untimely and will not be subject to further administrative **review or** appeal.

(B) Administrative Review.

1. A request for administrative review shall be made in writing, either on a form provided by the division or by letter. The division will publish a form on its website. The request for administrative review shall –

A. Include the name, address, telephone number, and email address of the person requesting administrative review;

B. State whether the division should provide the response and notice of final decision by first-class mail or by email;

C. Identify the decision the requestor wishes to be reviewed, the specific reasons the requestor believes the division's decision is erroneous, and why the requestor is aggrieved by the decision;

D. Include copies of any relevant documents, materials, or information that the requestor wishes to submit in support of the administrative review request; and

E. State whether the person requests that the review be considered on the basis of the materials submitted or whether the person requests a conference. If the person requests a review conference, then the person shall also provide dates and times within the next thirty (30) days when the person may be available and the reasons why the administrative review cannot be processed on the basis of the materials presented.

2. The request for administrative review shall be submitted to the division by certified first-class mail through the United States Postal Service return receipt requested to the address specified on the notice of ineligibility or submitted electronically by email to the division to the email address specified in the notice of ineligibility.

3. The administrative review shall be conducted and decided based upon the written materials submitted to the division and any information and materials presented at a review conference. The division will provide a review conference upon written request.

4. The review conference may take place by telephone conference call, video conference, or in-person meeting.

5. The administrative review process shall be informal. The rules of evidence shall not apply. There is no right to conduct discovery. There shall be no right to compel

the production of witnesses or evidence by subpoena or otherwise.

6. The administrative review shall be conducted by an individual designated by the director of the department or the division, who may be an employee of the division or the department. However, the individual shall not have been involved in making the decision which is subject to review.

7. The individual conducting the administrative review shall conduct the administrative review and render a written decision no later than thirty (30) days from the date that the division received the request for administrative review.

8. The decision upon administrative review shall be the final decision of the department as to any person that is not an applicant.

*[(B)]***(C)** Appeal.

1. Any applicant who is aggrieved by a decision *[finding the applicant ineligible]* **upon administrative review** shall have the right to appeal the decision to the Administrative Hearings Unit of the Division of Legal Services of the Department of Social Services. The applicant shall submit a notice of appeal to the division, within fourteen (14) days of the date of the *[notice of ineligibility]* **administrative review decision**, by certified first-class mail through the United States Postal Service return receipt requested to the address specified on the notice of ineligibility or submitted electronically by email to the division to the email address specified in the notice of *[ineligibility]* **decision upon administrative review**. The division must receive the notice of appeal within fourteen (14) days of the date of the decision. Any notice of appeal that is received after the deadline is untimely and the appeal will be dismissed. **Completion of the administrative review process is a condition precedent to the applicant's right to appeal.**

2. The parties to the appeal shall be the division and the applicant.

3. All appeals shall be processed and decided by a hearing officer from the Administrative Hearings Unit of the Division of Legal Services of the Department of Social Services. The decision of the hearing officer shall be the final decision of the department.

4. The following evidence shall be admitted and considered by the hearing officer on appeal as provided in this section without further foundation:

A. A copy of the application form and all supporting documentation;

B. A copy of the record of the court establishing that the applicant pled guilty or *nolo contendere* or has been found guilty of a crime or offense listed in 210.493, RSMo;

C. A copy of a letter or official communication from the applicable state, county, or local government agency stating that the applicant is listed as a perpetrator of child abuse or neglect in the state, county, or local government agency's registry or database of perpetrators of child abuse or neglect;

D. A copy of the report of the fingerprint-based background check conducted pursuant to section (3) of this regulation; and

E. A copy of a letter, official communication, or a print out of the applicable page of the National Sex Offender Registry or state sex offender registry.

5. The applicant or division may object to the hearing officer considering the information outlined in this regulation. The burden shall be on the objecting party to establish that the items of evidence shall not be considered by the hearing officer.

6. The hearings held under this section shall be informal, but they shall be held on the record and testimony will be adduced under oath. The rules of evidence do not apply. The applicant may be represented by an attorney.

7. Upon written request the division will provide the applicant with a copy of the fingerprint-based state and FBI background check.

8. The hearing shall not be an opportunity to collaterally attack or relitigate the validity of the underlying plea of guilt, plea of *nolo contendere*, or the underlying finding of child abuse, neglect, or maltreatment by the applicable state or local agency, or the accuracy of information in the federal, state, or local registry or repository.

9. The hearing shall be based upon the written submissions of the parties unless the applicant or the division requests a hearing by video or teleconference. The hearing officer may hold an in-person hearing only upon a showing that an in-person hearing is necessary to accommodate a special need of an applicant or the division.

10. The hearing officer shall issue a decision in writing, which will be sent by first-class mail (or by email at the election of the applicant) to the applicant at the applicant's address of record. If the applicant is represented by an attorney, the decision will be sent to the applicant's attorney. The written decision of the hearing officer shall be the final decision of the department.

*[(C)]***(D)** Judicial Review.

1. Any applicant aggrieved by the final decision of the department after appeal may seek judicial review as provided in section 536.150, RSMo.

2. Any person who is not an applicant who is aggrieved by the final decision of the department after administrative review may seek judicial review as provided in section 536.150, RSMo.

AUTHORITY: sections 207.020 and 660.017, RSMo 2016, and sections 210.493 and 210.1286, RSMo Supp. ***[2023] 2024****. Emergency rule filed Sept. 17, 2021, effective Oct. 1, 2021, expired March 29, 2022. Original rule filed Sept. 17, 2021, effective March 30, 2022. Emergency amendment filed May 30, 2023, effective June 13, 2023, expired Dec. 9, 2023. Amended: Filed May 30, 2023, effective Dec. 30, 2023. Amended: Filed April 23, 2024. Emergency amendment filed Oct. 24, 2024, effective Nov. 7, 2024, and expires May 5, 2025.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 15 – Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology. The division is amending section (1).

PURPOSE: This emergency amendment updates all documents incorporated by reference and used to create the outpatient

simplified fee schedule. This emergency amendment will also allow MO HealthNet to align with Medicare pricing of multiple procedure discounting and Modifier 50 bilateral procedure pricing and it increases the additional percent increase for nominal charge providers.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency amendment is necessary to preserve a compelling governmental interest as it allows MHD to continue to pay its hospital providers under a financially sustainable payment methodology. The Outpatient Simplified Fee Schedule (OSFS) payment methodology requires the most recent fee schedules published by Centers for Medicare & Medicaid Services (CMS) to be incorporated by reference to compute the OSFS fee schedule, which allows providers to be paid. Since the dates on which CMS updates its fee schedules vary throughout the year, an emergency amendment is necessary to maintain a correct fee schedule by July 1st of each year. This emergency amendment is necessary to incorporate the most recently published fee schedules into the methodology to comply with the regulation. Furthermore, this emergency amendment is necessary to secure a sustainable Medicaid program in Missouri and ensure that payments for outpatient services are in line with funds appropriated for that purpose. (See Beverly Enterprises-Missouri Inc. v. Dep't of Soc. Servs., Div. of Med. Servs., 349 S.W.3d 337, 350 (Mo. Ct. App. 2008)). As a result, MHD finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, will be published in this issue of the ***Missouri Register****. This emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions****. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed October 16, 2024, becomes effective October 30, 2024, and expires April 27, 2025.*

(1) *Outpatient Simplified Fee Schedule* (OSFS) Payment Methodology.

(A) Definitions. The following definitions will be used in administering section (1) of this rule:

1. Ambulatory Payment Classification (APC). Medicare's ambulatory payment classification assignment groups of Current Procedural Terminology (CPT) or Healthcare Common Procedures Coding System (HCPCS) codes. APCs classify and group clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources. All services within an APC group have the same relative weight used to calculate the payment rates;

2. APC conversion factor. The unadjusted national conversion factor calculated by Medicare effective January 1 of each year, as published with the Medicare Outpatient Prospective Payment System (OPPS) Final Rule, and used to convert the APC relative weights into a dollar payment. The Medicare OPPS Final Rule is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.govinfo.gov/content/pkg/FR-2022-11-23/pdf/2022-23918.pdf, November 23, 2022,]* **December 8, 2023.** This rule does not incorporate any subsequent amendments or additions;

3. APC relative weight. The national relative weights calculated by Medicare for the Outpatient Prospective Payment System;

4. Current Procedural Terminology (CPT). A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations;

5. Dental procedure codes. The procedure codes found in the Code on Dental Procedures and Nomenclature (CDT), a national uniform coding method for dental procedures maintained by the American Dental Association;

6. Federally Deemed Critical Access Hospital. Hospitals that meet the federal definition found in *[section 1820(c)(2)(B) of the Social Security Act]* **42 Code of Federal Regulation (CFR) 485.606(b) which is incorporated by reference in this rule as published by U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402, October 1, 2023. This rule does not incorporate any subsequent amendments or additions.**

7. HCPCS. The national uniform coding method maintained by the Centers for Medicare & Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians CPT and the three (3) HCPCS unique coding levels, I, II, and III;

8. Medicare Inpatient Prospective Payment System (IPPS) wage index. The wage area index values are calculated annually by Medicare, published as part of the Medicare IPPS Final Rule;

9. Missouri conversion factor. The single, statewide conversion factor used by the MO HealthNet Division (MHD) to determine the APC-based fees, uses a formula based on Medicare OPPS. The formula consists of sixty percent (60%) of the APC conversion factor, as defined in paragraph (1)(A)2. multiplied by the St. Louis, MO, Medicare IPPS wage index value, plus the remaining forty percent (40%) of the APC conversion factor, with no wage index adjustment;

10. Nominal charge provider. A nominal charge provider is determined from the third prior year audited Medicaid cost report. The hospital must meet the following criteria:

A. A public non-state governmental acute care hospital with a low-income utilization rate (LIUR) of at least *[forty percent (40%)]* **twenty percent (20%)** and a Medicaid inpatient utilization rate (MIUR) greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%). The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or

B. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and

C. A hospital physically located in the state of Missouri;

11. Outpatient Prospective Payment System (OPPS). Medicare's hospital outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA); *[and]*

12. Payment level adjustment. The percentage applied to the Medicare fee to derive the OSFS fee*[.]***; and**

13. Rural Emergency Hospital. Hospitals that meet the federal definition found in 42 CFR 485.502 which is incorporated by reference in this rule as published by U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402, October 1, 2023. This rule does not incorporate any subsequent amendments or additions.

(B) Effective for dates of service beginning July 20, 2021, outpatient hospital services shall be reimbursed on a predetermined fee-for-service basis using an OSFS based on

the APC groups and fees under the Medicare Hospital OPPS. When service coverage and payment policy differences exist between Medicare OPPS and Medicaid, MHD policies and fee schedules are used. The fee schedule will be updated as follows:

1. MHD will review and adjust the OSFS annually on July 1 based on the payment method described in subsection (1)(D); and

2. The OSFS is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[at its website at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, July 13, 2023]* **July 1, 2024**. This rule does not incorporate any subsequent amendments or additions.

(C) Payment will be the lower of the provider's charge or the payment as calculated in subsection (1)(D).

(D) Fee schedule methodology. Fees for outpatient hospital services covered by the MO HealthNet program are determined by the HCPCS procedure code at the line level and the following hierarchy:

1. The APC relative weight or payment rate assigned to the procedure in the Medicare OPPS *Addendum B* is used to calculate the fee for the service, with the exception of the hospital observation per hour fee which is calculated based on the method described in subparagraph (1)(D)1.B. Fees derived from APC weights and payment rates are established using the Medicare OPPS *Addendum B* effective as of January 1 of each year as published by the CMS for Medicare OPPS. The Medicare OPPS *Addendum B* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/january-2023, January 20, 2023,]* **December 22, 2023**. This rule does not incorporate any subsequent amendments or additions.

A. The fee is calculated using the APC relative weight times the Missouri conversion factor. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee.

B. The hourly fee for observation is calculated based on the relative weight for the Medicare APC (using the Medicare OPPS *Addendum A* effective as of January 1 of each year as published by the CMS for Medicare OPPS), which corresponds with comprehensive observation services multiplied by the Missouri conversion factor divided by forty (40), the maximum payable hours by Medicare. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee. The Medicare OPPS *Addendum A* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/january-2023-0, January 20, 2023]* **January 4, 2024**. This rule does not incorporate any subsequent amendments or additions.

C. For those APCs with no assigned relative weight, ninety percent (90%) of the Medicare APC payment rate is used as the fee;

2. If there is no APC relative weight or APC payment rate established for a particular service in the Medicare OPPS *Addendum B*, then the MHD approved fee will be ninety percent (90%) of the rate listed on other Medicare fee schedules, effective as of January 1 of each year: Clinical Laboratory Fee Schedule; Physician Fee Schedule; and Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule, applicable to the outpatient hospital service.

A. The Medicare *Clinical Laboratory Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/medicare/medicare-fee-service-payment/clinicallabfeesched/clinical-laboratory-fee-schedule-files/23clabq1, January 12, 2023]* **January 11, 2024**. This rule does not incorporate any subsequent amendments or additions.

B. The Medicare *Physician Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-carrier-specific-files/all-states-2, January 5, 2023]* **January 5, 2024**. This rule does not incorporate any subsequent amendments or additions.

C. The Medicare *Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/medicaremedicare-fee-service-paymentdmeposfeescheddmepos-fee-schedule/dme23, December 19, 2022]* **December 22, 2023**. This rule does not incorporate any subsequent amendments or additions;

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on thirty-eight and one half percent (38.5%) of the fiftieth percentile fee for Missouri reflected in the 2023 *National Dental Advisory Service* (NDAS). The 2023 NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental *[at its website at https://wasserman-medical.com/product-category/dental/ndas/, January 10, 2023]***, December 28, 2023**. This rule does not incorporate any subsequent amendments or additions;

4. If there is no APC relative weight, APC payment rate, other Medicare fee schedule rate, or NDAS rate established for a covered outpatient hospital service, then a MO HealthNet fee will be determined using the MHD *Dental, Medical, Other Medical or Independent Lab–Technical Component* fee schedules.

A. The MHD *Dental Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[and available at https://dss.mo.gov/mhd/provider/pages/cptagree.htm, March 8, 2023]* **May 13, 2024**. This rule does not incorporate any subsequent amendments or additions.

B. The MHD *Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[and available at https://dss.mo.gov/mhd/provider/pages/cptagree.htm, March 8, 2023]* **May 13, 2024**. This rule does not incorporate any subsequent amendments or additions.

C. The MHD *Other Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[and available at https://dss.mo.gov/mhd/provider/pages/cptagree.htm, March 8, 2023]* **May 13, 2024**. This rule does not incorporate any subsequent amendments or additions.

D. The MHD *Independent Lab–Technical Component Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[and available at https://dss.mo.gov/mhd/provider/pages/cptagree.htm, March 8, 2023]* **May 13, 2024**. This rule does not incorporate any subsequent amendments or additions;

5. In-state federally deemed critical access hospitals will receive an additional forty percent (40%) of the rate as determined in paragraph(1)(B)2. for each billed procedure code; *[and]*

6. Nominal charge providers will receive an additional *[twenty-five percent (25%)]* **forty percent (40%)** of the rate as determined in paragraph (1)(B)2. for each billed procedure code*[.]***; and**

7. Rural emergency hospitals will receive an additional forty percent (40%) of the rate as determined in paragraph (1)(B)2. for each billed procedure code.

(E) Packaged services. MHD adopts Medicare guidelines for procedure codes identified as "Items and Services Packaged into APC Rates" under Medicare OPPS *Addendum D1*. These procedures are designated as always packaged. Claim lines with packaged procedure codes will be considered paid but with a payment of zero (0). The Medicare OPPS *Addendum D1* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/license/ama?file=/files/zip/2023-nfrm-opps-addenda.zip, November 22, 2022]* **December 8, 2023**. This rule does not incorporate any subsequent amendments or additions.

(F) Inpatient only services. MHD adopts Medicare guidelines for procedure codes identified as "Inpatient Procedures" under Medicare OPPS *Addendum D1*. These procedures are designated as inpatient only (referred to as the inpatient only (IPO) list). Claim lines with inpatient only procedures will not be paid under the OSFS.

(G) Multiple procedure discounting. Effective for dates of service beginning July 1, 2024, MHD applies multiple procedure discounting for those procedure codes identified as "Procedure or Service, Multiple Procedure Reduction Applies" under Medicare OPPS Addendum D1. These procedures are paid separately but are discounted when two (2) or more services are billed on the same date of service. Procedure codes considered for the multiple procedure reduction under the OSFS exclude dental procedures. The multiple procedure claim line with the highest allowed amount is priced at one hundred percent (100%) of the maximum allowed amount. The second and subsequent covered procedures are priced at fifty percent (50%) of the maximum allowed amount. The Medicare OPPS Addendum D1 is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, December 8, 2023. This rule does not incorporate any subsequent amendments or additions.

(H) Modifier 50 Bilateral procedure pricing. Effective July 1, 2024, MHD applies bilateral procedure pricing for those procedure codes identified on the Medicare *National Physician Fee Schedule Relative Value File* with an indicator of one (1) under the BILAT SURG column. These procedures may be subject to a payment adjustment when billed with modifier 50 and performed bilaterally on both sides of the body at the same operative session. Claim lines appropriately billed with these bilateral procedures and modifier 50 are priced at one hundred and fifty percent (150%) of the maximum allowed amount for a single code. The Medicare *National Physician Fee Schedule Relative Value File* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, January 5, 2024. This rule does not incorporate any subsequent amendments or additions.

*[(G)]***(I)** Drugs. Effective for dates of service beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

*[(H)]***(J)** Payment for outpatient hospital services under this rule will be final, with no cost settlement.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. [2023] ***2024****. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Oct. 16, 2024, effective Oct. 30, 2024, expires April 27, 2025. A proposed amendment covering the same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will cost state agencies or political subdivisions $8.4 million in the time the emergency amendment is effective.

PRIVATE COST: This emergency amendment will cost private entities six thousand four hundred seventy-four dollars ($6,474) in the the time the emergency amendment is effective.

FISCAL NOTE
PUBLIC COST

I. Department Title: Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 15 – Hospital Program

Rule Number and Title:	13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) & State Hospitals enrolled in MO HealthNet - 32	**Net Estimated Increase in Payments for 6 months of SFY 2025: $4 million**
Department of Social Services, MO HealthNet Division	**Net Estimated cost for 6 months of SFY 2025: Total Cost is estimated at $8.4 million State Share is estimated at $2.9 million**

III. WORKSHEET

Other Government (Public) & State Hospitals Impact					
Estimated Impact for 6 months of SFY 2025					
	Total	OSFS	Nominal Charge Increase	Bilateral	Discounting
Public Hospitals Impact	$3,423,067	$916,075	$2,501,841	$215,743	($210,593)
State Hospitals Impact	$638,814	$656,190	$0	$27,029	($44,405)
Total Impact	$4,061,881	$1,572,265	$2,501,841	$242,773	($254,998)
SFY 2025 Blended FMAP	34.5%	34.5%	34.5%	34.5%	34.5%
State Share	$1,401,349	$542,431	$863,135	$83,757	($87,974)

Department of Social Services, MO HealthNet Division Impact					
Estimated Impact for 6 months of SFY 2025					
	Total	OSFS	Nominal Charge Increase	Bilateral	Discounting
Estimated Costs/(Savings)	$8,417,717	$5,644,505	$2,501,841	$1,116,199	($844,829)
Times SFY 2025 Blended FMAP	34.5%	34.5%	34.5%	34.5%	34.5%
Estimated State Share	$2,904,112	$1,933,144	$877,345	$385,089	($291,466)

IV. ASSUMPTIONS

The estimated cost to the state is due to Medicare increasing their rates for the following high volume services: emergency department visits, clinic visits, and some laboratory services and the MO HealthNet accommodation of the new multiple procedure discounting and bilateral procedure (Modifier 50) pricing, and the 15% additional increase for nominal charge providers. Medicare currently applies multiple procedure payment reduction. This is a discounted rate when more than one surgery is performed in the same setting. Currently MHD pays 100% of the MHD rate for each procedure performed in the same setting. Medicare allows 150% payment adjustment for bilateral procedures (Modifier 50). These are services performed on both sides of the body during the same session. These changes will be effective for date of service on or after July 1, 2024.

FISCAL NOTE
PRIVATE COST

I. Department Title: Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 15 – Hospital Program

Rule Number and Title:	13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
In-state hospitals – 76 **Out-of-state hospitals – 120**	**Private and Out-of-State Hospitals enrolled in MO HealthNet**	**Net Estimated Increase in Payments for 6 months of SFY 2025:** **$4.4 million**
In-state hospitals – 2		**Net Estimated Cost for 6 months of SFY 2025:** **$5,249**
Out-of-state hospitals – 15		**Net Estimated Cost for 6 months of SFY 2025:** **$1,225**

III. WORKSHEET

Private Hospitals Impact				
Estimated Impact for 6 months of SFY 2025				
	Total	**OSFS**	**Bilateral**	**Discounting**
In-State Private Hospitals Impact	$4,179,180	$3,921,147	$790,992	($532,960)
Out-of-State Private Hospitals Impact	$176,656	$151,093	$82,434	($56,872)
Total Impact	$4,355,836	$4,072,240	$873,426	($589,831)
SFY 2025 Blended FMAP	34.5%	34.5%	34.5%	34.5%
State Share	$1,502,763	$1,404,923	$301,332	($203,492)

The state estimates that there is no cost to private and out-of-state hospitals. The state anticipates an increase in payments to private entities in aggregate of $4.4 million.

IV. ASSUMPTIONS

The estimated cost to the state is due to Medicare increasing their rates for the following high volume services: emergency department visits, clinic visits, and some laboratory services and the MO HealthNet accommodation of the new multiple procedure discounting and bilateral procedure (Modifier 50) pricing. Medicare currently applies multiple procedure payment reduction. This is a discounted rate when more than one surgery is performed in the same setting. Currently MHD pays 100% of the MHD rate for each procedure performed in the same setting. Medicare allows 150% payment adjustment for bilateral procedures (Modifier 50). These are services performed on both sides of the body during the same session. These changes will be effective for dates of service on or after July 1, 2024.

TITLE 15 – ELECTED OFFICIALS
Division 30 – Secretary of State
Chapter 51 – Broker-Dealers, Agents, Investment Advisers, and Investment Adviser Representatives

EMERGENCY AMENDMENT

15 CSR 30-51.169 Fraudulent Practices of Broker-Dealers and Agents. The secretary is revising the purpose statement and amending section (1).

PURPOSE: This emergency amendment amends the rule to be in compliance with a federal court order.

*EMERGENCY STATEMENT: The Secretary of State finds that an immediate danger to the public welfare requires this emergency action and is necessary to preserve a compelling government interest in that a federal court determined certain elements of the original rule were invalid. The Secretary of State is filing this amendment in order to prevent confusion and uncertainty in the industry. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Secretary of State believes this emergency rule is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 23, 2024, becomes effective November 6, 2024, and expires May 4, 2025.*

*PURPOSE: This rule identifies practices in the [securities business which] **brokerage industry that** are generally associated with [schemes to manipulate] **acts that deceive and defraud**.*

(1) A broker-dealer or agent who engaged in one (1) or more of the following practices shall be deemed to have engaged in an "act, practice or course of business which operates or would operate as a fraud" as used in section 409.5-501 of the Missouri Securities Act of 2003 (the Act). This rule is not intended to be all inclusive and acts or practices not enumerated in this rule may also be deemed **deceitful or** fraudulent:

(G) Effecting any transaction in, or inducing the purchase or sale of any security by means of any manipulative, deceptive or other fraudulent device or contrivance including, but not limited to, the use of boiler-room tactics or use of fictitious or nominee accounts; *[and]*

(H) Failure to comply with any prospectus delivery requirement promulgated under federal law*[.]*; **and**

(I) Effecting any transaction with an investment objective that the customer has not authorized at or prior to the time such transaction is effected;

1. As used in this section (I), the following terms mean:

A. "Effecting any transaction" means having effected a discretionary purchase or sale of a security for a retail customer's account; solicited or recommended, or otherwise provided advice, to a retail customer to buy or sell a security; or solicited, recommended, or otherwise advised, a retail customer regarding the selection of a third-party manager or subadviser to manage the investments in such customer's account;

B. "Retail customer" means any person other than an institutional investor, regardless of whether the person has an account with the broker-dealer;

C. "Institutional investor," the same meaning as under section 409.1-102, RSMo;

D. "Broker-dealer," the same meaning as under section 409.1-102, RSMo; and

E. "Person," the same meaning as under section 409.1-102, RSMo.

2. Nothing in this subsection (I) shall require broker-dealers or their agents to create or retain any record memorializing the required customer authorization.

3. If any portion of this subsection (I) is adjudicated to be invalid or unenforceable for any reason or in any application, the intent of the Commissioner is that this application shall be severable and the remainder of the subsection (I) in its other applications shall be enforced.

*AUTHORITY: sections 409.2-201, [409.4-412,] 409.5-501, and 409.6-605, RSMo [Supp. 2003] 2016, **and section 409.4-412, RSMo Supp. 2024**. Original rule filed March 27, 1989, effective June 12, 1989. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 23, 2024, effective Nov. 6, 2024, expires May 4, 2025. A proposed amendment covering the same material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 15 – ELECTED OFFICIALS
Division 30 – Secretary of State
Chapter 51 – Broker-Dealers, Agents, Investment Advisers, and Investment Adviser Representatives

EMERGENCY AMENDMENT

15 CSR 30-51.170 Dishonest or Unethical Business Practices by Broker-Dealers and Agents. The secretary is deleting sections (3) and (4).

PURPOSE: This emergency amendment amends the rule to be in compliance with a federal court order.

*EMERGENCY STATEMENT: The Secretary of State finds that an immediate danger to the public welfare requires this emergency action and is necessary to preserve a compelling government interest in that a federal court determined certain elements of the original rule were invalid. The Secretary of State is filing this amendment in order to prevent confusion and uncertainty in the industry. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Secretary of State believes this emergency rule is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 23, 2024, becomes effective November 6, 2024, and expires May 4, 2025.*

[(3) Failing to disclose to any customer or prospective customer the following material fact:

(A) If a broker-dealer or agent incorporates a social objective or other nonfinancial objective into a discretionary investment

decision to buy or sell a security or commodity for a customer, a recommendation and/or solicitation to a customer for the purchase or sale of a security or commodity, or the selection, or recommendation or advice to a customer regarding the selection, of a third-party manager or subadviser to manage the investments in the customer's account, then such broker-dealer or agent shall disclose to such customer the existence of such incorporation;

(B) As used in this section, the following terms mean:

1. "Agent," the same meaning as under section 409.1-102;

2. "Broker-dealer," the same meaning as under section 409.1-102;

3. "Incorporates a social objective," means the material fact to consider socially responsible criteria in the investment or commitment of customer funds for the purpose of seeking to obtain an effect other than the maximization of financial return to the customer;

4. "Nonfinancial objective," means the material fact to consider criteria in the investment or commitment of customer funds for the purpose of seeking to obtain an effect other than the maximization of financial return to the customer;

5. "Socially responsible criteria," any criterion that is intended to further, or is branded, advertised, or otherwise publicly described by the broker-dealer or agent as furthering, any of the following:

A. International, domestic, or industry agreements relating to environmental or social goals;

B. Corporate governance structures based on social characteristics; or

C. Social or environmental goals;

(C) The disclosure obligation under subsection (3)(A) is satisfied by providing clear and conspicuous prior disclosure and obtaining written acknowledgment and consent from the customer. Written consent shall be obtained either—

1. At the establishment of the brokerage relationship; or

2. Prior to—

A. Effecting the initial discretionary investment for the customer's account;

B. Providing the initial recommendation, advice, or solicitation regarding the purchase or sale of a security or commodity in a customer's account; or

C. Selecting, or recommending or advising on the selection of, a third-party manager or subadvisor to manage the investments in a customer's account;

3. Such disclosure, thereafter, shall be provided to the customer on an annual basis and, no less than every three (3) years, consented in writing by the customer; and

(D) Written consent required under subsection (3)(C) shall contain language that is substantially similar to the following:

"I, [NAME OF CUSTOMER], consent to my [as applicable, NAME OF BROKER-DEALER OR AGENT] incorporating a social objective or other nonfinancial objective into any discretionary investment decision my [as applicable, broker-dealer or agent] makes for my account; any recommendation, advice, or solicitation my [as applicable, broker-dealer or agent] makes to me for the purchase or sale of a security or commodity; or the selection my [as applicable, broker-dealer or agent] makes, or recommendation or advice my [as applicable, broker-dealer or agent] makes to me regarding the selection of, a third-party manager or subadviser to manage the investments in my account. Also, I acknowledge and understand that incorporating a social objective or other nonfinancial objective into discretionary investment decisions, recommendations, advice, and/or the selection of a third-party manager or subadviser to manage the investments, in regards to my account, will result in investments and recommendations/advice that are not solely focused on maximizing a financial return for me or my account."

(4) The conduct set forth above is not inclusive. Engaging in other conduct such as nondisclosure or incomplete disclosure of material fact or other deceptive practices are dishonest or unethical business practices.]

AUTHORITY: section 409.6-605, RSMo 2016. Original rule filed June 25, 1968, effective Aug. 1, 1968. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 23, 2024, effective Nov. 6, 2024, expires May 4, 2025. A proposed amendment covering the same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 15 – ELECTED OFFICIALS
Division 30 – Secretary of State
Chapter 51 – Broker-Dealers, Agents, Investment Advisers, and Investment Adviser Representatives

EMERGENCY AMENDMENT

15 CSR 30-51.172 Dishonest or Unethical Business Practices by Investment Advisers and Investment Adviser Representatives. The secretary is deleting sections (3) and renumbering as necessary.

PURPOSE: This emergency amendment amends the rule to be in compliance with a federal court order.

EMERGENCY STATEMENT: The Secretary of State finds that an immediate danger to the public welfare requires this emergency action and is necessary to preserve a compelling government interest in that a federal court determined certain elements of the original rule were invalid. The Secretary of State is filing this amendment in order to prevent confusion and uncertainty in the industry. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Secretary of State believes this emergency rule is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 23, 2024, becomes effective November 6, 2024, and expires May 4, 2025.*

[(3) Failing to disclose to any client or prospective client the following material fact:

(A) If an investment adviser or investment adviser representative incorporates a social objective or other nonfinancial objective into a discretionary investment decision to buy or sell a security or commodity for a client, advice or a recommendation to a client for the purchase or sale of a security or commodity, or the selection, or advice or a recommendation to a client regarding the selection, of a third-party manager or subadviser to manage the investments in the client's

account, then such investment adviser or investment adviser representative shall disclose to such client the existence of such incorporation;

(B) As used in this section, the following terms mean:

1. "Incorporates a social objective," means the material fact to consider socially responsible criteria in the investment or commitment of client funds for the purpose of seeking to obtain an effect other than the maximization of financial return to the client;

2. "Investment adviser," the same meaning as under section 409.1-102;

3. "Investment adviser representative," the same meaning as under section 409.1-102;

4. "Nonfinancial objective," means the material fact to consider criteria in the investment or commitment of client funds for the purpose of seeking to obtain an effect other than the maximization of financial return to the client;

5. "Socially responsible criteria," any criterion that is intended to further, or is branded, advertised, or otherwise publicly described by the investment adviser or investment adviser representative as furthering, any of the following:

A. International, domestic, or industry agreements relating to environmental or social goals;

B. Corporate governance structures based on social characteristics; or

C. Social or environmental goals;

(C) The disclosure obligation under subsection (3)(A) is satisfied by providing clear and conspicuous prior disclosure and obtaining written acknowledgment and consent from the client. Written consent shall be obtained either—

1. At the establishment of the advisory relationship; or

2. Prior to—

A. Effecting the initial discretionary investment for the client's account;

B. Providing the initial recommendation or advice regarding the purchase or sale of a security or commodity in a client's account; or

C. Selecting, or recommending or advising on the selection of, a third-party manager or subadviser to manage the investments in a client's account;

3. Such disclosure, thereafter, shall be provided to the client on an annual basis and, no less than every three (3) years, consented in writing by the client; and

(D) Written consent required in subsection (3)(C) shall contain language that is substantially similar to the following:

"I, [NAME OF CLIENT], consent to my [as applicable, NAME OF INVESTMENT ADVISER OR INVESTMENT ADVISER REPRESENTATIVE] incorporating a social objective or other nonfinancial objective into any discretionary investment decision my [as applicable, investment adviser or investment adviser representative] makes for my account; any recommendation or advice my [as applicable, investment adviser or investment adviser representative] makes to me for the purchase or sale of a security or commodity; or the selection my [as applicable, investment adviser or investment adviser representative] makes, or recommendation or advice my [as applicable, investment adviser or investment adviser representative] makes to me regarding the selection of, a third-party manager or subadviser to manage the investments in my account. Also, I acknowledge and understand that incorporating a social objective or other nonfinancial objective into discretionary investment decisions, recommendations, advice, and/or the selection of a third-party manager or subadviser to manage the investments, in regards to my account, will result in investments and recommendations/ advice that are not solely focused on maximizing a financial return for me or my account."]

*[(4)]***(3)** The conduct set forth above is not inclusive. Engaging in other conduct such as nondisclosure or incomplete disclosure of material fact or other deceptive practices are dishonest or unethical business practices.

AUTHORITY: section 409.6-605, RSMo 2016. Original rule filed April 8, 2004, effective Oct. 30, 2004. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 23, 2024, effective Nov. 6, 2024, expires May 4, 2025. A proposed amendment covering the same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 15 – ELECTED OFFICIALS
Division 30 – Secretary of State
Chapter 51 – Broker-Dealers, Agents, Investment Advisers, and Investment Adviser Representatives

EMERGENCY RULE

15 CSR 30-51.174 Fraudulent Practices of Investment Advisers and Investment Adviser Representatives

EMERGENCY STATEMENT: The Secretary of State finds that an immediate danger to the public welfare requires this emergency action and is necessary to preserve a compelling government interest in that a federal court determined certain elements of Missouri rules regarding investment advisors and representatives were invalid. The Secretary of State is filing this rule in order to prevent confusion and uncertainty in the industry by clarifying what constitutes fraudulent practices by investment advisors and representatives. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Secretary of State believes this emergency rule is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 23, 2024, becomes effective November 6, 2024, and expires May 4, 2025.*

PURPOSE: This rule identifies practices in the investment adviser industry that are generally associated with acts that deceive and defraud.

(1) An investment adviser or investment adviser representative who has engaged in one (1) or more of the following practices shall be deemed to have engaged in fraud in connection with the offer, sale, or purchase of a security, directly or indirectly, in violation of section 490.5-501 of the Missouri Securities Act of 2003 (the "Act"), and to have engaged in an "act, practice or course of business which operates or would operate as a fraud" as used in section 409.5-502 of the Act. Each provision of this rule is intended to be severable. This rule is not intended to be all inclusive and acts or practices not enumerated in this rule

may also be deemed deceitful or fraudulent:

(A) Effecting any transaction with an investment objective that the client has not authorized at or prior to the time such transaction is affected;

1. As used in this section (1), the following terms mean:

A. "Effecting any transaction" means having effected a discretionary purchase or sale of a security for a retail client's account; solicited or recommended, or otherwise provided advice, to a retail client to buy or sell a security; or solicited, recommended, or otherwise advised, a retail client regarding the selection of a third-party manager or subadvisor to manage the investments in such client's account;

B. "Retail client" means any person other than an institutional investor, regardless of whether the person has an account with the investment adviser;

C. "Institutional investor," the same meaning as under section 409.1-102, RSMo;

D. "Investment adviser," the same meaning as under section 409.1-102, RSMo; and

E. "Person," the same meaning as under section 409.1-102, RSMo.

2. If any portion of this subsection (A) is adjudicated to be invalid or unenforceable for any reason or in any application, the intent of the Commissioner is that this application shall be severable and the remainder of the subsection (1)(A) in its other applications shall be enforced.

AUTHORITY: section 409.6-605, RSMo 2016, and section 409.4-412(d)(9), RSMo Supp. 2024. Emergency rule filed Oct. 23, 2024, effective Nov. 6, 2024, expires May 4, 2025. A proposed rule covering the same material is published in this issue of the ***Missouri Register****.*

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

PRIVATE COST: This emergency rule will not cost private entities more than five hundred dollars ($500) in the time the emergency rule is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This emergency amendment clarifies enrollment procedures when an eligible dependent loses MO HealthNet or Medicaid status and when a member becomes Medicare eligible.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

(3) Enrollment Procedures.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents or spouse/child(ren) at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date even if the retiree is continuing coverage as a variable-hour employee after retirement. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

C. If a retiree subscriber's eligible dependent loses MO HealthNet or Medicaid status, the retiree may enroll the eligible dependent within sixty (60) days of the date of loss.

3. If coverage was not maintained while on disability, the employee may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment, but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A retiree enrolled in the Medicare Advantage Plan may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

6. Default enrollment.

A. A retiree with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the retiree or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the retiree is not able to be enrolled in the Medicare Advantage Plan, the retiree and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year at the same level of coverage.

B. If a retiree with Medicare has a non-Medicare dependent enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

C. If a retiree without Medicare is enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

D. If a retiree without Medicare is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage, effective the first day of the next calendar year.

7. If a retiree is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

8. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

C. If a terminated vested subscriber's eligible dependent loses MO HealthNet or Medicaid status, the terminated vested subscriber may enroll the eligible dependent within sixty (60) days of the date of loss.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A terminated vested member enrolled in the Medicare Advantage Plan may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

4. Default enrollment.

A. A terminated vested subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the terminated vested subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the terminated vested subscriber is not able to be enrolled in the Medicare Advantage Plan, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

B. If a terminated vested subscriber without Medicare is enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

C. If a terminated vested subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

D. If a terminated vested subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

C. If a long-term disability subscriber's eligible dependent loses MO HealthNet or Medicaid status, the long-term disability subscriber may enroll the eligible dependent within sixty (60) days of the date of loss.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A long-term disability member enrolled in the Medicare Advantage Plan may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

4. Default enrollment.

A. A long-term disability subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the long-term disability subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the long-term disability subscriber is not able to be enrolled in the Medicare Advantage Plan, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

B. If a long-term disability subscriber without Medicare is enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

C. If a long-term disability subscriber with Medicare has a non-Medicare dependent enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

D. If a long-term disability subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

E. If a long-term disability subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor without Medicare must submit a survivor enrollment form within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor with Medicare will be automatically enrolled as a survivor following the death of the employee.

3. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums

end; or

(IV) COBRA coverage ends.

C. If a survivor's eligible dependent loses MO HealthNet or Medicaid status, the survivor may enroll the eligible dependent within sixty (60) days of the date of loss.

4. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A survivor enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

6. Default enrollment.

A. A survivor with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the survivor or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the survivor is not able to be enrolled in the Medicare Advantage Plan, the survivor and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

B. If a survivor without Medicare is enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

C. If a survivor with Medicare has a non-Medicare dependent enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

D. If a survivor without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

E. If a survivor is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(F) Medicare.

1. When a member becomes eligible for Medicare, the member must notify MCHCP pursuant to 22 CSR 10-2.020.

2. Non-active employee subscribers will be charged the Medicare Advantage Plan premium the first month after the member's Medicare Beneficiary Identifier (MBI) number is received by MCHCP.

3. If a member does not enroll in Medicare Part A when eligible, the member shall continue to be charged the premium for the plan in which they are enrolled and will not receive the Medicare premium until proof of enrollment in the form of the MBI number is received by MCHCP. If a member enrolls in Part A, but does not enroll in part B, the member will be charged the Medicare premium, but will be responsible for the charges Medicare Part B would have paid on a claim. This amount will not be added to the annual deductible or out of pocket accumulations.

4. Once MCHCP receives the MBI number, and the member is not an active employee, they will be transferred to the Medicare Advantage Plan defined in 22 CSR 2-2.088.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025 expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.025 Rule for Participating Higher Education Entity Entry into the Missouri Consolidated Health Care Plan. The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

PURPOSE: This emergency amendment revises the time frame for Participating Higher Education Entities (PHEE) to provide their letter of intent to join the plan and clarifies eligibility requirements for PHEEs that choose to cover retirees.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency

amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

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

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

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

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

(B) If the PHEE chooses to cover retirees, they shall provide to MCHCP appropriate documentation of initial and ongoing eligibility. Once provided by the PHEE, the retirees of the PHEE submitted shall be included in the term retiree used throughout this chapter.

AUTHORITY: section 103.059, RSMo 2016. Original rule filed Oct. 28, 2016, effective May 30, 2017. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (11) and (15).

PURPOSE: This emergency amendment clarifies how non-network plan payments are processed and revises language regarding members who are eligible for Medicare.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

(11) *[Maximum]* **Non-network** plan payment – non-network medical claims *[that are not otherwise subject to a contractual discount arrangement]* are processed *[at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* following the claim administrator's *[standard]* practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

(15) Medicare.

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

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

*[(C)]***(A)** If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section sections (11) and (15).

PURPOSE: This emergency amendment clarifies how non-network plan payments are processed and revises language regarding members who are eligible for Medicare.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

(11) *[Maximum]* **Non-network** plan payment – non-network medical claims *[that are not otherwise subject to a contractual discount arrangement]* are *[allowed]* **processed** *[at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* following the claim administrator's standard practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

(15) Medicare.

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

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

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (10), (17), and (24).

PURPOSE: This emergency amendment revises coverage of virtual visits, non-network payments, the timing of other deposits to health savings accounts and adds the right of MCHCP to recoup deposits members are not entitled to.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October. 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

(10) Virtual visits offered through the vendor's telehealth tool are covered at one hundred percent (100%) **after deductible is met unless Internal Revenue Service (IRS) guidance permits it to be paid at one hundred percent (100%) prior to deductible being met**.

(17) *[Maximum]* **Non-network** plan payment – Non-network medical claims *[that are not otherwise subject to a contractual discount arrangement] are processed [at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* following the claims administrator's *[standard]* practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

(24) Health Savings Account (HSA) Contributions.

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

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

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

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

(G) If a subscriber receives a deposit they are not entitled to, MCHCP reserves the right to recoup the deposit.

Deposit	Subscriber only	All other coverage levels
January	$500	$1,000
April (delayed contribution due to health care FSA grace period)	$500	$1,000
All others	A proration of $500	A proration of $1,000

*AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This emergency amendment revises the availability of transition of care and coverage of eyeglasses and contact lenses.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable

options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

[(2) Transition of Care. A transition of care option is available for members who seek to continue to remain under the care of a non-network provider who was treating them prior to the provider losing network status. A subscriber and his/her dependents may request to continue receiving care at the network benefit level. If approved, the member will be eligible to continue care with the current non-network provider at the network benefit level for a period of time until it is medically appropriate for the member to transfer care to a network provider. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. The following benefits are eligible for transition of care as determined by the claims administrator:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their third trimester of pregnancy;

(C) Radiation therapy;

(D) Dialysis;

(E) Cancer treatment;

(F) Physical, speech, or occupational therapy;

(G) Hospice care;

(H) Inpatient hospitalization at the time of the network change; or

(I) Mental health services.]

(2) Transition of care is available in accordance with federal and state law when a provider loses network status.

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250 Plan, and HSA Plan.

(D) Plan benefits for the PPO 750 Plan, PPO 1250 Plan, and HSA Plan are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms;

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

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

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

3. Applied behavior analysis (ABA) for autism;

4. Bariatric surgery;

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

6. Bone growth stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit;

7. Contraception and sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

8. Cardiac rehabilitation;

9. Chelation therapy;

10. Chiropractic services – manipulation and adjunct therapeutic procedures/modalities;

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

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

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

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

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

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

(I) National Institutes of Health (NIH);

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

(III) Agency for Health Care Research and Quality;

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

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

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

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

12. Cochlear implant and auditory brainstem implant;

13. Cryopreservation cycles.

A. Oocyte cryopreservation cycles including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery,

radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes).

B. Sperm cryopreservation including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes);

14. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. Treatment must be initiated within sixty (60) days of accident; and

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

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

15. Diabetes self-management education;

16. Dialysis is covered when received through a network provider;

17. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

18. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit;

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

A. Post cataract surgery. Coverage is limited to charges incurred in connection with the fitting of eyeglasses or contact lenses for initial placement within one (1) year post cataract surgery; or

B. Covered if medically necessary for conditions caused by aphakia, keratoconus, or injury;

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

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

(I) Diabetes mellitus;

(II) Peripheral vascular disease;

(III) Peripheral neuropathy; or

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

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

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

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

22. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

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

24. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

25. Hearing aids (per ear). Hearing aids covered once every two (2) years for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

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

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

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

D. Bone anchoring hearing aid (BAHA): three thousand five hundred dollars ($3,500);

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

27. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse,

licensed therapist, or a registered dietitian. Covered services include –

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as –

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

28. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill;

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

A. The following benefits are covered:

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

(II) Intensive care unit room and board;

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

(a) Cornea transplant;

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

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

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

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

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

(IV) Inpatient mental health services; and

(V) Outpatient mental health services;

30. Infertility coverage for members with a diagnosis of infertility, including in vitro fertilization (IVF) oocyte retrievals limited to two (2) cycles as a lifetime maximum, per member;

31. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

32. Injections. See preventive services for coverage of vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

33. Lab, x-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

34. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to applicable copayments, deductible, and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

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

36. Nutrition therapy;

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

38. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

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

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

B. Tumors and cysts, cancer, and post-surgical sequela;

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

D. Physical abnormality;

40. Orthotics.

A. Ankle-foot orthosis (AFO) and knee-ankle-foot

orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO not used during ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast boot, post-operative sandal or shoe, or healing shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial orthoses. Cranial orthosis is covered for synostotic and non-synostotic plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic plagiocephaly is due to premature closure of cranial sutures. Non-synostotic plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear incorporated into a brace for members with skeletally mature feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot orthoses. Custom, removable foot orthoses are covered.

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

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

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

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

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

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

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

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

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

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

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

J. Orthopedic footwear for diabetic members.

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

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

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

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

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

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41. Preventive services.

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

B. Vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other preventive services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified –

(I) Mammograms – no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears – no age limit;

(III) Prostate – no age limit; and

(IV) Colorectal screening – no age limit.

G. Digital diabetes prevention program offered through the plan's claims administrator.

H. The following services permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan:

(I) Blood pressure monitors for individuals diagnosed with hypertension;

(II) Retinopathy screenings for individuals diagnosed with diabetes;

(III) Hemoglobin A1c (HbA1c) testing for individuals diagnosed with diabetes;

(IV) Peak flow meters for individuals diagnosed with asthma; and

(V) International normalized ratio (INR) testing for individuals diagnosed with liver disease and/or bleeding disorders;

42. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

43. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

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

45. Telehealth services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

46. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver-provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

47. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s') travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging – maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel – IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals – not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

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

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, see the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: filed Oct. 25, 2024. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This emergency amendment adds an occurrence in which MCHCP may allow one (1) additional reinstatement and revises the time frame in which MCHCP may approve an appeal where a subscriber missed a deadline.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP

*trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. Decisions concerning eligibility for Medicare primary members may not be able to be granted pursuant to these guidelines if the decision is contrary to the rules controlling eligibility for Medicare Advantage plan as put forth by Centers for Medicare and Medicaid. Valid proof of eligibility must be included with the appeal if the enrollment request includes addition of dependent(s). Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account*[;]* **MCHCP may allow one (1) additional reinstatement if the subscriber submits an automatic withdrawal authorization or authorizes in writing that payment shall be deducted from their MOSERS retirement benefit;**

(K) Once *[per lifetime of the account]* **every five (5) years per account**, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This emergency amendment revises Medicare Part D coverage stages and amounts.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

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

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

1. The Centers for Medicare & Medicaid Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial coverage stage. Until a member's total yearly Part D prescription drug costs reach *[five thousand thirty dollars ($5,030)]* **two thousand dollars ($2,000)**, the member will pay the following copayments:

A. Preferred formulary generic drugs: thirty-one- (31-) day supply has a ten dollar ($10) copayment; sixty- (60-) day supply has a twenty dollar ($20) copayment; ninety- (90-) day supply at retail has a thirty dollar ($30) copayment; and a ninety- (90-) day supply through home delivery has a twenty-five dollar ($25) copayment;

B. Preferred formulary brand drugs: thirty-one- (31-) day supply has a forty dollar ($40) copayment; sixty- (60-) day supply

has an eighty dollar ($80) copayment; ninety- (90-) day supply at retail has a one hundred twenty dollar ($120) copayment; and a ninety- (90-) day supply through home delivery has a one hundred dollar ($100) copayment; and

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

[3. Coverage gap stage. After a member's total yearly Part D prescription drug costs exceed five thousand thirty dollars ($5,030) and remain below eight thousand dollars ($8,000), the member will continue to pay the same cost-sharing amount as in the initial coverage stage until the yearly out-of-pocket Part D prescription drug costs reach eight thousand dollars ($8,000);

*[4.]***3.** Catastrophic coverage stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[eight thousand dollars ($8,000)]* **two thousand dollars ($2,000)**, the member will pay zero dollars ($0); and

*[5.]***4.** Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This emergency amendment corrects the omission of the maximum amount Health Savings Account members will pay for non-preferred formulary drugs and approved excluded drugs.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

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

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

1. Network:

A. Preferred formulary generic drug: ten percent (10%) coinsurance up to fifty dollars ($50) per thirty-one- (31-) day supply after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: twenty percent (20%) coinsurance up to one hundred dollars ($100) per thirty-one- (31-) day supply after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: forty percent (40%) coinsurance **up to two hundred dollars ($200)** after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance, not to exceed:

(I) Twenty-five dollars ($25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars ($50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars ($100) per thirty-one- (31-) day supply for non-preferred formulary drug;

E. Ninety- (90-) day supply of prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program or at select retail pharmacies, as designated by the PBM;

F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-)

day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

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

G. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy;

H. Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are covered at one hundred percent (100%) when filled at a network pharmacy;

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

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

(II) One (1) preferred glucometer;

J. If any ingredient in a compound drug is excluded by the plan, the compound will be denied; and

K. Drugs permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan are not subject to the deductible when filled at a network pharmacy. Applicable coinsurance will apply.

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

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

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

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

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.140 Strive for Wellness® Health Center Provisions, Charges, and Services. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This emergency amendment revises eligibility for the Strive for Wellness® Health Center.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

(1) Eligibility. *[Members]* **Subscribers and their dependents** aged eighteen (18) years and older **enrolled in MCHCP medical coverage** shall be eligible for and able to access the services available at the health center as described in this rule.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This emergency amendment clarifies enrollment procedures when an eligible dependent loses MO HealthNet or Medicaid status.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

(3) Enrollment Procedures.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a separate group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances, and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

C. If a retiree subscriber's eligible dependent loses MO HealthNet or Medicaid status, the retiree may enroll the eligible dependent within sixty (60) days of the date of loss.

3. If coverage was not maintained while on disability, the employee and his/her dependents may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

6. If a retiree is enrolled and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the retiree and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's

responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

C. If a terminated vested subscriber's eligible dependent loses MO HealthNet or Medicaid status, the terminated vested subscriber may enroll the eligible dependent within sixty (60) days of the date of loss.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a terminated vested subscriber is enrolled and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

C. If a long-term disability subscriber's eligible dependent loses MO HealthNet or Medicaid status, the long-term disability subscriber may enroll the eligible dependent within sixty (60) days of the date of loss.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a long-term disability subscriber is enrolled and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(E) Survivor Coverage.

1. A survivor must submit a form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

C. If a survivor's eligible dependent loses MO HealthNet or Medicaid status, the survivor may enroll the

eligible dependent within sixty (60) days of the date of loss.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

5. If a survivor is enrolled and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the survivor and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 3 – Public Entity Membership
EMERGENCY AMENDMENT

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (10) and (16).

PURPOSE: This emergency amendment revises coverage of virtual visits and non-network payments.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024 becomes effective January 1, 2025 and expires June 29, 2025.*

(10) Virtual visits offered through the vendor's telehealth tool are covered at one hundred percent (100%) **after deductible is met unless Internal Revenue Service (IRS) guidance permits it to be paid at one hundred percent (100%) prior to deductible being met**.

(16) *[Maximum]* **Non-network** plan payment – Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed *[at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* following the claims administrator's *[standard]* practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This emergency amendment revises the availability of transition of care and coverage of eyeglasses and contact lenses.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

[(2) Transition of Care. A transition of care option is available for members who seek to continue to remain under the care of a non-network provider who was treating them prior to the provider losing network status. A subscriber and his/her dependents may request to continue receiving care at the network benefit level. If approved, the member will be eligible to continue care with the current non-network provider at the network benefit level for a period of time until it is medically appropriate for the member to transfer care to a network provider. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. The following benefits are eligible for transition of care as determined by the claims administrator:

(A) Upcoming surgery or prospective transplant;
(B) Services for women in their third trimester of pregnancy;
(C) Radiation therapy;
(D) Dialysis;
(E) Cancer treatment;
(F) Physical, speech, or occupational therapy;
(G) Hospice care;
(H) Inpatient hospitalization at the time of the network change; or
(I) Mental health services.]

(2) Transition of care is available in accordance with federal and state law when a provider loses network status.

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250 Plan, and HSA Plan.

(D) Plan benefits for the PPO 750 Plan, PPO 1250 Plan, and HSA Plan are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms;

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

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

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

3. Applied behavior analysis (ABA) for autism;

4. Bariatric surgery;

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

6. Bone growth stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit;

7. Contraception and sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

8. Cardiac rehabilitation;

9. Chelation therapy;

10. Chiropractic services – manipulation and adjunct therapeutic procedures/modalities;

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

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

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

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

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

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

(I) National Institutes of Health (NIH);

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

(III) Agency for Health Care Research and Quality;

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

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

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

(VII) A study or investigation that is conducted by the

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

12. Cochlear implant and auditory brainstem implant;

13. Cryopreservation cycles.

A. Oocyte cryopreservation cycles including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes).

B. Sperm cryopreservation including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes);

14. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. Treatment must be initiated within sixty (60) days of accident; and

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

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

15. Diabetes self-management education;

16. Dialysis is covered when received through a network provider;

17. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes but is not limited to the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

18. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit;

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

A. Post cataract surgery. Coverage is limited to charges incurred in connection with the fitting of eyeglasses or contact lenses for initial placement within one (1) year post cataract surgery; or

B. Covered if medically necessary for conditions caused by aphakia, keratoconus, or injury;

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

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

(I) Diabetes mellitus;

(II) Peripheral vascular disease;

(III) Peripheral neuropathy; or

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

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

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

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

22. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

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

24. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

25. Hearing aids (per ear). Hearing aids covered once every two (2) years for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

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

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

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

D. Bone anchoring hearing aid (BAHA): three thousand five hundred dollars ($3,500);

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

27. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include –

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as –

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

28. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill;

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

A. The following benefits are covered:

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

(II) Intensive care unit room and board;

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

(a) Cornea transplant;

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

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

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

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

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

(IV) Inpatient mental health services; and

(V) Outpatient mental health services;

30. Infertility coverage for members with a diagnosis of infertility, including in vitro fertilization (IVF) oocyte retrievals limited to two (2) cycles as a lifetime maximum, per member;

31. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

32. Injections. See preventive services for coverage of vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

33. Lab, x-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

34. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to applicable copayments, deductible, and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

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

36. Nutrition therapy;

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

38. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

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

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

B. Tumors and cysts, cancer, and post-surgical sequela;

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

D. Physical abnormality;

40. Orthotics.

A. Ankle-foot orthosis (AFO) and knee-ankle-foot orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO not used during ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast boot, post-operative sandal or shoe, or healing shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial orthoses. Cranial orthosis is covered for synostotic and non-synostotic plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic plagiocephaly is due to premature closure of cranial sutures. Non-synostotic plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear incorporated into a brace for members with skeletally mature feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot orthoses. Custom, removable foot orthoses are covered.

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

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

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

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

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

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

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

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

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

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

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

J. Orthopedic footwear for diabetic members.

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

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

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

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

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

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41. Preventive services.

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

B. Vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other preventive services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified:

(I) Mammograms – no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears – no age limit;

(III) Prostate – no age limit; and

(IV) Colorectal screening – no age limit.

G. Digital diabetes prevention program offered through the plan's claims administrator.

H. The following services permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan:

(I) Blood pressure monitors for individuals diagnosed with hypertension;

(II) Retinopathy screenings for individuals diagnosed with diabetes;

(III) Hemoglobin A1c (HbA1c) testing for individuals diagnosed with diabetes;

(IV) Peak flow meters for individuals diagnosed with asthma; and

(V) International normalized ratio (INR) testing for individuals diagnosed with liver disease and/or bleeding disorders;

42. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

43. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

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

45. Telehealth services. Telehealth services are covered

for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

46. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver-provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language, and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

47. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s') travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging – maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel – IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals – not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

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

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (11).

PURPOSE: This emergency amendment clarifies how non-network plan payments are processed.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and

significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024 becomes effective January 1, 2025, and expires June 29, 2025.*

(11) *[Maximum]* **Non-network** plan payment – non-network medical claims *[that are not otherwise subject to a contractual discount arrangement]* are processed *[at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* following the claim administrator's *[standard]* practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (11).

PURPOSE: This emergency amendment clarifies how non-network plan payments are processed.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

(11) *[Maximum]* **Non-network** plan payment – non-network medical claims *[that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* **are processed** following the claim administrator's standard practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This emergency amendment adds an occurrence in

which MCHCP may allow one (1) additional reinstatement and revises the time frame in which MCHCP may approve an appeal where a subscriber missed a deadline.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account. Payment in full for all past and current premiums due for reinstatement must be included with the appeal**. MCHCP may allow one (1) additional reinstatement if the subscriber submits an automatic withdrawal authorization**;

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

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

EMERGENCY AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This emergency amendment corrects the omission of the maximum amount Health Savings Account members will pay for non-preferred formulary drugs and approved excluded drugs.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

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

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Preferred formulary generic drug: ten percent (10%) coinsurance up to fifty dollars ($50) per thirty-one- (31-) day supply after deductible has been met for a generic drug on the formulary.

B. Preferred formulary brand drug: twenty percent (20%) coinsurance up to one hundred dollars ($100) per thirty-one-

(31-) day supply after deductible has been met for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: forty percent (40%) coinsurance **to two hundred dollars ($200)** after deductible has been met.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance, not to exceed:

(I) Twenty-five dollars ($25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars ($50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars ($100) per thirty-one- (31-) day supply for non-preferred formulary drug.

E. Ninety- (90-) day supply of prescriptions may be filled through the PBM's home delivery program or at select retail pharmacies, as designated by the PBM.

F. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program.

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

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

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

H. Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are covered at one hundred percent (100%) when filled at a network pharmacy.

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

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

(II) One (1) preferred glucometer.

J. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

K. Drugs permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan are not subject to the deductible when filled at a network pharmacy. Applicable coinsurance will apply.

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

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

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

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

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency amendment is effective.

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo.

EXECUTIVE ORDER
24-11

WHEREAS, article IV, section 1 of the Missouri Constitution vests the Governor with the supreme executive power of the State; and

WHEREAS, the Governor may exercise this executive power through various means, including the issuance of executive orders; and

WHEREAS, an executive order may be issued by a governor to respond to a particular consequential event, to guide policy and/or action within the executive branch, to create a board or commission, to institute a reorganization of offices or functions within the executive branch, and to direct members of the Missouri National Guard, among other reasons; and

WHEREAS, it is now common practice for executive orders to be issued with a specific date of rescission to ensure executive orders do not linger in effect unnecessarily; and

WHEREAS, there are a number of historic executive orders that remain in effect that are no longer necessary or applicable; and

WHEREAS, the Governor may rescind any executive order enacted by a previous governor; and

WHEREAS, rescinding executive orders that are no longer necessary or applicable will aid in ensuring a smaller government with less bureaucracy and more efficient and effective operations of government.

NOW, THEREFORE, I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby rescind the following 177 executive orders:

- 80-11
- 80-13
- 80-15
- 80-17
- 80-18
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- 80-25
- 80-26
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- 18-12

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 23rd day of October, 2024.

MICHAEL L. PARSON
GOVERNOR

ATTEST:

JOHN R. ASHCROFT
SECRETARY OF STATE

EXECUTIVE ORDER
24-12

WHEREAS, Executive Order 24-11 rescinded Executive Order 97-97, among 176 other executive orders; and

WHEREAS, the rescission of Executive Order 97-97 was inadvertent.

NOW, THEREFORE, I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby revoke the rescission of Executive Order 97-97, thereby giving it the full force and effect that it had prior to its recission.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 24th day of October, 2024.

MICHAEL L. PARSON
GOVERNOR

ATTEST:

JOHN R. ASHCROFT
SECRETARY OF STATE

24-13

WHEREAS, the negative effects of drought are being experienced in numerous areas across the State of Missouri, including among farmers and agricultural producers; and

WHEREAS, I have been advised by the Director of the Department of Natural Resources that parts of the State of Missouri are experiencing drought conditions; and

WHEREAS, the U.S. Drought Monitor indicates all or portions of 88 counties are in moderate, severe or extreme drought; and

WHEREAS, early response to pending drought can greatly reduce negative impacts upon Missouri citizens; and

WHEREAS, receiving local impact reports from citizens can greatly help ensure Missouri's drought map is accurate and that decision-makers know what assistance would be most useful to citizens; and

WHEREAS, state and federal agencies have interdependent roles in identifying and mitigating drought impacts; and

WHEREAS, the State Water Resources Plan established pursuant to section 640.415, RSMo, has recommended an update to the Missouri Drought Mitigation and Response Plan; and

WHEREAS, the Missouri Drought Mitigation and Response Plan calls for intergovernmental communication, cooperation, and coordination of efforts in drought mitigation activities.

NOW THEREFORE, I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, by virtue and authority vested in me by the Constitution and laws of the State of Missouri, do hereby declare a Drought Alert for the counties of Adair, Andrew, Atchison, Audrain, Barry, Barton, Bates, Benton, Buchanan, Caldwell, Callaway, Camden, Carroll, Cass, Cedar, Chariton, Christian, Clark, Clay, Clinton, Cole, Cooper, Crawford, Dade, Dallas, Daviess, DeKalb, Dent, Douglas, Franklin, Gasconade, Gentry, Greene, Grundy, Harrison, Henry, Hickory, Holt, Howard, Howell, Jackson, Jasper, Johnson, Knox, Laclede, Lafayette, Lawrence, Lewis, Linn, Livingston, Macon, Maries, Marion, McDonald, Mercer, Miller, Moniteau, Monroe, Morgan, Newton, Nodaway, Osage, Ozark, Pettis, Phelps, Pike, Platte, Polk, Pulaski, Putnam, Ralls, Randolph, Ray, Reynolds, Saint Clair, Saline, Schuyler, Scotland, Shannon, Shelby, Stone, Sullivan, Taney, Texas, Vernon, Webster, Worth, and Wright.

I further direct that as additional counties enter moderate, severe, extreme, or exceptional drought according to the U.S. Drought Monitor, they shall be declared in Drought Alert in accordance with the Missouri Drought Mitigation and Response Plan.

I further order and direct the Director of the Department of Natural Resources to activate and designate a chairperson for the Drought Assessment Committee and request that all Missouri and federal agencies participate as needed.

I further direct the Director of the Department of Natural Resources to promote the use of the Condition Monitoring Observer Reports (CMOR) to better identify statewide and localized drought impacts.

I further direct all state agencies to provide assistance in mitigating the effects of drought conditions in all affected communities.

This Executive Order shall be effective immediately and shall remain in effect until March 31, 2025, unless terminated or extended by subsequent order.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 29th day of October, 2024.

MICHAEL L. PARSON
GOVERNOR

ATTEST:

JOHN R. ASHCROFT
SECRETARY OF STATE

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

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

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

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

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

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

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

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 15 – Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology. The division is amending sections (2), (6), (8), and (12).

PURPOSE: This proposed amendment updates the incorporation by reference and the definition of a safety net hospital. It also updates the Acuity Adjustment Payment and Stop Loss Payment methodologies.

(2) Definitions.

(O) Incorporation by reference. This rule incorporates by reference the following:

1. The *Hospital [Provider] Manual* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at *[http://manuals.momed.com/manuals/, June 8, 2022]* **https://mydss.mo.gov/media/pdf/hospital-manual, June 27, 2024**. This rule does not incorporate any subsequent amendments or additions;

2. *[Medicare/Medicaid Cost Report CMS 2552-10,]* **Chapter 40 of *The Provider Reimbursement Manual* – Part 2, that includes the CMS 2552-10 cost report form and instructions,** which is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services (CMS) at its website *[http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html, June 8, 2022]* **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935, February 21, 2024**. This rule does not incorporate any subsequent amendments or additions; and

3. 42 CFR 413, which is incorporated by reference and made a part of this rule as published by the U.S. Government Publishing Office and available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413?toc=1, June 8, 2022. This rule does not incorporate any subsequent amendments or additions. Only the cost principles from 42 CFR 413 are incorporated by reference.

(6) Acuity Adjustment Payment (AAP).

(B) Private ownership. A hospital shall receive an AAP if the hospital's MO HealthNet case mix index is greater than a threshold set annually by the division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet case mix index times the estimated Medicaid FFS claims payments for the coming SFY. If the hospital's estimated Medicaid FFS claims payments for the coming SFY plus the preliminary AAP exceeds the hospital's *[prior]* SFY **2023** Medicaid FFS payments received increased by a stop-gain percentage, the preliminary AAP will be reduced so the estimated Medicaid FFS claims payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's *[prior]* SFY **2023** Medicaid FFS payments received. If no reduction is necessary, the preliminary AAP shall be considered final.

(C) Non-state government owned or operated (NSGO) ownership. A hospital shall receive an AAP if the hospital's MO HealthNet case mix index is greater than a threshold set annually by the division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet case mix index times the estimated Medicaid FFS claims payments for the coming SFY. If the hospital's estimated Medicaid FFS claims payments for the coming SFY plus the preliminary AAP exceeds the hospital's *[prior]* SFY **2023** Medicaid FFS payments received increased by a stop-gain percentage, the preliminary AAP will be reduced so the estimated Medicaid FFS claims payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's *[prior]* SFY **2023** Medicaid FFS payments received. If no reduction is necessary**,** the preliminary AAP shall be considered final.

(8) Stop Loss Payment (SLP).

(B) Private ownership. Total estimated Medicaid FFS payments for the coming SFY for each hospital shall include estimated Medicaid FFS claims payments, and any final AAP and PC payment. The total estimated Medicaid FFS payments for each hospital shall be subtracted from the hospital's *[prior]* SFY **2023** Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire private ownership group. A positive result represents a decrease in

payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the private ownership group, this amount shall represent the total stop loss amount.

1. SLP will be made if a total stop loss amount was calculated in subsection (8)(B). Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total stop loss amount. If the sum is greater than the total stop loss amount, each hospital's SLP shall be calculated by multiplying the total stop loss amount times the ratio of the hospital's decrease in Medicaid payments to the total decrease in payments for the entire private ownership group.

2. Privately owned free-standing psychiatric hospitals. Total estimated Medicaid FFS payments for the coming SFY for each hospital shall include estimated Medicaid FFS claims payments, and any final AAP and PC payment. The total estimated Medicaid FFS payments for each hospital shall be subtracted from the hospital's *[prior]* SFY **2023** Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire privately owned free-standing psychiatric hospital ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments.

A. If a hospital has a decrease in payments as calculated in paragraph (8)(B)2., the hospital will receive a payment equal to the amount of payment decrease. If the hospital has an increase in payments as calculated in paragraph (8)(B)2., the hospital will not receive any additional payments.

(C) NSGO ownership. Total estimated Medicaid FFS payments for the coming SFY for each hospital shall include estimated Medicaid FFS claims payments, and any final AAP and PC payment. The total estimated Medicaid FFS payments for each hospital shall be subtracted from the hospital's *[prior]* SFY **2023** Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire NSGO ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the NSGO ownership group, this amount shall represent the total stop loss amount.

1. SLP will be made if a total stop loss amount was calculated in subsection (8)(C). Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total stop loss amount. If the sum is greater than the total stop loss amount, each hospital's SLP shall be calculated by multiplying the total stop loss amount times the ratio of the hospital's decrease in Medicaid payments to the total decrease in payments for the entire NSGO ownership group.

(12) Safety Net Hospitals.

(A) *[Inpatient]* **A** hospital *[providers]* may qualify as a safety net hospital based on the following criteria. Hospitals shall qualify for a period of only one (1) SFY and must requalify at the beginning of each SFY to continue their safety net hospital designation*[.]***:**

1. *[If the facility offered non-emergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to those services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer non-emergency obstetric services as of December 21, 1987;]* **The hospital must meet the specific obstetric requirements set forth in 13 CSR 70-15.220(1)(B)1.;**

2. As determined from the audited base year cost report, the facility must have either –

A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) (including such patients who receive benefits through a managed care entity) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded*[;]***.**

MIUR = TMD / TNID; or

B. A low-income utilization rate in excess of twenty-five percent (25%).

(I) The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(a) Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges minus contractual allowances, discounts, etc.) for patient services plus the cash subsidies; and

(b) The total amount of the hospital's charges for patient services attributable to charity care (CC) less cash subsidies directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to charity care shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a state plan.
LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC – CS) / THC)**; and**

3. As determined from the audited base year cost report –

[A. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or

B. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%); or]

*[C.]***A.** A public non-state governmental acute care hospital with an LIUR of at least *[forty percent (40%)]* **twenty percent (20%)** and an MIUR greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%); or

*[D.]***B.** The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo; or

*[E.]***C.** *T*he hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

AUTHORITY: sections ***[208.153,]*** *208.201****[,]*** *and 660.017, RSMo*

*2016, and section**s** 208.152 **and 208.153**, RSMo Supp. **[2023] 2024**. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed July 26, 2024, effective Aug. 9, 2024, expires Feb. 27, 2025. Amended: Filed Oct. 23, 2024.*

PUBLIC COST: This proposed amendment is estimated to cost state agencies $230 million for SFY 2025. This proposed amendment is estimated to cost public hospitals one hundred thirty-eight thousand two hundred sixty-two dollars ($138,262) for SFY 2025.

PRIVATE COST: This proposed amendment is estimated to cost private entities $200 million for SFY 2025.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing will not be scheduled.*

FISCAL NOTE
PUBLIC COST

I. **Department Title:** 13 Social Services
Division Title: 70 MO HealthNet Division
Chapter Title: 15 Hospital Program

Rule Number and Title:	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) Hospitals enrolled in MO HealthNet - 15	**Net Estimated Increase in Payments for SFY 2025: $30.3 million**
Other Government (Public) Hospitals enrolled in MO HealthNet - 3	**Net Estimated Cost for SFY 2025: $138 thousand**
Department of Social Services, MO HealthNet Division	**Net Estimated Cost for SFY 2025: $230 million**

III. WORKSHEET

Other Government (Public) Hospitals Impact	
Estimated Impact for 2025	
	Total
In-State Public Hospitals Gain	$30,332,022
In-State Public Hospitals (Cost)	($138,262)
Total Impact	$30,193,760
SFY 2025 Blended FMAP	34.5%
State Share	$10,416,847

Department of Social Services, MO HealthNet Division Impact	
Estimated Impact for SFY 2025	
Estimated Cost	$230,075,305
Times SFY 2025 Blended FMAP	34.5%
Estimated State Share	$79,375,980

IV. ASSUMPTIONS

FISCAL NOTE
PRIVATE COST

I. Department Title: 13 Social Services
Division Title: 70 MO HealthNet Division
Chapter Title: 15 Hospital Program

Rule Number and Title:	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
In-state Hospitals – 69	**In-state Private Hospitals enrolled in MO HealthNet**	**Net Estimated Increase in Payments for SFY 2025: $207.1 million**
In-state Hospitals – 7	**Private Hospitals enrolled in MO HealthNet**	**Net Estimated Cost for SFY 2025: $7.2 million**

III. WORKSHEET

Private Hospitals Impact	
Estimated Impact for SFY 2025	
	Total
In-State Private Hospitals Gain	$207,126,825
In-State Private Hospitals (Cost)	($7,245,280)
Total Impact	$199,881,545
SFY 2025 Blended FMAP	34.5%
State Share	$68,959,133

IV. ASSUMPTIONS

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 15 – Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology. The division is amending section (1).

PURPOSE: This proposed amendment updates all documents incorporated by reference and is used to create the outpatient simplified fee schedule. This proposed amendment will also allow MO HealthNet to align with Medicare pricing of multiple procedure discounting and Modifier 50 bilateral procedure pricing and it increases the additional percent increase for nominal charge providers.

(1) *Outpatient Simplified Fee Schedule* (OSFS) Payment Methodology.

(A) Definitions. The following definitions will be used in administering section (1) of this rule:

1. Ambulatory Payment Classification (APC). Medicare's ambulatory payment classification assignment groups of Current Procedural Terminology (CPT) or Healthcare Common Procedures Coding System (HCPCS) codes. APCs classify and group clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources. All services within an APC group have the same relative weight used to calculate the payment rates;

2. APC conversion factor. The unadjusted national conversion factor calculated by Medicare effective January 1 of each year, as published with the Medicare Outpatient Prospective Payment System (OPPS) Final Rule, and used to convert the APC relative weights into a dollar payment. The Medicare OPPS Final Rule is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.govinfo.gov/content/pkg/FR-2022-11-23/pdf/2022-23918.pdf, November 23, 2022,]* **December 8, 2023**. This rule does not incorporate any subsequent amendments or additions;

3. APC relative weight. The national relative weights calculated by Medicare for the Outpatient Prospective Payment System;

4. Current Procedural Terminology (CPT). A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations;

5. Dental procedure codes. The procedure codes found in the Code on Dental Procedures and Nomenclature (CDT), a national uniform coding method for dental procedures maintained by the American Dental Association;

6. Federally Deemed Critical Access Hospital. Hospitals that meet the federal definition found in *[section 1820(c)(2)(B) of the Social Security Act]* **42 Code of Federal Regulations (CFR) 485.606(b), which is incorporated by reference in this rule as published by U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402, October 1, 2023, and available at https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol5/pdf/CFR-2023-title42-vol5.pdf. This rule does not incorporate any subsequent amendments or additions.**

7. HCPCS. The national uniform coding method maintained by the Centers for Medicare & Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians CPT and the three (3) HCPCS unique coding levels*[,]* I, II, and III;

8. Medicare Inpatient Prospective Payment System (IPPS) wage index. The wage area index values are calculated annually by Medicare, published as part of the Medicare IPPS Final Rule;

9. Missouri conversion factor. The single, statewide conversion factor used by the MO HealthNet Division (MHD) to determine the APC-based fees, uses a formula based on Medicare OPPS. The formula consists of sixty percent (60%) of the APC conversion factor, as defined in paragraph (1)(A)2. multiplied by the St. Louis, MO, Medicare IPPS wage index value, plus the remaining forty percent (40%) of the APC conversion factor, with no wage index adjustment;

10. Nominal charge provider. A nominal charge provider is determined from the third prior year audited Medicaid cost report. The hospital must meet the following criteria:

A. A public non-state governmental acute care hospital with a low-income utilization rate (LIUR) of at least *[forty percent (40%)]* **twenty percent (20%)** and a Medicaid inpatient utilization rate (MIUR) greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%). The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or

B. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and

C. A hospital physically located in the state of Missouri;

11. Outpatient Prospective Payment System (OPPS). Medicare's hospital outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA); *[and]*

12. Payment level adjustment. The percentage applied to the Medicare fee to derive the OSFS fee*[.]***; and**

13. Rural emergency hospital. Hospitals that meet the federal definition found in 42 CFR 485.502, which is incorporated by reference in this rule as published by U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402, October 1, 2023, and available at https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol5/pdf/CFR-2023-title42-vol5.pdf. This rule does not incorporate any subsequent amendments or additions.

(B) Effective for dates of service beginning July 20, 2021, outpatient hospital services shall be reimbursed on a predetermined fee-for-service basis using an OSFS based on the APC groups and fees under the Medicare Hospital OPPS. When service coverage and payment policy differences exist between Medicare OPPS and Medicaid, MHD policies and fee schedules are used. The fee schedule will be updated as follows:

1. MHD will review and adjust the OSFS annually on July 1 based on the payment method described in subsection (1)(D); and

2. The OSFS is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[at its website at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, July 13, 2023]* **July 1, 2024**. This rule does not incorporate any subsequent amendments or additions.

(D) Fee schedule methodology. Fees for outpatient hospital services covered by the MO HealthNet program are determined by the HCPCS procedure code at the line level and the following hierarchy:

1. The APC relative weight or payment rate assigned to the procedure in the Medicare OPPS *Addendum B* is used to calculate the fee for the service, with the exception of the hospital observation per hour fee which is calculated based on the method described in subparagraph (1)(D)1.B. Fees derived from APC weights and payment rates are established using the Medicare OPPS *Addendum B* effective as of January 1 of each year as published by the CMS for Medicare OPPS. The Medicare OPPS *Addendum B* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/january-2023, January 20, 2023]* **December 22, 2023**. This rule does not incorporate any subsequent amendments or additions.

A. The fee is calculated using the APC relative weight times the Missouri conversion factor. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee.

B. The hourly fee for observation is calculated based on the relative weight for the Medicare APC (using the Medicare OPPS *Addendum A* effective as of January 1 of each year as published by the CMS for Medicare OPPS), which corresponds with comprehensive observation services multiplied by the Missouri conversion factor divided by forty (40), the maximum payable hours by Medicare. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee. The Medicare OPPS *Addendum A* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/january-2023-0, January 20, 2023]* **January 4, 2024**. This rule does not incorporate any subsequent amendments or additions.

C. For those APCs with no assigned relative weight, ninety percent (90%) of the Medicare APC payment rate is used as the fee;

2. If there is no APC relative weight or APC payment rate established for a particular service in the Medicare OPPS *Addendum B*, then the MHD approved fee will be ninety percent (90%) of the rate listed on other Medicare fee schedules, effective as of January 1 of each year: Clinical Laboratory Fee Schedule; Physician Fee Schedule; and Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule, applicable to the outpatient hospital service.

A. The Medicare *Clinical Laboratory Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/medicare/medicare-fee-service-payment/clinicallabfeesched/clinical-laboratory-fee-schedule-files/23clabq1, January 12, 2023]* **January 11, 2024**. This rule does not incorporate any subsequent amendments or additions.

B. The Medicare *Physician Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-carrier-specific-files/all-states-2, January 5, 2023]* **January 11, 2024**. This rule does not incorporate any subsequent amendments or additions.

C. The Medicare *Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/medicaremedicare-fee-service-paymentdmeposfeescheddmepos-fee-schedule/dme23, December 19, 2022]* **December 22, 2023**. This rule does not incorporate any subsequent amendments or additions;

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on thirty-eight and one half percent (38.5%) of the fiftieth percentile fee for Missouri reflected in the 2023 *National Dental Advisory Service* (NDAS). The 2023 NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental *[at its website at https://wasserman-medical.com/product-category/dental/ndas/, January 10, 2023]***, PO Box 510949, Milwaukee, WI 53203, December 28, 2023.** This rule does not incorporate any subsequent amendments or additions;

4. If there is no APC relative weight, APC payment rate, other Medicare fee schedule rate, or NDAS rate established for a covered outpatient hospital service, then a MO HealthNet fee will be determined using the MHD *Dental, Medical, Other Medical or Independent Lab–Technical Component* fee schedules.

A. The MHD *Dental Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[and available at https://dss.mo.gov/mhd/provider/pages/cptagree.htm, March 8, 2023]* **May 13, 2024**. This rule does not incorporate any subsequent amendments or additions.

B. The MHD *Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[and available at https://dss.mo.gov/mhd/provider/pages/cptagree.htm, March 8, 2023]* **May 13, 2024**. This rule does not incorporate any subsequent amendments or additions.

C. The MHD *Other Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[and available at https://dss.mo.gov/mhd/provider/pages/cptagree.htm, March 8, 2023]* **May 13, 2024**. This rule does not incorporate any subsequent amendments or additions.

D. The MHD *Independent Lab–Technical Component Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[and available at https://dss.mo.gov/mhd/provider/pages/cptagree.htm, March 8, 2023]* **May 13, 2024**. This rule does not incorporate any subsequent amendments or additions;

5. In-state federally deemed critical access hospitals will receive an additional forty percent (40%) of the rate as determined in paragraph(1)(B)2. for each billed procedure code; *[and]*

6. Nominal charge providers will receive an additional *[twenty-five percent (25%)]* **forty percent (40%)** of the rate as determined in paragraph (1)(B)2. for each billed procedure code**; and**

7. Rural emergency hospitals will receive an additional forty percent (40%) of the rate as determined in paragraph (1)(B)2. for each billed procedure code.

(E) Packaged services. MHD adopts Medicare guidelines for procedure codes identified as "Items and Services Packaged into APC Rates" under Medicare OPPS *Addendum D1*. These procedures are designated as always packaged. Claim lines with packaged procedure codes will be considered paid but with a payment of zero (0). The Medicare OPPS *Addendum D1* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, *[and available at https://www.cms.gov/license/ama?file=/files/zip/2023-nfrm-opps-addenda.zip, November 22, 2022]* **December 8, 2023**. This rule does not incorporate any subsequent amendments or additions.

(G) Multiple procedure discounting. Effective for dates of service beginning July 1, 2024, MHD applies multiple procedure discounting for those procedure codes identified as "Procedure or Service, Multiple Procedure Reduction Applies" under Medicare OPPS *Addendum D1*. These procedures are paid separately but are discounted when two (2) or more services are billed on the same date of service. Procedure codes considered for the multiple procedure reduction under the OSFS exclude dental procedures. The multiple procedure claim line with the highest allowed amount is priced at one hundred percent (100%) of the maximum allowed amount. The second and subsequent covered procedures are priced at fifty percent (50%) of the maximum allowed amount. The Medicare OPPS *Addendum D1* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, December 8, 2023. This rule does not incorporate any subsequent amendments or additions.

(H) Modifier 50 Bilateral procedure pricing. Effective for dates of service beginning July 1, 2024, MHD applies bilateral procedure pricing for those procedure codes identified on the Medicare *National Physician Fee Schedule Relative Value File* with an indicator of one (1) under the BILAT SURG column. These procedures may be subject to a payment adjustment when billed with modifier 50 and performed bilaterally on both sides of the body at the same operative session. Claim lines appropriately billed with these bilateral procedures and modifier 50 are priced at one hundred and fifty percent (150%) of the maximum allowed amount for a single code. The Medicare *National Physician Fee Schedule Relative Value File* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, January 5, 2024. This rule does not incorporate any subsequent amendments or additions.

*[(G)]***(I)** Drugs. Effective for dates of service beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

*[(H)]***(J)** Payment for outpatient hospital services under this rule will be final, with no cost settlement.

*AUTHORITY: sections [208.153,] 208.201[,] and 660.017, RSMo 2016, and section**s** 208.152 **and 208.153**, RSMo Supp. **[2023] 2024**. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 16, 2024, effective Oct. 30, 2024, expires April 27, 2025. Amended: Filed Oct. 16, 2024.*

PUBLIC COST: This proposed amendment is estimated to cost state agencies or political subdivisions $16.8 million in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities twelve thousand nine hundred forty-eight dollars ($12,948) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing will not be scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 15 – Hospital Program

Rule Number and Title:	13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) & State Hospitals enrolled in MO HealthNet - 32	**Net Estimated Increase in Payments for SFY 2025: $8.1 million**
Department of Social Services, MO HealthNet Division	**Estimated Cost for SFY 2025: Total Cost is estimated at $16.8 million; State Share is estimated at $5.8 million**

III. WORKSHEET

Other Government (Public) & State Hospitals Impact					
Estimated Impact for SFY 2025					
	Total	**OSFS**	**NC Boost**	**Bilateral**	**Discounting**
Public Hospitals Gain/(Cost)	$6,846,134	$1,832,151	$5,003,683	$431,487	($421,187)
State Hospitals Gain/(Cost)	$1,277,629	$1,312,379	$0	$54,059	($88,809)
Total Gain/(Cost)	$8,123,763	$3,144,530	$5,003,683	$485,546	($509,996)
SFY 2025 Blended FMAP	34.5%	34.5%	34.5%	34.5%	34.5%
State Share	$2,802,698	$1,084,863	$1,726,271	$167,513	($175,949)

Department of Social Services, MO HealthNet Division Impact					
Estimated Impact for SFY 2025					
Estimated Costs/(Savings)	$16,835,434	$11,289,011	$5,003,683	$2,232,399	($1,689,659)
Times SFY 2025 Blended FMAP	34.5%	34.5%	34.5%	34.5%	34.5%
Estimated State Share	$5,808,225	$3,894,709	$1,726,271	$770,178	($582,932)

The state estimates that there is no cost to other government (public) and state hospitals. The state anticipates an increase in payments in aggregate of $8.1 million.

IV. ASSUMPTIONS

The estimated cost to the state is due to Medicare increasing their rates for the following high volume services: emergency department visits, clinic visits, and some laboratory and the MO HealthNet accommodation of the new multiple procedure discounting and bilateral procedure (Modifier 50) pricing, and the 15% additional increase for nominal charge providers. Medicare currently applies multiple procedure payment reduction. This is a discounted rate when more than one surgery is performed in the same setting. Currently MHD pays 100% of the MHD rate for each procedure performed in the same setting. Medicare allows 150% payment adjustment for bilateral procedures (Modifier 50). These are services performed on both sides of the body during the same session. These changes will be effective for dates of service on or after July 1, 2024.

FISCAL NOTE
PRIVATE COST

I. Department Title: Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 15 – Hospital Program

Rule Number and Title:	13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
In-state hospitals – 76 **Out-of-state hospitals – 120**	**Private and Out-of-State Hospitals enrolled in MO HealthNet**	**Net Estimated Increase in Payments for SFY 2025: $8.7 million**
In-state hospitals – 2		**Net Estimated Cost for SFY 2025: $10,498**
Out-of-state hospitals – 15		**Net Estimated Cost for SFY 2025: $2,450**

III. WORKSHEET

Private Hospitals Impact				
Estimated Impact for SFY 2025				
	Total	**OSFS**	**Bilateral**	**Discounting**
In-State Private Hospitals Gain/(Cost)	$8,358,360	$7,842,294	$1,581,984	($1,065,919)
Out-of-State Private Hospitals Gain/(Cost)	$353,312	$302,187	$164,869	($113,743)
Total Impact	$8,711,671	$8,144,481	$1,746,853	($1,179,663)
SFY 2025 Blended FMAP	34.5%	34.5%	34.5%	34.5%
State Share	$3,005,527	$2,809,846	$602,664	($406,984)

The state estimates that there is no cost to private and out-of-state hospitals. The state anticipates an increase in payments to private entities in aggregate of $8.7 million.

IV. ASSUMPTIONS

The estimated cost to the state is due to Medicare increasing their rates for the following high volume services: emergency department visits, clinic visits, and some laboratory services and the MO HealthNet accommodation of the new multiple procedure discounting and bilateral procedure (Modifier 50) pricing. Medicare currently applies multiple procedure payment reduction. This is a discounted rate when more than one surgery is performed in the same setting. Currently MHD pays 100% of the MHD rate for each procedure performed in the same setting. Medicare allows 150% payment adjustment for bilateral procedures (Modifier 50). These are services performed on both sides of the body during the same session. These changes will be effective for dates of service on or after July 1, 2024.

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 20 – Pharmacy Program

PROPOSED AMENDMENT

13 CSR 70-20.045 *[Thirty-One-]* ***Maximum*** **Day Supply** *[Maximum Restriction]* ***Limit*** **on** *[Pharmacy Services]* ***Prescriptions*** **Reimbursed by the MO HealthNet Division**. The department is amending the title, purpose statement, and sections (1)–(5).

PURPOSE: The purpose of this amendment is to simplify existing language and clarify information for providers.

PURPOSE: This rule establishes a thirty-one- (31-) day supply maximum restriction per dispensing on ***[pharmacy services] prescriptions*** *reimbursed by the MO HealthNet Division[on behalf of participants eligible for any of the fee-for-service programs] (MHD).*

(1) The maximum days' supply *[of medication that may be provided per dispensing]* **for prescriptions dispensed** on behalf of a participant eligible for any *[of the]* fee-for-service programs is **a maximum of** thirty-one (31) days, except for those *[drugs and/or categories]* **prescriptions** under the provisions of this rule. *[Medication may be dispensed]* **MHD providers may dispense prescriptions** in quantities less than a thirty-one- (31-) day supply*[,]* if *[so]* ordered by the prescriber, except as specified elsewhere in this rule.

(2) *[Drugs and/or categories of medications]* **Prescriptions** that are exempt from the thirty-one- (31-) day supply *[limitation]* **limit** and therefore may be dispensed in quantities exceeding a thirty-one- (31-) day supply are made available in the *[MO HealthNet]* **MHD** Pharmacy Manual*[, section 13.6.D(1)]*. The *[MO HealthNet]* **MHD** Pharmacy Manual is incorporated by reference in this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[at its website http:// manuals.momed.com/manuals/October 2, 2020]* **April 15, 2024**. This rule does not incorporate any subsequent amendments or additions. The division reserves the right to effectuate changes in the list of *[drugs]* **prescriptions** and*[/or]* categories *[of medications that are]* exempt from the thirty-one- (31-) day supply *[limitation]* **limit** by amending this rule.

(3) All spend down participants are exempt from the *[MO HealthNet]* **MHD** thirty-one- (31-) day supply *[maximum restriction]* **limit** on pharmacy services.

(4) Exemptions from the thirty-one- (31-) day supply *[limitation]* **limit** may be given with prior authorization by the *[MO HealthNet Division]* **MHD** to prevent a higher level of care.

(5) *[Drugs and/or categories of medications]* **Prescriptions** identified by 13 CSR 70-20.047 are exempt from the thirty-one- (31-) day supply *[limitation]* **limit**.

AUTHORITY: sections ***[208.153,]*** *208.201[,] and 660.017, RSMo 2016, and section 208.152* ***and 208.153****, RSMo Supp.* ***[2020] 2024****. Emergency rule filed Nov. 21, 2000, effective Dec. 1, 2000, expired May 29, 2001. Original rule filed June 29, 2000, effective Feb. 28, 2001. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Oct. 23, 2024.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 20 – Pharmacy Program

PROPOSED AMENDMENT

13 CSR 70-20.250 Prior Authorization of New Drug Entities or New Drug Dosage Form. The Department of Social Services is amending the purpose and sections (1)–(6).

PURPOSE: This amendment further clarifies and adds more detail to the new drug process.

PURPOSE: This rule outlines ***[the process by which] how*** *new drugs or new drug dosage forms of existing drugs may be subject to prior authorization* ***[prior to] before*** *payment by [Missouri's medical assistance program]* ***MO HealthNet Division (MHD)****.*

(1) New drug entities*[,]* and new drug product dosage forms of existing drug entities*[, that have been approved by the Food and Drug Administration and are available on the market,]* **are eligible to be covered, as defined in 13 CSR 70-20.030, and** shall comply with prior authorization requirements imposed by *[the division]* **MHD**, in compliance with federal law.

(2) Prior authorization *[restrictions]* shall continue on new drug entities and new drug product dosage forms of existing drugs until reviewed by *[the division]* **MHD** and *[the division]* **MHD** eliminates the *[restriction]* **prior authorization** or makes a final determination to require *[restriction. The division]* **continued prior authorization. MHD** shall consider known cost and *[use]* **utilization** data, medical and clinical criteria, and prudent utilization of state funds in the review. Interested parties may present clinical data to *[the division]* **MHD**.

(3) The review referenced in section (2) shall *[occur]* **begin** within thirty (30) business days after *[the division]* **MHD** receives notice through *[pricing updates]* **the weekly national compendia file** of the availability of the drug entity on the market **and if the drug is eligible to be covered as defined in 13 CSR 70-20.030, whichever is later. The review shall take no more than forty-five (45) business days from the start of the review.** Upon completion of the review, *[the division]* **MHD** shall *[make the drug available for use by all MO HealthNet participants]* **remove the prior authorization requirements** or refer the new drug or new drug dosage form to the *[MO HealthNet Drug Utilization Review (DUR) Board]* **Prior Authorization Committee** with a recommendation for continued prior authorization. *[Staff]* **MHD** recommendations

regarding continued prior authorization of a new drug or new drug dosage form shall be made in writing to the *[DUR Board]* **Prior Authorization Committee**. A copy shall be available to the public *[prior to]* **before** the *[DUR Board]* **Prior Authorization Committee** meeting in which the continued prior authorization is to be discussed.

(4) The *[DUR Board]* **Prior Authorization Committee** shall consider any recommendations related to continued prior authorization **requirements** of a new drug or new drug dosage form *[at the next scheduled DUR Board meeting. The division and the DUR Board may actively seek comments about the proposed restrictions]* **no later than one hundred ninety (190) calendar days after the new drug review is completed**. The *[DUR Board]* **Prior Authorization Committee** shall *[include five (5)]* **allow three (3)** minutes for any interested parties who have notified *[the division in advance of]* **MHD before** the scheduled meeting to comment about such proposed *[restrictions]* **prior authorization requirements**.

(5) If the *[DUR Board]* **Prior Authorization Committee** finds that *[use]* **utilization** and cost data, pharmacoeconomic information, *[along with]* **and** medical and clinical implications of restriction*[,]* are documented and *[restriction]* **prior authorization** is warranted, the *[DUR Board]* **Prior Authorization Committee** shall *[hold a public hearing regarding the continued restriction and]* make a recommendation to *[the division]* **MHD**. Such recommendation shall be provided to *[the division, in writing,]* **MHD** prior to *[the division]* **MHD** making a final determination. *[The division]* **MHD** shall provide notice of the final determination through the Department of Social Services, *[MO HealthNet Division]* **MHD** website at *[dss.state.mo.gov/ mhd, provider bulletins, and updates to the provider manual]* **https://mydss.mo.gov/mhd/pharmacy-clinical-edits-pdl**.

(6) If, after the hearing referenced in section (5) above, prior authorization of the new drug or new drug dosage form is required, the prior authorization requirement shall be reviewed at least once every twelve (12) months by the *[DUR Board]* **Prior Authorization Committee**.

AUTHORITY: sections ***[208.153,]*** *208.201[,] and 660.017, RSMo 2016****, and section 208.153, RSMo Supp. 2024****. Emergency rule filed May 22, 2002, effective June 1, 2002, expired Nov. 27, 2002. Original rule filed June 3, 2002, effective Nov. 30, 2002. Amended: Filed Sept. 16, 2013, effective March 30, 2014. Amended: Filed Jan. 20, 2021, effective July 30, 2021. Amended: Filed Oct. 16, 2024.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 70 – MO HealthNet Division
Chapter 20 – Pharmacy Program

PROPOSED AMENDMENT

13 CSR 70-20.300 Retrospective Drug Use Review Process. The department is amending the purpose statement and sections (2), (3), (5), (6), (8), (9), (10), (11)**,** and (12), removing sections (7) and (14), and renumbering accordingly.

PURPOSE: The purpose of this amendment is to simplify language.

PURPOSE: This rule establishes [the division] ***the MO HealthNet Division (MHD)*** *process by which the Drug Utilization Review Board [will be]* ***is*** *established as required by Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990) and by section 208.175, RSMo.*

(2) *[A chairperson shall be elected by the board members]* **The board members shall elect a chairperson**.

(3) The DUR Board shall meet at least once every ninety (90) days. A quorum of two-thirds (2/3) of the total members, including no fewer than three (3) physicians *[or]* **and** three (3) pharmacists, is required for the board to act in its official capacity.

(5) The members of the DUR Board shall receive no compensation for their services other than reasonable expenses *[actually incurred in the performance of]* **incurred in performing** their official duties.

(6) The DUR Board shall hold a public hearing during which *[the MO HealthNet Division]* **MHD** shall make recommendations to the board. *[The hearing shall be prior to any final decision by the division to require prior authorization for that pharmaceutical product, class, or category.]*

[(7) The tentative meeting agenda of the DUR Board with the therapeutic classes to be discussed shall be posted on the MO HealthNet Division website (www.dss.mo.gov/mhd) approximately fourteen (14) days prior but no less than seven (7) days prior to the meeting.

(A) The specific therapeutic class or classes to be considered at the next regularly scheduled DUR Board meeting shall be placed on the current agenda or posted on the website approximately thirty (30) days prior to the scheduled meeting.

(B) Any interested party shall be granted the opportunity for clinically relevant public comment for up to five (5) minutes per medication under review by the DUR Board. The responsibility of scheduling the presentation shall rest with the interested party. Interested parties representing a manufacturer shall be granted five (5) minutes in the aggregate per medication under review by the DUR Board.

(C) Following the consideration of all presented information, the DUR Board may accept or alter the recommendations from the MO HealthNet Division. The board shall make their final recommendation to the MO HealthNet Division by a majority vote of the members of the committee present thereto in a recorded roll call vote.

(D) The specific therapeutic class or classes recommended for restriction by means of step therapy, clinical edit, fiscal edit, or preferred drug list shall be available on the division website at www.dss.mo.gov/mhd approximately fifteen (15) calendar days after the meeting.]

*[(8)]***(7) MHD shall make available** *[A]***a**ny changes recommended by the DUR Board *[shall be made available]* via the approved minutes of the DUR Board meeting in a timely fashion, at least thirty (30) days *[prior to]* **before** the implementation of the recommendations.

*[(9)]***(8)** The DUR Board shall provide, either directly or through contracts between *[the MO HealthNet Division]* **MHD** and accredited health-care schools, state medical societies, or state pharmacist associations or societies**,** or other appropriate organizations, for educational outreach programs as required by P.L. 101-508, Section 4401, to educate practitioners on common drug therapy problems *[with the aim of improving]* **and improve** prescribing and dispensing practices. This outreach shall include an educational newsletter to *[MO HealthNet]* **MHD** providers including appropriate drug use guidelines and *[MO HealthNet]* **MHD** utilization statistics. The board activities shall *[include]* **consist of***[:]*–

(A) Establishment and implementation of medical standards and criteria for the prospective and retrospective DUR program;

(B) Development, selection, application, and assessment of educational interventions for physicians, pharmacists, and participants that improve care; and

(C) Administration of the Drug Prior Authorization Process as outlined in 13 CSR 70-20.200.

*[(10)]***(9)** As specified by P.L. 101-508, Section 4401, the DUR Board shall monitor drug use*[,]* and prescribing and dispensing practices in the *[MO HealthNet]* **MHD** program. This monitoring shall include reviewing and refining therapeutic criteria modules used in *[both]* retrospective and prospective DUR*[, as well as]* **and** overseeing retrospective DUR intervention methods *[used]*.

*[(11)]***(10)** The DUR Board shall advise *[the Department of Social Services]* **MHD** regarding all activities associated with the DUR process, including identifying types of intervention methods *[to be initiated by the review committees,]* ranging from letters to physicians and pharmacists, face-to-face education, and educational symposiums for targeted providers. The board shall provide educational support and guidance as needed by the review committees. The review committees, in turn, shall report intervention results and make recommendations *[based on these results]* to the board **based on these results**.

*[(12)]***(11)** Patterns of inappropriate or aberrant prescribing or dispensing shall be identified and referred to the board *[in order for targeted education to be formulated]* **to formulate targeted education**.

*[(13)]***(12)** Agency Responsibility Regarding Confidentiality of Information. All information concerning applicants and *[MO HealthNet]* **MHD** participants shall be confidential**,** and any disclosure of this information shall be restricted to purposes directly related to the administration of the medical assistance program. Purposes directly related to administration of the medical assistance program include*[:]*–

(A) Establishing eligibility;

(B) Determining the amount of medical assistance;

(C) Providing services for recipients; and

(D) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the program.

[(14) Provider Responsibility Regarding Confidentiality of Information. All information concerning applicants and participants of medical services shall be confidential. Any disclosure of this information shall be restricted to purposes directly related to the treatment of the patient and promotion of improved quality of care. The confidential information includes:

(A) Names and addresses;

(B) Social Security number;

(C) Medical services provided;

(D) Social and economic conditions or circumstances;

(E) Medical data, including diagnosis and past history of disease or disability;

(F) Any information received for verifying income eligibility; and

(G) Any information received in connection with the identification of legally liable third-party resources.]

AUTHORITY: sections ***[208.153,]*** *208.175, 208.201, and 660.017, RSMo 2016****, and section 208.153, RSMo Supp. 2024****. Original rule filed Dec. 14, 1992, effective June 7, 1993. Amended: Filed Sept. 16, 2013, effective March 30, 2014. Amended: Filed Sept. 16, 2020, effective March 30, 2021. Amended: Filed Oct. 23, 2024.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TITLE 15 – ELECTED OFFICIALS
Division 30 – Secretary of State
Chapter 51 – Broker-Dealers, Agents, Investment Advisers, and Investment Adviser Representatives

PROPOSED AMENDMENT

15 CSR 30-51.169 Fraudulent Practices of Broker-Dealers and Agents. The secretary is amending the purpose statement and amending section (1).

PURPOSE: This amendment revises the rule to be in compliance with a federal court order.

PURPOSE: This rule identifies practices in the ***[securities business which] brokerage industry that*** *are generally associated with* ***[schemes to manipulate] acts that deceive and defraud****.*

(1) A broker-dealer or agent who engaged in one (1) or more of the following practices shall be deemed to have engaged in an "act, practice, or course of business which operates or would operate as a fraud" as used in section 409.5-501 of the Missouri Securities Act of 2003 (the Act). This rule is not intended to be all inclusive and acts or practices not enumerated in this rule may also be deemed **deceitful or** fraudulent:

(G) Effecting any transaction in*[,]* or inducing the purchase or sale of any security by means of any manipulative, deceptive**,** or other fraudulent device or contrivance including*[,]* but not

limited to*[,]* the use of boiler-room tactics or use of fictitious or nominee accounts; *[and]*

(H) Failure to comply with any prospectus delivery requirement promulgated under federal law*[.]*; **and**

(I) Effecting any transaction with an investment objective that the customer has not authorized at or prior to the time such transaction is effected.

1. As used in section (1), the following terms mean –

A. "Effecting any transaction" means having effected a discretionary purchase or sale of a security for a retail customer's account; solicited, recommended, or otherwise provided advice to a retail customer to buy or sell a security; or solicited, recommended, or otherwise advised a retail customer regarding the selection of a third-party manager or subadviser to manage the investments in such customer's account;

B. "Retail customer" means any person other than an institutional investor, regardless of whether the person has an account with the broker-dealer;

C. "Institutional investor," the same meaning as under section 409.1-102, RSMo;

D. "Broker-dealer," the same meaning as under section 409.1-102, RSMo; and

E. "Person," the same meaning as under section 409.1-102, RSMo.

2. Nothing in subsection (1)(I) shall require broker-dealers or their agents to create or retain any record memorializing the required customer authorization.

3. If any portion of subsection (1)(I) is adjudicated to be invalid or unenforceable for any reason or in any application, the intent of the commissioner is that this application shall be severable and the remainder of subsection (1)(I) in its other applications shall be enforced.

AUTHORITY: sections 409.2-201, [409.4-412,] 409.5-501 and 409.6-605, RSMo [Supp. 2003] ***2016, and section 409.4-412, RSMo Supp. 2024****. Original rule filed March 27, 1989, effective June 12, 1989. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Oct. 23, 2024, effective Nov. 6, 2024, expires May 4, 2025. Amended: Filed Oct. 23, 2024.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of Secretary of State, PO Box 1767, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TITLE 15 – ELECTED OFFICIALS
Division 30 – Secretary of State
Chapter 51 – Broker-Dealers, Agents, Investment Advisers, and Investment Adviser Representatives

PROPOSED AMENDMENT

15 CSR 30-51.170 Dishonest or Unethical Business Practices by Broker-Dealers and Agents. The secretary is deleting sections (3) and (4).

PURPOSE: This amendment revises the rule to be in compliance with a federal court order.

[(3) Failing to disclose to any customer or prospective customer the following material fact:

(A) If a broker-dealer or agent incorporates a social objective or other nonfinancial objective into a discretionary investment decision to buy or sell a security or commodity for a customer, a recommendation and/or solicitation to a customer for the purchase or sale of a security or commodity, or the selection, or recommendation or advice to a customer regarding the selection, of a third-party manager or subadviser to manage the investments in the customer's account, then such broker-dealer or agent shall disclose to such customer the existence of such incorporation;

(B) As used in this section, the following terms mean:

1. "Agent," the same meaning as under section 409.1-102;

2. "Broker-dealer," the same meaning as under section 409.1-102;

3. "Incorporates a social objective," means the material fact to consider socially responsible criteria in the investment or commitment of customer funds for the purpose of seeking to obtain an effect other than the maximization of financial return to the customer;

4. "Nonfinancial objective," means the material fact to consider criteria in the investment or commitment of customer funds for the purpose of seeking to obtain an effect other than the maximization of financial return to the customer;

5. "Socially responsible criteria," any criterion that is intended to further, or is branded, advertised, or otherwise publicly described by the broker-dealer or agent as furthering, any of the following:

A. International, domestic, or industry agreements relating to environmental or social goals;

B. Corporate governance structures based on social characteristics; or

C. Social or environmental goals;

(C) The disclosure obligation under subsection (3)(A) is satisfied by providing clear and conspicuous prior disclosure and obtaining written acknowledgment and consent from the customer. Written consent shall be obtained either—

1. At the establishment of the brokerage relationship; or

2. Prior to—

A. Effecting the initial discretionary investment for the customer's account;

B. Providing the initial recommendation, advice, or solicitation regarding the purchase or sale of a security or commodity in a customer's account; or

C. Selecting, or recommending or advising on the selection of, a third-party manager or subadvisor to manage the investments in a customer's account;

3. Such disclosure, thereafter, shall be provided to the customer on an annual basis and, no less than every three (3) years, consented in writing by the customer; and

(D) Written consent required under subsection (3)(C) shall contain language that is substantially similar to the following:

"I, [NAME OF CUSTOMER], consent to my [as applicable, NAME OF BROKER-DEALER OR AGENT] incorporating a social objective or other nonfinancial objective into any discretionary investment decision my [as applicable, broker-dealer or agent] makes for my account; any recommendation, advice, or solicitation my [as applicable, broker-dealer or

agent] makes to me for the purchase or sale of a security or commodity; or the selection my [as applicable, broker-dealer or agent] makes, or recommendation or advice my [as applicable, broker-dealer or agent] makes to me regarding the selection of, a third-party manager or subadviser to manage the investments in my account. Also, I acknowledge and understand that incorporating a social objective or other nonfinancial objective into discretionary investment decisions, recommendations, advice, and/or the selection of a third-party manager or subadviser to manage the investments, in regards to my account, will result in investments and recommendations/ advice that are not solely focused on maximizing a financial return for me or my account."

(4) The conduct set forth above is not inclusive. Engaging in other conduct such as nondisclosure or incomplete disclosure of material fact or other deceptive practices are dishonest or unethical business practices.]

AUTHORITY: section 409.6-605, RSMo 2016. Original rule filed June 25, 1968, effective Aug. 1, 1968. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 23, 2024, effective Nov. 6, 2024, expires May 4, 2024. Amended: Filed Oct. 23, 2024.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of Secretary of State, PO Box 1767, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TITLE 15 – ELECTED OFFICIALS
Division 30 – Secretary of State
Chapter 51 – Broker-Dealers, Agents, Investment Advisers, and Investment Adviser Representatives

PROPOSED AMENDMENT

15 CSR 30-51.172 Dishonest or Unethical Business Practices by Investment Advisers and Investment Adviser Representatives. The secretary is deleting sections (3) and renumbering as necessary.

PURPOSE: This amendment revises the rule to be in compliance with a federal court order.

[(3) Failing to disclose to any client or prospective client the following material fact:

(A) If an investment adviser or investment adviser representative incorporates a social objective or other nonfinancial objective into a discretionary investment decision to buy or sell a security or commodity for a client, advice or a recommendation to a client for the purchase or sale of a security or commodity, or the selection, or advice or a recommendation to a client regarding the selection, of a third-party manager or subadviser to manage the investments in the client's account, then such investment adviser or investment adviser representative shall disclose to such client the existence of such incorporation;

(B) As used in this section, the following terms mean:

1. "Incorporates a social objective," means the material fact to consider socially responsible criteria in the investment or commitment of client funds for the purpose of seeking to obtain an effect other than the maximization of financial return to the client;

2. "Investment adviser," the same meaning as under section 409.1-102;

3. "Investment adviser representative," the same meaning as under section 409.1-102;

4. "Nonfinancial objective," means the material fact to consider criteria in the investment or commitment of client funds for the purpose of seeking to obtain an effect other than the maximization of financial return to the client;

5. "Socially responsible criteria," any criterion that is intended to further, or is branded, advertised, or otherwise publicly described by the investment adviser or investment adviser representative as furthering, any of the following:

A. International, domestic, or industry agreements relating to environmental or social goals;

B. Corporate governance structures based on social characteristics; or

C. Social or environmental goals;

(C) The disclosure obligation under subsection (3)(A) is satisfied by providing clear and conspicuous prior disclosure and obtaining written acknowledgment and consent from the client. Written consent shall be obtained either—

1. At the establishment of the advisory relationship; or

2. Prior to—

A. Effecting the initial discretionary investment for the client's account;

B. Providing the initial recommendation or advice regarding the purchase or sale of a security or commodity in a client's account; or

C. Selecting, or recommending or advising on the selection of, a third-party manager or subadviser to manage the investments in a client's account;

3. Such disclosure, thereafter, shall be provided to the client on an annual basis and, no less than every three (3) years, consented in writing by the client; and

(D) Written consent required in subsection (3)(C) shall contain language that is substantially similar to the following:

"I, [NAME OF CLIENT], consent to my [as applicable, NAME OF INVESTMENT ADVISER OR INVESTMENT ADVISER REPRESENTATIVE] incorporating a social objective or other nonfinancial objective into any discretionary investment decision my [as applicable, investment adviser or investment adviser representative] makes for my account; any recommendation or advice my [as applicable, investment adviser or investment adviser representative] makes to me for the purchase or sale of a security or commodity; or the selection my [as applicable, investment adviser or investment adviser representative] makes, or recommendation or advice my [as applicable, investment adviser or investment adviser representative] makes to me regarding the selection of, a third-party manager or subadviser to manage the investments in my account. Also, I acknowledge and understand that incorporating a social objective or other nonfinancial objective into discretionary investment decisions, recommendations, advice, and/or the selection of a third-party manager or subadviser to manage the investments, in regards to my account, will result in investments and recommendations/ advice that are not solely focused on maximizing a financial

return for me or my account."]

*[(4)]***(3)** The conduct set forth above is not inclusive. Engaging in other conduct such as nondisclosure or incomplete disclosure of material fact or other deceptive practices are dishonest or unethical business practices.

AUTHORITY: section 409.6-605, RSMo 2016. Original rule filed April 8, 2004, effective Oct. 30, 2004. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 23, 2024, effective Nov. 6, 2024, expires May 4, 2025. Amended: Filed Oct. 23, 2024.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of Secretary of State, PO Box 1767, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TITLE 15 – ELECTED OFFICIALS
Division 30 – Secretary of State
Chapter 51 – Broker-Dealers, Agents, Investment Advisers, and Investment Adviser Representatives

PROPOSED RULE

15 CSR 30-51.174 Fraudulent Practices of Investment Advisers and Investment Adviser Representatives

PURPOSE: This rule identifies practices in the investment adviser industry that are generally associated with acts that deceive and defraud.

(1) An investment adviser or investment adviser representative who has engaged in one (1) or more of the following practices shall be deemed to have engaged in fraud in connection with the offer, sale, or purchase of a security, directly or indirectly, in violation of section 490.5-501 of the Missouri Securities Act of 2003 (the "Act") and to have engaged in an "act, practice, or course of business which operates or would operate as a fraud" as used in section 409.5-502 of the Act. Each provision of this rule is intended to be severable. This rule is not intended to be all-inclusive and acts or practices not enumerated in this rule may also be deemed deceitful or fraudulent:

(A) Effecting any transaction with an investment objective that the client has not authorized at or prior to the time such transaction is affected.

1. As used in section (1), the following terms mean –

A. "Effecting any transaction" means having effected a discretionary purchase or sale of a security for a retail client's account; solicited, recommended, or otherwise provided advice to a retail client to buy or sell a security; or solicited, recommended, or otherwise advised a retail client regarding the selection of a third-party manager or subadvisor to manage the investments in such client's account;

B. "Retail client" means any person other than an institutional investor, regardless of whether the person has an account with the investment adviser;

C. "Institutional investor," the same meaning as under section 409.1-102, RSMo;

D. "Investment adviser," the same meaning as under section 409.1-102, RSMo; and

E. "Person," the same meaning as under section 409.1-102, RSMo.

2. If any portion of subsection (1)(A) is adjudicated to be invalid or unenforceable for any reason or in any application, the intent of the commissioner is that this application shall be severable and the remainder of subsection (1)(A) in its other applications shall be enforced.

AUTHORITY: section 409.6-605, RSMo 2016, and section 409.4-412(d)(9), RSMo Supp. 2024. Emergency rule filed Oct. 23, 2024, effective Nov. 6, 2024, expires May 4, 2025. Original rule filed Oct. 23, 2024.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Office of Secretary of State, PO Box 1767, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2110 – Missouri Dental Board
Chapter 2 – General Rules

PROPOSED AMENDMENT

20 CSR 2110-2.010 Licensure by Examination – Dentists. The board is amending sections (2) and (3).

PURPOSE: This proposed amendment clarifies when an applicant for licensure who fails a clinical competency exam may need remediation and creates a requirement that applicants undergo a criminal background check to qualify for licensure.

(2) To apply for a certificate of registration and a license to practice, each applicant shall submit the following:

(A) A completed application form provided by the board; *[and]*

(B) A nonrefundable application/examination fee payable to the Missouri Dental Board; *[and]*

(C) A two-inch by three-inch (2" × 3") photograph or passport photograph taken no more than six (6) months prior to the application date; *[and]*

(D) An official copy of his/her educational transcript from an accredited dental school as defined in **section** 332.011, RSMo. Transcripts must be sent directly to the board from the accredited dental school; *[and]*

(E) A copy of his/her current certification in the American Heart Association's Basic Life Support for the Healthcare Provider (BLS) or an equivalent certification approved by the

Missouri Dental Board; *[and]*

(F) Certification of passage of the National Board Examination sent directly to the board from the sponsoring body; *[and]*

(G) A copy of his/her competency examination scores sent directly to the board from the testing agent(s); *[and]*

(H) A form provided by the board verifying licensure in other state(s), if applicable. Verification forms must be sent directly to the board from the licensure board(s) from which the applicant currently holds or has ever held a dental license; *[and]*

(I) A completed Missouri State Highway Patrol and Federal Bureau of Investigation fingerprint background check. Proof shall consist of any documentation acceptable to the board. Any fees due shall be paid by the applicant directly to the Missouri State Highway Patrol or its approved vendor; and

*[(I)]***(J)** Each application form and documentation must be completed within one (1) year from the date of submission to the board, including the taking and passing of the jurisprudence examination. If not completed within one (1) year, an application becomes invalid and a new application process must begin.

(3) Should an applicant fail **any individual section of** a clinical competency examination twice, the board may require the applicant to complete remedial instruction in the deficient area(s) from an accredited dental school before further re-examination. **After failing an individual section of a clinical competency examination twice, the candidate/applicant shall contact the board for permission to take the examination again.** If the applicant fails a third examination, the board may deny the application pursuant to section 332.321.2(5), RSMo. Before entering a program of remedial instruction, the applicant shall –

*AUTHORITY: sections 332.031, 332.141, **and** 332.151, [and 332.181,] RSMo 2016**, and sections 43.543 and 332.181, RSMo Supp. 2024**. This rule originally filed as 4 CSR 110-2.010. Original rule filed Dec. 12, 1975, effective Jan. 12, 1976. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 1, 2024.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Dental Board, PO Box 1367, Jefferson City, MO 65102, by facsimile at (573) 751-8216, or via email at dental@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2110 – Missouri Dental Board
Chapter 2 – General Rules

PROPOSED AMENDMENT

20 CSR 2110-2.050 Licensure by Examination – Dental Hygienists. The board is amending section (2).

PURPOSE: This proposed amendment creates a requirement that applicants undergo a criminal background check to qualify for licensure.

(2) To apply for a certificate of registration and a license to practice, each applicant shall submit the following:

(H) A form provided by the board verifying licensure in other state(s), if applicable. Verification forms must be sent directly to the board from the licensure board(s) from which the applicant currently holds or has ever held a dental hygiene license; *[and]*

(I) A completed Missouri State Highway Patrol and Federal Bureau of Investigation fingerprint background check. Proof shall consist of any documentation acceptable to the board. Any fees due shall be paid by the applicant directly to the Missouri State Highway Patrol or its approved vendor; and

*[(I)]***(J)** Each application must be completed within one (1) year from the date of submission to the board, including the taking and passing of the jurisprudence examination. If not completed within one (1) year, an application becomes invalid and a new application process must begin.

*AUTHORITY: sections 332.031, 332.241, and 332.261, RSMo 2016, and sections **43.543,** 332.231**,** and 332.251, RSMo Supp. **[2022] 2024**. This rule originally filed as 4 CSR 110-2.050. Original rule filed Dec. 12, 1975, effective Jan. 12, 1976. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 1, 2024.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Dental Board, PO Box 1367, Jefferson City, MO 65102, by facsimile at (573) 751-8216, or via email at dental@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2110 – Missouri Dental Board
Chapter 2 – General Rules

PROPOSED AMENDMENT

20 CSR 2110-2.170 Fees. The board is amending section (1).

PURPOSE: This amendment adds language regarding a fingerprint fee and removes outdated language.

(1) The following fees are established by the Missouri Dental Board:

(C) Biennial License Renewal Fee

1. Dentist License $150

[A. Effective September 1, 2018 to August 31, 2020	*$100]*
2. Dental Specialist License	$150
[A. Effective September 1, 2018 to August 31, 2020	*$100]*
3. Dental Hygienist License	$ 60
4. Limited Teaching License	$250
(F) Miscellaneous Fees	
1. Corporation Name Approval	$ 15
2. Verification of Licensure – Dentist/Dental Specialist/Dental Hygienist	$ 20
3. Duplicate Original Certificate	$ 50
4. Duplicate Renewal License (over two (2) per duplicate)	$ 5
5. Uncollected Fee (for any uncollectible check or other uncollectible financial instrument)	$ 25
6. Fingerprinting Fee (amount determined by the Missouri State Highway Patrol)	

*AUTHORITY: section 332.031, RSMo 2016, and section**s 43.543 and** 332.183, RSMo Supp. **[2020] 2024**. This rule originally filed as 4 CSR 110-2.170. Emergency rule filed June 30, 1981, effective July 9, 1981, expired Nov. 6, 1981. Original rule filed June 30, 1981, effective Oct. 11, 1981. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 1, 2024.*

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

PRIVATE COST: This proposed amendment will cost private entities approximately twenty-six thousand eight hundred fifty dollars ($26,850) annually for the life of the rule.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Dental Board, PO Box 1367, Jefferson City, MO 65102, by facsimile at (573) 751-8216, or via email at dental@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

PRIVATE FISCAL NOTE

I. RULE NUMBER

TITLE 20—Department of Commerce and Insurance
Division 2110—Missouri Dental Board
Chapter 2—General Rules
Proposed Amendment to 20 CSR 2110-2.170 Fees

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated costs for the life of the rule by affected entities:
300	Fingerprint Background Check - Dentists (Fee Increase @ $44.75)	$13,425
300	Fingerprint Background Check - Dental Hygienists (Fee Increase @ $44.75)	$13,425
	Estimated Cost Beginning in FY25 and Annually Thereafter	**$26,850**

III. WORKSHEET

See Table Above

IV. ASSUMPTION

1. The fee due for fingerprint background checks shall be paid by the applicant directly to the Missouri State Highway Patrol or its approved vendor. The Missouri State Highway Patrol retains $20 of the $44.75 fee.
2. Actual cost may vary based on the number of applications received.
3. Applicants may incur minimal travel expenses to have fingerprints taken. However, travel expenses are not being calculated in this fiscal note due to the various geographic locations of the applicants and the distance they will need to travel that we cannot determine.
4. It is anticipated that the total costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment clarifies enrollment procedures when an eligible dependent loses MO HealthNet or Medicaid status and when a member becomes Medicare eligible.

(3) Enrollment Procedures.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents or spouse/child(ren) at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date even if the retiree is continuing coverage as a variable-hour employee after retirement. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; ***[or]***

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends***[.]*****; or**

C. If a retiree subscriber's eligible dependent loses MO HealthNet or Medicaid status, the retiree may enroll the eligible dependent within sixty (60) days of the date of loss.

3. If coverage was not maintained while on disability, the employee may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment, but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A retiree enrolled in the Medicare Advantage Plan may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

6. Default enrollment.

A. A retiree with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the retiree or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the retiree is not able to be enrolled in the Medicare Advantage Plan, the retiree and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year at the same level of coverage.

B. If a retiree with Medicare has a non-Medicare dependent enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

C. If a retiree without Medicare is enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

D. If a retiree without Medicare is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage, effective the first day of the next calendar year.

7. If a retiree is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

8. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; ***[or]***

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employ-

er-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends*[.]***; or**

C. If a terminated vested subscriber's eligible dependent loses MO HealthNet or Medicaid status, the terminated vested subscriber may enroll the eligible dependent within sixty (60) days of the date of loss.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A terminated vested member enrolled in the Medicare Advantage Plan may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

4. Default enrollment.

A. A terminated vested subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the terminated vested subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the terminated vested subscriber is not able to be enrolled in the Medicare Advantage Plan, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

B. If a terminated vested subscriber without Medicare is enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

C. If a terminated vested subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

D. If a terminated vested subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; *[or]*

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends*[.]***; or**

C. If a long-term disability subscriber's eligible dependent loses MO HealthNet or Medicaid status, the long-term disability subscriber may enroll the eligible dependent within sixty (60) days of the date of loss.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A long-term disability member enrolled in the Medicare Advantage Plan may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

4. Default enrollment.

A. A long-term disability subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the long-term disability subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the long-term disability subscriber is not able to be enrolled in the Medicare Advantage Plan, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

B. If a long-term disability subscriber without Medicare is enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

C. If a long-term disability subscriber with Medicare has a non-Medicare dependent enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

D. If a long-term disability subscriber without Medicare

is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

E. If a long-term disability subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor without Medicare must submit a survivor enrollment form within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor with Medicare will be automatically enrolled as a survivor following the death of the employee.

3. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; *[or]*

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends*[.]*; **or**

C. If a survivor's eligible dependent loses MO HealthNet or Medicaid status, the survivor may enroll the eligible dependent within sixty (60) days of the date of loss.

4. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A survivor enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;

B. Eligible for Medicaid nursing home coverage, also known as "vendor coverage"; and

C. Not a Qualified Medicare Beneficiary.

6. Default enrollment.

A. A survivor with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the survivor or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the survivor is not able to be enrolled in the Medicare Advantage Plan, the survivor and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

B. If a survivor without Medicare is enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

C. If a survivor with Medicare has a non-Medicare dependent enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.

D. If a survivor without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

E. If a survivor is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(F) Medicare.

1. When a member becomes eligible for Medicare, the member must notify MCHCP pursuant to 22 CSR 10-2.020(12).

2. Non-active employee subscribers will be charged the Medicare Advantage Plan premium the first month after the member's Medicare Beneficiary Identifier (MBI) number is received by MCHCP.

3. If a member does not enroll in Medicare Part A when eligible, the member shall continue to be charged the premium for the plan in which they are enrolled and will not receive the Medicare premium until proof of enrollment in the form of the MBI number is received by MCHCP. If a member enrolls in Part A but does not enroll in part B, the member will be charged the Medicare premium but will be responsible for the charges Medicare Part B would have paid on a claim. This amount will not be added to the annual deductible or out-of-pocket accumulations.

4. Once MCHCP receives the MBI number and the member is not an active employee, they will be transferred to

the Medicare Advantage Plan defined in 22 CSR 10-2.088.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.025 Rule for Participating Higher Education Entity Entry into the Missouri Consolidated Health Care Plan. The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

PURPOSE: This amendment revises the time frame for Participating Higher Education Entities (PHEE) to provide their letter of intent to join the plan and clarifies eligibility requirements for PHEEs that choose to cover retirees.

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

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

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

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

(B) If the PHEE chooses to cover retirees, they shall provide to MCHCP appropriate documentation of initial and ongoing eligibility. Once provided by the PHEE, the retirees of the PHEE submitted shall be included in the term retiree used throughout this chapter.

AUTHORITY: section 103.059, RSMo 2016. Original rule filed Oct. 28, 2016, effective May 30, 2017. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.

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

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (11) and (15).

PURPOSE: This amendment clarifies how non-network plan payments are processed and revises language regarding members who are eligible for Medicare.

(11) *[Maximum]* **Non-network** plan payment – non-network medical claims *[that are not otherwise subject to a contractual discount arrangement]* are processed *[at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* following the claim administrator's *[standard]* practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

(15) Medicare.

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

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

*[(C)]***(A)** If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if,

for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (11) and (15).

PURPOSE: This amendment clarifies how non-network plan payments are processed and revises language regarding members who are eligible for Medicare.

(11) *[Maximum]* **Non-network** plan payment – non-network medical claims *[that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* **are processed** following the claim administrator's *[standard]* practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

(15) Medicare.

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

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

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (10), (17), and (24).

PURPOSE: This amendment revises coverage of virtual visits, non-network payments, and the timing of other deposits to health savings accounts and adds the right of MCHCP to recoup deposits members are not entitled to.

(10) Virtual visits offered through the vendor's telehealth tool are covered at one hundred percent (100%) **after deductible is met unless Internal Revenue Service (IRS) guidance permits it to be paid at one hundred percent (100%) prior to deductible being met**.

(17) *[Maximum]* **Non-network** plan payment – *[N]***n**on-network medical claims *[that are not otherwise subject to a contractual discount arrangement]* are processed *[at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* following the claims administrator's *[standard]* practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed

amount.

(24) Health Savings Account (HSA) Contributions.

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

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

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

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

Deposit	Subscriber only	All other coverage levels
January	$500	$1,000
April (delayed contribution due to health care FSA grace period)	$500	$1,000
All others	A proration of $500	A proration of $1,000

(G) If a subscriber receives a deposit they are not entitled to, MCHCP reserves the right to recoup the deposit.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This amendment revises the availability of transition of care and coverage of eyeglasses and contact lenses.

(2) Transition of *[Care. A transition of care option is available for members who seek to continue to remain under the care of a non-network provider who was treating them prior to the provider losing network status. A subscriber and his/her dependents may request to continue receiving care at the network benefit level. If approved, the member will be eligible to continue care with the current non-network provider at the network benefit level for a period of time until it is medically appropriate for the member to transfer care to a network provider. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. The following benefits are eligible for transition of care as determined by the claims administrator:*

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their third trimester of pregnancy;

(C) Radiation therapy;

(D) Dialysis;

(E) Cancer treatment;

(F) Physical, speech, or occupational therapy;

(G) Hospice care;

(H) Inpatient hospitalization at the time of the network change; or

(I) Mental health services.] **care is available in accordance with federal and state law when a provider loses network status.**

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250 Plan, and HSA Plan.

(D) Plan benefits for the PPO 750 Plan, PPO 1250 Plan, and HSA Plan are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms;

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

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

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

3. Applied behavior analysis (ABA) for autism;

4. Bariatric surgery;

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

6. Bone growth stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit;

7. Contraception and sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

8. Cardiac rehabilitation;

9. Chelation therapy;

10. Chiropractic services – manipulation and adjunct therapeutic procedures/modalities;

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

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

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condi-

tion means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted;

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

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

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

(I) National Institutes of Health (NIH);

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

(III) Agency for Health Care Research and Quality;

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

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

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

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

12. Cochlear implant and auditory brainstem implant;

13. Cryopreservation cycles.

A. Oocyte cryopreservation cycles including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes).

B. Sperm cryopreservation including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes);

14. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. Treatment must be initiated within sixty (60) days of accident; and

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

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

15. Diabetes self-management education;

16. Dialysis is covered when received through a network provider;

17. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

18. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit;

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

A. Post cataract surgery. Coverage is limited to charges incurred in connection with the fitting of eyeglasses or contact lenses for initial placement within one (1) year post cataract surgery.

B. Covered if medically necessary for conditions caused by aphakia, keratoconus, or injury;

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

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

(I) Diabetes mellitus;

(II) Peripheral vascular disease;

(III) Peripheral neuropathy; or

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

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

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

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

22. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following

criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

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

24. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

25. Hearing aids (per ear). Hearing aids covered once every two (2) years for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

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

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

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

D. Bone anchoring hearing aid (BAHA): three thousand five hundred dollars ($3,500);

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

27. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include –

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as –

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

28. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill;

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

A. The following benefits are covered:

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

(II) Intensive care unit room and board;

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

(a) Cornea transplant;

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

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

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

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

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

(IV) Inpatient mental health services; and

(V) Outpatient mental health services;

30. Infertility coverage for members with a diagnosis of infertility, including in vitro fertilization (IVF) oocyte retrievals limited to two (2) cycles as a lifetime maximum, per member;

31. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

32. Injections. See preventive services for coverage of vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

33. Lab, x-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

34. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recom-

mended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to applicable copayments, deductible, and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

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

36. Nutrition therapy;

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

38. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

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

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

B. Tumors and cysts, cancer, and post-surgical sequela;

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

D. Physical abnormality;

40. Orthotics.

A. Ankle-foot orthosis (AFO) and knee-ankle-foot orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO not used during ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast boot, post-operative sandal or shoe, or healing shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial orthoses. Cranial orthosis is covered for synostotic and non-synostotic plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic plagiocephaly is due to premature closure of cranial sutures. Non-synostotic plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear incorporated into a brace for members with skeletally mature feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot orthoses. Custom, removable foot orthoses are covered.

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

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

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

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

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

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

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

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

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

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

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

J. Orthopedic footwear for diabetic members.

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

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

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

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

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

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41. Preventive services.

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

B. Vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other preventive services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified –

(I) Mammograms – no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears – no age limit;

(III) Prostate – no age limit; and

(IV) Colorectal screening – no age limit.

G. Digital diabetes prevention program offered through the plan's claims administrator.

H. The following services permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan:

(I) Blood pressure monitors for individuals diagnosed with hypertension;

(II) Retinopathy screenings for individuals diagnosed with diabetes;

(III) Hemoglobin A1c (HbA1c) testing for individuals diagnosed with diabetes;

(IV) Peak flow meters for individuals diagnosed with asthma; and

(V) International normalized ratio (INR) testing for individuals diagnosed with liver disease and/or bleeding disorders;

42. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

43. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis,

myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

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

45. Telehealth services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

46. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver-provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

47. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s') travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging – maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel – IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals – not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

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

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment adds an occurrence in which MCHCP may allow one (1) additional reinstatement and revises the time frame in which MCHCP may approve an appeal where a subscriber missed a deadline.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. Decisions concerning eligibility for Medicare primary members may not be able to be granted pursuant to these guidelines if the decision is contrary to the rules controlling eligibility for Medicare Advantage plan as put forth by Centers for Medicare and Medicaid. Valid proof of eligibility must be included with the appeal if the enrollment request includes addition of dependent(s). Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account**. MCHCP may allow one (1) additional reinstatement if the subscriber submits an automatic withdrawal authorization or authorizes in writing that payment shall be deducted from their MOSERS retirement benefit**;

(K) Once *[per lifetime of the]* **every five (5) years per** account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancelation or an appeal of a deadline that is statutorily mandated.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment revises Medicare Part D coverage stages and amounts.

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

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

1. The Centers for Medicare & Medicaid Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial coverage stage. Until a member's total yearly Part D prescription drug costs reach *[five thousand thirty dollars ($5,030)]* **two thousand dollars ($2,000)**, the member will pay the following copayments:

A. Preferred formulary generic drugs: thirty-one- (31-) day supply has a ten dollar ($10) copayment; sixty- (60-) day supply has a twenty dollar ($20) copayment; ninety- (90-) day supply at retail has a thirty dollar ($30) copayment; and a ninety- (90-) day supply through home delivery has a twenty-five dollar ($25) copayment;

B. Preferred formulary brand drugs: thirty-one- (31) day supply has a forty dollar ($40) copayment; sixty- (60-) day supply has an eighty dollar ($80) copayment; ninety- (90) day supply at retail has a one hundred twenty dollar ($120) copayment; and a ninety- (90-) day supply through home delivery has a one hundred dollar ($100) copayment; and

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

[3.Coverage gap stage. After a member's total yearly Part D prescription drug costs exceed five thousand thirty dollars ($5,030) and remain below eight thousand dollars ($8,000), the member will continue to pay the same cost-sharing amount as in the initial coverage stage until the yearly out-of-pocket Part D prescription drug costs reach eight thousand dollars ($8,000);]

*[4.]***3.** Catastrophic coverage stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[eight thousand dollars ($8,000)]* **two thousand dollars ($2,000)**, the member will pay zero dollars ($0); and

*[5.]***4.** Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment corrects the omission of the maximum amount Health Savings Account members will pay for non-preferred formulary drugs and approved excluded drugs.

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

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

1. Network:

A. Preferred formulary generic drug: ten percent (10%) coinsurance up to fifty dollars ($50) per thirty-one- (31-) day supply after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: twenty percent (20%) coinsurance up to one hundred dollars ($100) per thirty-one- (31-) day supply after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: forty percent (40%) coinsurance **up to two hundred dollars ($200)** after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance, not to exceed:

(I) Twenty-five dollars ($25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars ($50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars ($100) per thirty-one- (31-) day supply for non-preferred formulary drug;

E. Ninety- (90-) day supply of prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program or at select retail pharmacies, as designated by the PBM;

F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program.

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

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

G. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy;

H. Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are covered at one hundred percent (100%) when filled at a network pharmacy;

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

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

(II) One (1) preferred glucometer;

J. If any ingredient in a compound drug is excluded by the plan, the compound will be denied; and

K. Drugs permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan are not subject to the deductible when filled at a network pharmacy. Applicable coinsurance will apply.

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

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

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

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

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed

Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.120 Partnership Incentive Provisions and Limitations. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment revises the requirements to participate in the incentive.

(5) Participation.

(A) In order to receive the Partnership Incentive, eligible members must complete *[all of the following]* **MCHCP's health assessment** every plan year for the incentive to be effective the first day of the second month after the requirements are completed*[:]***.**

[1. The Partnership Promise;

2. The Health Assessment; and

3. The Health Education Quiz. A series of questions administered by MCHCP designed to measure understanding of MCHCP benefits and/or general health knowledge.]

(C) Eligible members adding medical coverage must complete *[all of the following]* **MCHCP's health assessment** within thirty-one (31) days of his/her medical coverage effective date (unless otherwise specified) for the incentive to be effective the first day his/her medical coverage is effective*[:]***.**

[1. The Partnership Promise;

2. The Health Assessment; and

3. The Health Education Quiz.]

(F) Eligible members who have earned the incentive may earn a *de minimis* gift for completing one (1) or more *[of the following]* MCHCP-approved health actions. An eligible member must report the completion of the health action to MCHCP by December 31 of each plan year, and may receive only one (1) gift per year. *[MCHCP-approved health actions are as follows:*

1. Receiving a preventive lab screening such as cholesterol and blood sugar;

2. Receiving an annual preventive exam;

3. Attending three (3) Strive for Wellness® sponsored health education or physical activity events;

4. Participating in physical activity such as walking, jogging, Zumba, yoga, or weight-training for one hundred fifty (150) minutes each week for three (3) months;

5. Standing for at least two (2) hours during each workday for three (3) months; or

6. Walking one (1) million steps.]

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Oct. 25, 2024.*

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

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

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

TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

PROPOSED AMENDMENT

22 CSR 10-2.140 Strive for Wellness® Health Center Provisions, Charges, and Services. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment revises eligibility for the Strive for Wellness® Health Center.

(1) Eligibility. *[Members]* **Subscribers and their dependents** aged eighteen (18) years and older **enrolled in MCHCP medical coverage** shall be eligible for and able to access the services available at the health center as described in this rule.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments

*must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment clarifies enrollment procedures when an eligible dependent loses MOHealthNet status.

(3) Enrollment Procedures.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a separate group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; *[or]*

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances, and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends*[.]***; or**

C. If a retiree subscriber's eligible dependent loses MO HealthNet or Medicaid status, the retiree may enroll the eligible dependent within sixty (60) days of the date of loss.

3. If coverage was not maintained while on disability, the employee and his/her dependents may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

6. If a retiree is enrolled and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the retiree and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; *[or]*

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends*[.]***; or**

C. If a terminated vested subscriber's eligible dependent loses MO HealthNet or Medicaid status, the terminated vested subscriber may enroll the eligible dependent within sixty (60) days of the date of loss.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a terminated vested subscriber is enrolled and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers

two (2) plan options, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; *[or]*

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends*[.]***; or**

C. If a long-term disability subscriber's eligible dependent loses MO HealthNet or Medicaid status, the long-term disability subscriber may enroll the eligible dependent within sixty (60) days of the date of loss.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a long-term disability subscriber is enrolled and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(E) Survivor Coverage.

1. A survivor must submit a form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; *[or]*

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends*[.]***; or**

C. If a survivor's eligible dependent loses MO HealthNet or Medicaid status, the survivor may enroll the eligible dependent within sixty (60) days of the date of loss.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

5. If a survivor is enrolled and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the survivor and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box

*104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (10) and (16).

PURPOSE: This amendment revises coverage of virtual visits and non-network payments.

(10) Virtual visits offered through the vendor's telehealth tool are covered at one hundred percent (100%) **after deductible is met unless Internal Revenue Service (IRS) guidance permits it to be paid at one hundred percent (100%) prior to deductible being met**.

(16) *[Maximum]* **Non-network** plan payment – *[N]***n**on-network medical claims that are not otherwise subject to a contractual discount arrangement are processed *[at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* following the claims administrator's *[standard]* practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

*AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This amendment revised the availability of transition of care and coverage of eyeglasses and contact lenses.

[(2) Transition of Care. A transition of care option is available for members who seek to continue to remain under the care of a non-network provider who was treating them prior to the provider losing network status. A subscriber and his/her dependents may request to continue receiving care at the network benefit level. If approved, the member will be eligible to continue care with the current non-network provider at the network benefit level for a period of time until it is medically appropriate for the member to transfer care to a network provider. The rate of payment during the transitional period shall be the fee paid prior to leaving the network. The following benefits are eligible for transition of care as determined by the claims administrator:

(A) Upcoming surgery or prospective transplant;
(B) Services for women in their third trimester of pregnancy;
(C) Radiation therapy;
(D) Dialysis;
(E) Cancer treatment;
(F) Physical, speech, or occupational therapy;
(G) Hospice care;
(H) Inpatient hospitalization at the time of the network change; or
(I) Mental health services.]

(2) Transition of care is available in accordance with federal and state law when a provider loses network status.

(3) Covered Charges Applicable to the PPO 750 Plan, PPO 1250 Plan, and HSA Plan.

(D) Plan benefits for the PPO 750 Plan, PPO 1250 Plan, and HSA Plan are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms;

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

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

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

3. Applied behavior analysis (ABA) for autism;

4. Bariatric surgery;

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

6. Bone growth stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit;

7. Contraception and sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

8. Cardiac rehabilitation;

9. Chelation therapy;

10. Chiropractic services – manipulation and adjunct therapeutic procedures/modalities;

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

when –

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

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

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

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

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

(I) National Institutes of Health (NIH);

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

(III) Agency for Health Care Research and Quality;

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

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

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

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

12. Cochlear implant and auditory brainstem implant;

13. Cryopreservation cycles.

A. Oocyte cryopreservation cycles including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes).

B. Sperm cryopreservation including one (1) year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes);

14. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. Treatment must be initiated within sixty (60) days of accident; and

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

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

15. Diabetes self-management education;

16. Dialysis is covered when received through a network provider;

17. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes but is not limited to the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

18. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit;

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

A. Post cataract surgery. Coverage is limited to charges incurred in connection with the fitting of eyeglasses or contact lenses for initial placement within one (1) year post cataract surgery; or

B. Covered if medically necessary for conditions caused by aphakia, keratoconus, or injury;

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

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

(I) Diabetes mellitus;

(II) Peripheral vascular disease;

(III) Peripheral neuropathy; or

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

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

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

21. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic

counselor are covered when a member is recommended for covered heritable genetic testing;

22. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

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

24. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

25. Hearing aids (per ear). Hearing aids covered once every two (2) years for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

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

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

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

D. Bone anchoring hearing aid (BAHA): three thousand five hundred dollars ($3,500);

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

27. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include –

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as –

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

28. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill;

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

A. The following benefits are covered:

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

(II) Intensive care unit room and board;

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

(a) Cornea transplant;

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

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

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

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

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

(IV) Inpatient mental health services; and

(V) Outpatient mental health services;

30. Infertility coverage for members with a diagnosis of infertility, including in vitro fertilization (IVF) oocyte retrievals limited to two (2) cycles as a lifetime maximum, per member;

31. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

32. Injections. See preventive services for coverage of vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

33. Lab, x-ray, and other diagnostic procedures. Outpatient

diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

34. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to applicable copayments, deductible, and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

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

36. Nutrition therapy;

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

38. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

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

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

B. Tumors and cysts, cancer, and post-surgical sequela;

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

D. Physical abnormality;

40. Orthotics.

A. Ankle-foot orthosis (AFO) and knee-ankle-foot orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO not used during ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast boot, post-operative sandal or shoe, or healing shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial orthoses. Cranial orthosis is covered for synostotic and non-synostotic plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic plagiocephaly is due to premature closure of cranial sutures. Non-synostotic plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear incorporated into a brace for members with skeletally mature feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot orthoses. Custom, removable foot orthoses are covered.

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

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

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

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

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

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

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

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

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

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

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

J. Orthopedic footwear for diabetic members.

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

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

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

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

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

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41. Preventive services.

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

B. Vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other preventive services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified:

(I) Mammograms – no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears – no age limit;

(III) Prostate – no age limit; and

(IV) Colorectal screening – no age limit.

G. Digital diabetes prevention program offered through the plan's claims administrator.

H. The following services permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan:

(I) Blood pressure monitors for individuals diagnosed with hypertension;

(II) Retinopathy screenings for individuals diagnosed with diabetes;

(III) Hemoglobin A1c (HbA1c) testing for individuals diagnosed with diabetes;

(IV) Peak flow meters for individuals diagnosed with asthma; and

(V) International normalized ratio (INR) testing for individuals diagnosed with liver disease and/or bleeding disorders;

42. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

43. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL)

or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

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

45. Telehealth services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

46. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver-provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language, and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

47. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s') travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging – maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel – IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals – not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

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

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

PRIVATE COST: This proposed amendment will not cost private

entities more than five hundred dollars ($500) in the aggregate.

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

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

PROPOSED AMENDMENT

22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (11).

PURPOSE: This amendment clarifies how non-network plan payments are processed.

(11) *[Maximum]* **Non-network** plan payment – non-network medical claims *[that are not otherwise subject to a contractual discount arrangement]* are processed *[at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* following the claim administrator's *[standard]* practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (11).

PURPOSE: This amendment clarifies how non-network plan payments are processed.

(11) *[Maximum]* **Non-network** plan payment – non-network medical claims *[that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and]* **are processed** following the claim administrator's *[standard]* practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Original rule filed Oct. 31, 2018, effective May 30, 2019. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending section (5).

Purpose: This amendment adds an occurrence in which MCHCP may allow one (1) additional reinstatement and revises the time frame in which MCHCP may approve an appeal where a subscriber missed a deadline.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account. Payment in full for all past and current premiums due for reinstatement must be included with the appeal**. MCHCP may allow one (1) additional reinstatement if the subscriber submits an automatic withdrawal authorization**;

(J) Once *[per lifetime of the]* **every five (5) years per** account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this

guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment corrects the omission of the maximum amount Health Savings Account members will pay for non-preferred formulary drugs and approved excluded drugs.

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

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Preferred formulary generic drug: ten percent (10%) coinsurance up to fifty dollars ($50) per thirty-one- (31-) day supply after deductible has been met for a generic drug on the formulary.

B. Preferred formulary brand drug: twenty percent (20%) coinsurance up to one hundred dollars ($100) per thirty-one- (31-) day supply after deductible has been met for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: forty percent (40%) coinsurance **to two hundred dollars ($200)** after deductible has been met.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance, not to exceed:

(I) Twenty-five dollars ($25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars ($50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars ($100) per thirty-one- (31-) day supply for non-preferred formulary drug.

E. Ninety- (90-) day supply of prescriptions may be filled through the PBM's home delivery program or at select retail pharmacies, as designated by the PBM.

F. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program.

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

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

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

H. Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are covered at one hundred percent (100%) when filled at a network pharmacy.

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

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

(II) One (1) preferred glucometer.

J. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

K. Drugs permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan are not subject to the deductible when filled at a network pharmacy. Applicable coinsurance will apply.

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

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

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

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

D. Diabetic drug (as designated by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance

after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. Amended: Filed Oct. 25, 2024.*

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

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

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

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order or rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted that has been changed from the text contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments that are opposed in whole or in part to the proposed rule. The ninety-(90-) day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 500 – Office of Adult Learning and Rehabilitation Services

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 178.600, 178.610, and 178.620, RSMo 2016, the board amends a rule as follows:

5 CSR 20-500.130 Confidentiality and Release of Information **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2024 (49 MoReg 1051-1052). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 500 – Office of Adult Learning and Rehabilitation Services

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 178.600, 178.610, and 178.620, RSMo 2016, the board amends a rule as follows:

5 CSR 20-500.170 Appeals **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2024 (49 MoReg 1052). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 500 – Office of Adult Learning and Rehabilitation Services

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 178.600, 178.610, and 178.620, RSMo 2016, the board amends a rule as follows:

5 CSR 20-500.180 Informal Review **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2024 (49 MoReg 1052-1053). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 500 – Office of Adult Learning and Rehabilitation Services

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 178.600, 178.610, and 178.620, RSMo 2016, the board amends a rule as follows:

5 CSR 20-500.190 Due Process Hearing **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2024 (49 MoReg 1053-1054). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20 – Division of Learning Services
Chapter 500 – Office of Adult Learning and Rehabilitation Services

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 178.600, 178.610, and 178.620, RSMo 2016, the board amends a rule as follows:

5 CSR 20-500.200 Mediation **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2024 (49 MoReg 1054). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 10 – DEPARTMENT OF NATURAL RESOURCES
Division 40 – Missouri Mining Commission
Chapter 10 – Permit and Performance Requirements for Industrial Mineral Open Pit and In-Stream Sand and Gravel Operations

ORDER OF RULEMAKING

By the authority vested in the Department of Natural Resources pursuant to section 256.700, RSMo Supp. 2024, the department adopts a rule as follows:

10 CSR 40-10.025 Geologic Resources Fees **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on June 17, 2024 (49 MoReg 885-886). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Natural Resources received one (1) comment on the proposed rule.

COMMENT #1: Dan Kleinsorge, Executive Director of the Missouri Limestone Producers Association (MLPA), commented that MLPA supports the modest increase in fees that MLPA members pay to fund the work of the Geological Survey Program and the Industrial Minerals Advisory Council.
RESPONSE: No changes have been made to the rule as a result of this comment.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 30 – Office of the Director
Chapter 1 – General Organization

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 536.023, RSMo 2016, the director amends a rule as follows:

11 CSR 30-1.010 Organization and Operations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2024 (49 MoReg 987). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 30 – Office of the Director
Chapter 8 – Local Government/School District Partnership Program

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under sections 589.300 – 589.310, RSMo 2016, the director rescinds a rule as follows:

11 CSR 30-8.010 Definitions **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2024 (49 MoReg 987). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 30 – Office of the Director
Chapter 8 – Local Government/School District Partnership Program

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under sections 589.300 – 589.310, RSMo 2016, the director rescinds a rule as follows:

11 CSR 30-8.020 Eligible Applicants **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2024 (49 MoReg 988). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 30 – Office of the Director
Chapter 8 – Local Government/School District Partnership Program

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 589.307, RSMo 2016, the director rescinds a rule as follows:

11 CSR 30-8.030 Notification and Filing Procedure
is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2024 (49 MoReg 988). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 30 – Office of the Director
Chapter 8 – Local Government/School District Partnership Program

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under sections 589.300 – 589.310, RSMo 2016, the director rescinds a rule as follows:

11 CSR 30-8.040 Contract Awards, Monitoring and Review
is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 1, 2024 (49 MoReg 988). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 30 – Office of the Director
Chapter 19 – Viewing Crime Scene Photographs and Video Recordings

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 610.205, RSMo 2016, the department adopts a rule as follows:

11 CSR 30-19.010 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2024 (49 MoReg 988-989). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended July 31, 2024. Two (2) comments were received.

COMMENT #1: The attorney representing the Missouri Press Association (MPA) commented that 11 CSR 30-19.010(1) exceeds its statutory authority and poses First Amendment issues. Section 610.205.6 contains no language that would delegate to the Department of Public Safety the authority, or responsibility, to define what a "bona fide credentialed member of the press" may be. The statute only tasks the department with issuing rules governing the process by which such people may view otherwise closed materials. MPA urges the department not to attempt a definition of "bona fide credentialed member of the press." Otherwise, the MPA supports sections (2)-(4).
RESPONSE: The statutory authority, section 610.205, does not define "bona fide credentialed member of the press"; therefore, the Department of Public Safety is acting within its statutory authority by providing such a definition for this limited process, which the department is tasked with establishing.

COMMENT #2: The attorney representing the Missouri Broadcasters Association (MBA) commented that 11 CSR 30-19.010(1) does not provide a mechanism for who makes the determination of whether an access request comes from a "bona fide credentialed member of the press."

Second, "who represents a bona fide media organization" prohibits access by reporters who are not employed by media organizations, such as a freelance journalists and bloggers who are acting as reporters and reporting about matters of public concern. MBA suggests removing "who represents a bona fide media organization" limitation from the proposed rule.

Third, "has reported on matters of public concern" arguably prohibits access by new reporters and newly formed media entities. MBA suggests removing the "has reported on matters of public concern" limitation from the proposed rule.

Last, MBA is concerned about the proposed language prohibiting a media entity from duplicating material viewed, which would prohibit a media entity from writing on its website or describing in its broadcast what its reporter observed in the material viewed. MBA does not believe a member of the agency needs to be present when viewing photos or videos.
RESPONSE AND EXPLANATION OF CHANGE: First, the Department of Public Safety does not find that the definition of a "bona fide credentialed member of the press" needs to be altered. Second, the Department does agree to remove "or other means" language to avoid any confusion about what conduct is and is not permitted.

11 CSR 30-19.010 Credentialed Members of the Press Viewing Crime Scene Photographs and Videos

(4) The bona fide credentialed member of the press shall not remove, duplicate, or record – either by audio or video – any material viewed under this rule.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 50 – Missouri State Highway Patrol
Chapter 2 – Motor Vehicle Inspection

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.010 Definitions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2024 (49 MoReg 1293-1294). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 50 – Missouri State Highway Patrol
Chapter 2 – Motor Vehicle Inspection

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.020 Minimum Inspection Station Requirements **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2024 (49 MoReg 1294). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 50 – Missouri State Highway Patrol
Chapter 2 – Motor Vehicle Inspection

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.060 Display of Permits, Signs, and Poster **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2024 (49 MoReg 1294-1295). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 50 – Missouri State Highway Patrol
Chapter 2 – Motor Vehicle Inspection

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.070 Hours of Operation **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2024 (49 MoReg 1295). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 50 – Missouri State Highway Patrol
Chapter 2 – Motor Vehicle Inspection

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.090 Inspection Station Operational Requirements **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2024 (49 MoReg 1295-1296). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 50 – Missouri State Highway Patrol
Chapter 2 – Motor Vehicle Inspection

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.100 Requisition of Inspection Stickers, Authorities, and Decals **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2024 (49 MoReg 1296). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 50 – Missouri State Highway Patrol
Chapter 2 – Motor Vehicle Inspection

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.110 Issuance of Inspection Stickers and Decals **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2024 (49 MoReg 1296-1297). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 50 – Missouri State Highway Patrol
Chapter 2 – Motor Vehicle Inspection

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.120 Safety Inspection Certificate **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2024 (49 MoReg 1297-1299). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 11 – DEPARTMENT OF PUBLIC SAFETY
Division 50 – Missouri State Highway Patrol
Chapter 2 – Motor Vehicle Inspection

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.140 Sale of Vehicles for Junk, Salvage, or Rebuilding **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2024 (49 MoReg 1299-1302). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 13 – DEPARTMENT OF SOCIAL SERVICES
Division 40 – Family Support Division
Chapter 100 – Child Support Program, General Administration

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, Family Support Division, under sections 454.400 and 660.017, RSMo 2016, the division amends a rule as follows:

13 CSR 40-100.020 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2024 (49 MoReg 1134-1139). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Family Support Division received one (1) comment on the proposed amendment. The comment contained multiple subpoints that will be addressed separately.

COMMENT #1: Phil Telfeyan, Lily Milwit, and Caroline McCance, with Equal Justice Under the Law, comment the following: Section 454.1005.1, RSMo, which provides that a request for hearing shall be made within sixty (60) days of the date of service of the notice of intent to suspend a license and 13 CSR 40-100.020(5) which provides for thirty (30) days from the date of notice are in conflict. The rule and the notice should make clear that the hearing request must be in writing, how a hearing request should be submitted, if a hearing request must contain special or specific language, that license suspension will be stayed pending the hearing decision, and that obligors should be given approximate timelines for receipt of hearing notices and hearing decisions.
RESPONSE AND EXPLANATION OF CHANGE: In response to the comments received, language has been added to subsection (5)(A) to clarify that when a hearing request is granted by the division, the division will notify the parties in writing and the Administrative Hearings Section will send the parties the date and time of the hearing, the procedures for participating in the hearing, and the action or actions that the hearing will address. Language was added to subsection (6)(A) to clarify the meaning of "the director shall stay the suspension of the license pending the hearing decision."

No additional changes have been made as every notice of intent to suspend a license is statutorily required by section 454.1003.3, RSMo, to contain the language that the obligor's license shall be suspended sixty (60) days after service unless the obligor takes one (1) of three (3) required actions. All notices advise the obligor that hearings are subject to the contested

provisions of Chapter 536, RSMo, including section 536.063, RSMo, that hearing requests must be made in writing to the stated name and address. After the written hearing request is received by the division at the address provided in the notice, the parties are notified if the request is granted, resolved, or denied and reason for the denial. Under the provisions of section 536.067, RSMo, hearings are scheduled and notices sent by the Administrative Hearings Section giving the obligor, obligee, and the division at least the required minimum ten (10) days statutory notice of the hearing date. Every license suspension is stayed pending the hearing decision, per section 454.1005.3, RSMo, and the hearing decision must be issued within thirty days of the hearing record being closed.

COMMENT #2: Phil Telfeyan, Lily Milwit, and Caroline McCance, with Equal Justice Under the Law, comment the following: The rule and the hearing notice should be specific about evidentiary requirements including what types of evidence obligors are permitted to present, how and when evidence must be presented, and that the requirement for evidence to be submitted five days prior to hearing and the hearing officer's discretional authority to receive evidence at hearing and post hearing are in conflict.
RESPONSE AND EXPLANATION OF CHANGE: In response to comments received, the following changes have been made to provide clarification. In regard to the comment concerning what evidence the division will be presenting on a child support case, a definition of an administrative hearing packet was added to subsection (1)(I) and included with the exhibits that shall be submitted to the Administrative Hearings Section within five (5) days prior to hearing in subsection (2)(D). To clarify the evidence that is allowed to be considered at hearing, language has been added to subsection (6)(C) that the hearing officer shall consider evidence offered by the obligor, the obligee, the division, and other witnesses that may be received by testimony, exhibits submitted prior to hearing, and exhibits admitted by the discretion of the hearing officer before the hearing record is closed. Further, to clarify evidence that may be submitted, language was added related to providing evidence on the enumerated factors in section 454.1005.4, RSMo, and that the obligor failed to comply with the payment obligation for good cause as set forth in section 454.1005.5, RSMo. The agency chooses to make no further changes as 13 CSR 40-100.020(2)(D) gives the Administrative Hearing Officer discretionary authority to admit any relevant evidence at hearing or post hearing. Additionally, the statute does not limit the types of evidence that the parties may seek to present at hearing. The statute lists factors for consideration in section 454.1005.4, RSMo, and includes a non-exhaustive list of good cause examples in section 454.1005.5, RSMo. The determination of whether license suspension is appropriate and whether the obligor failed to comply with the child support payment obligation without good cause is fact specific. Receipt of evidence and the relevance of such evidence is for Administrator Hearing Officer as the trier of fact, not the agency that serves the role of an adjudicator. Garland v. Ruhl, 455 S. W. 3d 422 (Mo. en banc 2015).

COMMENT #3: Phil Telfeyan, Lily Milwit, and Caroline McCance, with Equal Justice Under the Law, comment the following: The rule and notice do not require the Agency to provide Obligor's updated information on the status on the Obligor's license suspension.
RESPONSE: No change is needed as the license suspension is stayed and no order suspending a license is issued to the licensing authority until the Administrative Hearings Section issues a written decision within thirty (30) days of the hearing record being closed finding that the obligor failed to comply with the child support payment obligation without good cause and orders the suspension of the obligor's license pursuant to sections 454.1005.3, 454.1005.4, 454.1005.6, RSMo, and 13 CSR 40-100.020(6)(A) and (B).

COMMENT #4: Phil Telfeyan, Lily Milwit, and Caroline McCance, with Equal Justice Under the Law, comment the following: The rule does not allow for an appeals process.
RESPONSE: No change is needed as sections 454.475.5 and 536.140, RSMo, allow any parent adversely affected by an administrative decision to obtain judicial review pursuant to sections 536.100 to 536.140, RSMo, by filing a petition for judicial review in circuit court within thirty (30) days of mailing of the decision. Further, section 454.1010, RSMo, provides that a court may stay the suspension of a license upon a showing that a license suspension would create a significant hardship to the obligor, the obligor's dependents, employees, businesses, or other entities served by the obligor.

COMMENT #5: Phil Telfeyan, Lily Milwit, and Caroline McCance, with Equal Justice Under the Law, comment the following: The rule must define inability to pay.
RESPONSE: No change is needed as each obligor's individual circumstances are fact-specific and vary on a case-by-case basis. Section 454.1005.4, RSMo, enumerates specific factors for the administrative hearing officer to issue written findings of fact and conclusions of law regarding the obligor's individual circumstances and whether license suspension is appropriate. Section 454.1005.5, RSMo, includes a non-exhaustive list of good cause examples. The determination of whether license suspension is appropriate is best determined by the administrative hearing officer as the trier of fact after receiving evidence in the form of documentary evidence and oral testimony, including eliciting testimony from the obligor.

COMMENT #6: Phil Telfeyan, Lily Milwit, and Caroline McCance, with Equal Justice Under the Law, comment the following: The rule must be amended to account for the long-term and ongoing nature of obligors' inability to pay in 13 CSR 40-100.020 (6)(E).
RESPONSE: No change is needed as section 454.1005.5, RSMo, allows a new notice of intent to suspend a license to be filed under the requirements of section 454.1003, RSMo.

COMMENT #7: Phil Telfeyan, Lily Milwit, and Caroline McCance, with Equal Justice Under the Law, comment the following: The rule must provide for retroactive relief for obligors whose licenses have previously been suspended under 454.1003, RSMo.
RESPONSE: No change is needed as section 454.1005.1, RSMo, allows an obligor to request a hearing from the division that issued a notice of intent to suspend a license prior to the license being suspended by the director. Upon a request for hearing, section 454.1005.3, RSMo, requires the director to stay the pending license suspension action and no order suspending an obligor's license is sent to the licensing agency until an administrative decision orders the obligor's license to be suspended as set forth in section 454.1005.6, RSMo. An administrative hearing held pursuant to section 454.1005, RSMo, cannot involve a child support case where an order of suspension has been issued for that child support case. If an order of suspension has been issued by the director either a hearing has previously been held or the obligor failed to request a hearing.

However, please note that section 454.1010, RSMo, permits

an obligor to petition the court or the director for a stay of a license suspension at any time. The court or the director may stay the suspension of a license when the obligor makes an agreement to pay their child support obligation or agrees to comply with an existing payment plan. Additionally, section 454.1010.3, RSMo, permits a court to issue a stay on a license suspension if the suspension would create a significant hardship for the obligor, the obligor's dependents, employees, businesses, or other entities served by the obligor.

13 CSR 40-100.020 Administrative Hearings

(1) Definitions.

(I) "Administrative hearing packet" means a packet containing documents from the child support case record and submitted by the division to the Administrative Hearing Section to be offered as evidence in an administrative hearing on a child support case.

(2) Administrative Hearing Procedures.

(D) All exhibits to be submitted as hearing exhibits in an administrative hearing, including the division's administrative hearing packet(s), shall be submitted to the Administrative Hearings Section, the division, and all parties within five (5) days prior to the hearing. If hearing exhibits are not received five (5) days prior to the hearing, admission of exhibits as evidence any time thereafter shall be at the discretion of the hearing officer. The hearing officer shall have the discretion to leave the hearing record open for the submission of exhibits as evidence as long as copies of all exhibits are provided to the division and all parties, with the opportunity for the division or any party to submit rebutting evidence.

(5) Hearing Requests.

(A) If the parties are entitled to a hearing under federal or state law or regulation or the division has notified the party of the right to a hearing due to an action taken by the division in the administration of the child support program, the division will provide, upon request, a hearing as set forth in section 454.475, RSMo. Any request for hearing must comply with any request procedure as set out in the law or regulation authorizing the hearing. For Missouri tax refund offset hearings for the obligor or nonobligated spouse, the notice to contest the tax offset is deemed received ten (10) calendar days after the date on the notice, unless refuted by competent evidence to the contrary. If the parties are entitled to a hearing, but federal or state law or regulation does not provide specific procedures or timelines for when the hearing requests must be made, then the parties to the child support case have thirty (30) calendar days from the date of the notice of the division's action to request a hearing. The hearing request, unless it is for a federal tax refund offset, must be in writing and provided to the division, unless the authorizing law or regulation requires otherwise. Hearing requests on federal tax refund offsets may be verbal or in writing. The division will review the hearing request and may contact the party requesting the hearing in an effort to resolve the issues raised by the hearing request. The division will notify the parties in writing if the hearing request is granted, resolved, or denied and the reason for the denial. If the request for hearing is granted, the division will forward the hearing request and administrative hearing packet to the Administrative Hearings Section. The Administrative Hearings Section will schedule a hearing and send notice to the parties. The administrative hearing notice shall state the date and time of the hearing, the procedures for participating in the hearing, and state the action or actions that the administrative hearing will address. The division may deny a request for an administrative hearing for any one (1) of the following reasons:

1. The party's hearing request is based solely on issues that have previously been litigated and decided by a court of law;

2. The hearing request was untimely as set forth in either federal or state law or regulation; or

3. The party's request for administrative hearing is based solely on issues which cannot be decided in an administrative hearing including but not limited to visitation, legal custody, and nonpaternity.

(6) Administrative Hearings Procedures for License Suspension.

(A) The Administrative Hearings Section shall use procedures contained in this section to conduct hearings to determine whether suspension of a license is appropriate when the director has issued a notice of intent to suspend a license pursuant to section 454.1003, RSMo, on a child support case when an obligor is not making child support payments in accordance with a support order. The obligor may request an administrative hearing on the notice of intent to suspend a license the division issued on the obligor's child support case. The suspension of the license shall be stayed pursuant to section 454.1005.3, RSMo, until the Administrative Hearings Section issues a decision containing written findings of facts and conclusions of law on the factors enumerated within section 454.1005, RSMo, determining whether the license suspension is appropriate. As used in section 454.1005.3, RSMo, "the director shall stay suspension of the license pending the outcome of the hearing" means that the director's action to suspend the obligor's license on the child support case shall be stayed pending the hearing decision and no order suspending the license on the child support case shall be issued by the director to the license authority until a decision is entered and an order is issued pursuant to section 454.1005.6, RSMo.

(B) The hearing officer shall have thirty (30) days to issue written findings of facts and conclusions of law after the hearing has ended and the hearing record has closed.

(C) In determining whether license suspension is appropriate, the hearing officer shall consider relevant factors presented by the obligor, the obligee, the division, and other witnesses that may be received by testimony, exhibits submitted prior to hearing, and exhibits admitted by the discretion of the hearing officer before the hearing record is closed. The obligor shall bear the burden of production and persuasion to show cause why suspension of a license is not appropriate under the totality of the obligor's circumstances enumerated in section 454.1005.4, RSMo, and that the obligor failed to comply with the child support payment obligation for good cause as set forth in section 454.1005.5, RSMo. In providing evidence regarding license suspension, the obligor will submit such documentation or supporting evidence as requested by the hearing officer if the documentation or supporting evidence has not been submitted by the obligor prior to the hearing.

1. When considering the relevant factors regarding payments, "payments" mean any amount or amounts ordered to be paid pursuant to a "support order" as defined by section 454.1000(13), RSMo.

2. When considering the relevant factors regarding payments, "arrearage" means arrearage as defined by section 454.1000(1), RSMo.

3. When considering the relevant factor of payments that are in arrearage, the hearing officer at the hearing officer's discretion and the circumstances of the child support case may limit the hearing officer's consideration to a time frame less than the entire lifetime of the child support obligation.

4. When considering the relevant factor of transportation, "extracurricular activities" means an activity related to

a school, job, or profession, but outside of the regular curriculum of the school or outside of the usual duties of the job or profession.

TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20 – Division of Community and Public Health
Chapter 80 – Coroner Standards and Training Commission

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Health and Senior Services under section 58.035, RSMo Supp. 2024, the Missouri Department of Health and Senior Services adopts a rule as follows:

19 CSR 20-80.010 Training Standards Relating to the Office of the Coroner **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2024 (49 MoReg 990). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: The department received comments from fourteen (14) individuals/entities resulting in nineteen (19) comments on the proposed rule.

COMMENT #1: The department received nine (9) comments related to the effective date of the proposed rule. Willie Harlow, Board of Directors, Missouri Coroners and Medical Examiners Association (MCMEA); Mark Seesing; John Voss, Missouri State Representative; Christy Young-Clover; Joe Chapman, Carter County Coroner; Daniel Rose; Cheryl A. Reinagel; Brandi Ray; and Desma Renee Reno commented that they are concerned with the timing the of rule and how it may affect coroners and deputy coroners, especially new elected coroners, and having enough time to complete training in order to assume office on January 1, 2025.
RESPONSE: The proposed rule will not be effective until after January 1, 2025. The department believes coroners, deputy coroners, and newly elected coroners should be able to comply with training requirements and still assume elected office. No changes have been made as a result of this comment.

COMMENT #2: The department received two (2) comments from the Missouri Suicide Prevention Network (MSPN) Executive Committee and Missouri Foundation for Health (MFH) that they were in support of establishing training standards for coroners, the overall direction of the rule, and offered a suggestion for improvement. MSPN and MFH suggest that information on suicide be included in the training topics under subsection (1)(A) as this knowledge is critical and should be required of the office.
RESPONSE: The department agrees that suicide is an important topic to include in trainings. The proposed training standards address suicide in paragraph (1)(A)5. under etiology and medical certification. No changes have been made as a result of this comment.

COMMENT #3: John Voss, Missouri State Representative, commented that the proposed scope of training only partially addresses the scope that the commission was statutorily prescribed to complete. The proposed rule only addresses the technical skills and knowledge required of the office. The scope of training for the operation of the office and the legal responsibilities of the office are not part of the proposed rule.
RESPONSE: The Coroner Standards and Training Commission (commission) was established pursuant to section 58.035, RSMo, and requires the commission to establish, by rule, training standards relating to the office of the county coroner that relate to the operation of the office, the legal responsibilities of the office, and the technical skills and knowledge required by the office. The commission convened, discussed, and created a list of proposed training standards as required in section 58.035, RSMo, the scope of training for the operation of the office and the legal responsibilities of the office are addressed in the proposed rule throughout paragraphs (1)(A)1.–19. The commission believes the proposed rule meets its statutory requirement in section 58.035, RSMo. No changes have been made as a result of this comment.

COMMENT #4: The department received four (4) comments related to House Bill 2777 (HB 2777). Daniel Rose, Christy Young-Clover, Cheryl A. Reinagel, and Brandi Ray commented that the proposed rule was a step in the right direction but falls short of what was proposed in HB 2777.
RESPONSE: HB 2777 was proposed legislation from the 2024 Missouri Legislative Session to amend section 58.035, RSMo; however, the proposed legislation did not pass. The proposed rule is not in response to the proposed HB 2777, the proposed rule relates to the commission's duty to establish by rule, training standards relating to the office of the county coroner that relate to the operation of the office, the legal responsibilities of the office, and the technical skills and knowledge required by the office set forth in section 58.035, RSMo. No changes have been made as a result of this comment.

COMMENT #5: Sandy Prichard inquired who is going to teach the trainings and what background do they have to teach the trainings.
RESPONSE: The commission members are appointed by the governor and require consent of senate. Section 58.035, RSMo, sets forth who the members of commission shall consist of. The proposed rule sets forth in section (1) what acceptable training shall include; the training standards do not set requirements for instructors of trainings. No changes have been made as a result of this comment.

COMMENT #6: Sandy Prichard inquired regarding commission authority to establish the training subjects and requirements.
RESPONSE: The Coroner Standards and Training Commission was established pursuant to section 58.035, RSMo, and requires the commission to establish, by rule, training standards relating to the office of the county coroner that relate to the operation of the office, the legal responsibilities of the office, and the technical skills and knowledge required by the office. The commission members are appointed by the governor and require consent of senate. Section 58.035, RSMo, sets forth who the members of commission shall consist of. No changes have been made as a result of this comment.

COMMENT #7: The department received four (4) comments from Christy Young-Clover, Brandi Ray, Cheryl A. Reinagel, and Daniel Rose regarding the length of time it took for the commission to establish proposed training standards.
RESPONSE: The Coroner Standards and Training Commission

was established pursuant to section 58.035, RSMo, and requires the commission to establish, by rule, training standards relating to the office of the county coroner that relate to the operation of the office, the legal responsibilities of the office, and the technical skills and knowledge required by the office. The commission was established in August, 2020, however did not have a quorum until 2022, and the quorum was not consistently maintained until 2023. A quorum is required for the commission to convene and hold meetings. The commission members are appointed by the governor and require consent of senate. Section 58.035, RSMo, sets forth who the members of commission shall consist of. No changes have been made as a result of this comment.

COMMENT #8: The department received three (3) comments related to the number of training hours. Sandy Prichard, Christy Young-Clover, and Brandi Ray commented that twenty (20) hours of training is not sufficient time to cover nineteen (19) subjects for the required training for the office of coroner.
RESPONSE: Coroners are required to complete at least twenty (20) hours of classroom instruction each calendar year pursuant to section 58.095.2, RSMo. Requiring more hours than what is required in statute is outside the commission's scope/authority. No changes have been made as a result of this comment.

COMMENT #9: Sandy Prichard inquired whether there will be annual follow-ups with each coroner to see if they retain the information and the coroner is doing what is required of the office.
RESPONSE: Coroners are required to complete at least twenty (20) hours of classroom instruction each calendar year pursuant to section 58.095.2, RSMo. Requiring coroners to be evaluated annually and/or requiring certification is outside the commission's scope/authority set forth in section 58.035, RSMo. No changes have been made as a result of this comment.

COMMENT #10: Christy Young-Clover inquired how coroner's competency will be ensured upon completion of the training and will coroners receive certification upon completion of training.
RESPONSE: Coroners are required to complete at least twenty (20) hours of classroom instruction each calendar year pursuant to section 58.095.2, RSMo. Requiring coroners to be evaluated/certification is outside the commission's scope/authority set forth in section 58.035, RSMo. No changes have been made as a result of this comment.

COMMENT #11: Daniel Rose inquired if coroners will be evaluated such as by requiring a testing component that requires a minimum score to certify or a demonstration of competency to pass the training.
RESPONSE: Coroners are required to complete at least twenty (20) hours of classroom instruction each calendar year pursuant to section 58.095.2, RSMo. Requiring coroners to be evaluated and/or obtain certification is outside the commission's scope/authority set forth in section 58.035, RSMo. No changes have been made as a result of this comment.

COMMENT #12: Desma Renee Reno commented that there needs to be ongoing continuing education to address the common practice needs for coroners. Ms. Reno recommends that the commission investigate other alternatives for providing training such as webinars, online learning, and self-study programs.
RESPONSE: Coroners are required to complete at least twenty (20) hours of classroom instruction each calendar year pursuant to Section 58.095.2, RSMo. Requiring coroners to complete ongoing training in addition to the required annual training is outside the commission's authority set forth in section 58.035, RSMo. The commission establishes the training standards, which do not set format requirements, the format of the training is up to the training provider. No changes have been made as a result of this comment.

COMMENT #13: Desma Renee Reno commented that Missouri needs to continue to address the overall issue for educational requirements for the office of coroner.
RESPONSE: Section 58.030, RSMo, sets forth the qualifications for the office of the coroner. Qualifications for the office of the coroner is outside of the commission's scope/authority. No changes have been made as a result of this comment.

COMMENT #14: Brandi Ray commented that higher minimum qualifications are needed to be eligible to run for and hold the position of coroner.
RESPONSE: Section 58.030, RSMo, sets forth the qualifications for the office of the coroner. Qualifications for the office of the coroner is outside of the commission's scope/authority. No changes have been made as a result of this comment.

COMMENT #15: Cheryl A. Reinagel commented that section 58.030, RSMo, is an antiquated statute that must be revised and changes implemented.
RESPONSE: Section 58.030, RSMo, sets forth the qualifications for the office of the coroner. The Coroner Standards and Training Commission was established pursuant to section 58.035, RSMo, and requires the commission to establish, by rule, training standards relating to the office of the county coroner that relate to the operation of the office, the legal responsibilities of the office, and the technical skills and knowledge required by the office. Qualifications for the office of the coroner is outside of the commission's scope/authority. No changes have been made as a result of this comment.

COMMENT #16: Jim Akers, Butler County Coroner, commented that the proposed rule does not follow the statutory duties of the office and does not include training on taking the oath to the constitution. Mr. Akers suggests the training should include topics on conservator of the peace, performing duties of the sheriff, conducting arrests, holding inquests, written warrants, subpoenas, and taking testimony.
RESPONSE: The proposed training standards address ethical conduct and statutory duties in paragraphs (1)(A)4., 6., and 19. The commission feels the proposed rule meets requirements of section 58.035, RSMo, to establish training standards relating to the office of the county coroner that relate to the operation of the office, the legal responsibilities of the office, and the technical skills and knowledge required by the office. No changes have been made as a result of this comment.

COMMENT #17: Jim Akers, Butler County Coroner, commented that coroners need skills in investigating and the training should be geared for investigating.
RESPONSE: The commission agrees that investigation is an important topic to include in trainings. The proposed training standards address investigation in paragraph (1)(A)17. No changes have been made as a result of this comment.

COMMENT #18: Jim Akers, Butler County Coroner, commented that the law now states the sheriff will appoint a medical professional if a coroner is not certified and cannot sign a death certificate; however, the undefined medical professional has not had the required training.

RESPONSE: The Coroner Standards and Training Commission was established pursuant to section 58.035, RSMo, which requires the commission to establish training standards relating to the office of the county coroner that relate to the operation of the office, the legal responsibilities of the office, and the technical skills and knowledge required by the office. Section 193.145.11, RSMo, provides "In the event a coroner cannot fulfill his or her duties or is no longer qualified to attest to the accuracy of a death certificate, the sheriff of the county shall appoint a medical professional to attest death certificates until such time as the coroner can resume his or her duties or another coroner is appointed or elected to the office." Appointment of the sheriff is outside of the commission's authority. No changes have been made as a result of this comment.

COMMENT #19: Wavis Jordan commented that he is in agreement that new coroners need to have required training.
RESPONSE: No changes have been made as a result of this comment.

TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2115 – State Committee of Dietitians
Chapter 1 – General Rules

ORDER OF RULEMAKING

By the authority vested in the State Committee of Dietitians under section 324.203, RSMo 2016, the committee amends a rule as follows:

20 CSR 2115-1.040 Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2024 (49 MoReg 1302-1304). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2120 – State Board of Embalmers and Funeral Directors
Chapter 3 – Preneed

ORDER OF RULEMAKING

By the authority vested in the State Board of Embalmers and Funeral Directors under section 436.520, RSMo 2016, the board adopts a rule as follows:

20 CSR 2120-3.210 Requirements for a Preneed Contract Joint Account **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2024 (49 MoReg 1189-1190). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE
Division 2220 – State Board of Pharmacy
Chapter 2 – General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Pharmacy under sections 338.013, 338.240, and 338.280, RSMo 2016, and sections 338.140, 338.210, and 338.215, RSMo Supp. 2024, the board adopts a rule as follows:

20 CSR 2220-2.715 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2024 (49 MoReg 1190). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received four (4) comments from the Missouri Hospital Association and Tom Glenski (Missouri Board of Pharmacy, Chief Inspector).

COMMENT #1: The Missouri Hospital Association (MHA) suggested the board reconsider use of the terms "advising" or "consulting" in subsection (2)(C). Specifically, MHA suggested the terms are overly broad and could be interpreted to prohibit pharmacy technicians from documenting patient information in the medical record.
RESPONSE AND EXPLANATION OF CHANGE: Pursuant to Missouri law, the referenced terms would be interpreted in accordance with their plain and ordinary meaning. As commonly defined, "advising" would not include manually recording/documenting patient information as referenced. No changes have been made in response to the recommendation to delete "advising." The reference to "consulting" was intended to address patient counseling, which is separately addressed in subsection (2)(C). After further review of the comment, "consulting" has been deleted as duplicative.

COMMENT #2: MHA suggested the board reconsider use of the term "recommending" in subsection (2)(D). MHA indicated the term is overly broad and could be construed to prohibit pharmacy technicians from directing patients and consumers in finding "requested medications and homeopathic remedies."
RESPONSE: Subsection (2)(D) will only prohibit pharmacy technicians from recommending specific medications/remedies to patients and would not, by its terms, prohibit a pharmacy technician from advising patients on how or where to locate medication or homeopathic remedies requested by the patient. The board's intent was to clearly delineate that recommendations on specific medications/remedies require a pharmacist's professional judgment and should not be performed by a pharmacy technician. In the interest of patient safety, no changes have been made in response to the comment; however, additional education will be provided after the rule effective date to clarify allowed activities.

COMMENT #3: MHA expressed concerns with authorizing an individual to work as both a pharmacy technician and a community health worker (CHW) at the same time. MHA stated the job roles are uniquely different and suggested authorizing a pharmacy technician to dually work as a CHW will create licensee confusion and generate potential liability for employers and the individual pharmacy technician/CHW. MHA recommended deleting section (4) in its entirety or, at a minimum, deleting subsections (4)(A) and (B) leaving only "the ability to incorporate traditionally non-technician related activities." MHA further noted the board does not have regulatory jurisdiction over CHWs.
RESPONSE: Section (4) was drafted in response to requests from the Missouri Pharmacy Association (MPA) and other Missouri licensees/pharmacy stakeholders that the board recognize and clarify authorized activities for pharmacy technicians dually working as CHWs. Stakeholders indicated the dual use of pharmacy technicians as CHWs to facilitate patient access to health/social services has increased statewide, as healthcare delivery models continue to expand to include pharmacies/pharmacists as major healthcare providers/access points. The board believes section (4) would achieve the requested goal and provide needed regulatory clarity. Accordingly, no changes have been made in response to the comment. However, additional education will be provided after the rule effective date to clarify the board's jurisdiction and encourage delineation of applicable duties in the pharmacy policies/procedures required by section (4).

COMMENT #4: Tom Glenski suggested the board amend subsection (2)(A) to require that pharmacies allowing pharmacy technicians to read information from the prescription label, medication container, or other pharmacist-approved written communication must have a policy and procedure governing delegated activities.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees and has amended subsection (2)(A) to incorporate the suggestion.

20 CSR 2220-2.715 Authorized Pharmacy Technician Duties

(2) Except as otherwise authorized by law/rule or section (3) of this rule, pharmacy technicians shall not perform any activity that requires the professional judgment of a pharmacist, including but not limited to –

(A) Patient counseling on medication or medical therapy, provided a pharmacy technician may read directions or information exactly as printed on a prescription label, medication container, or other pharmacist-approved written communication, if authorized by the delegating pharmacist and the pharmacy has a written policy and procedure detailing allowed activities;

(C) Advising on therapeutic duplications, drug-disease contraindications, drug interactions, drug-allergy interactions, or prescription and non-prescription drug recommendations;

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

TITLE 10 – DEPARTMENT OF NATURAL RESOURCES
Division 140 – Division of Energy
Chapter 2 – Energy Set-Aside Fund

IN ADDITION

Notification: Applications will be accepted between December 2, 2024, and March 31, 2025, for the Energy Efficiency and Renewable Energy Loan Cycle.

The Missouri Department of Natural Resources' Division of Energy is making available approximately five (5) million dollars in loan financing for qualified energy efficiency and renewable energy projects. Energy-saving investments may include projects such as insulation, lighting systems, heating and cooling systems, pumps, motors, aerators, renewable energy systems, and other measures that reduce energy use and cost. Recipients repay loans with money saved on energy costs.

Eligible Energy-Using Sectors: Loan funds will be allocated to eligible energy-using sectors as follows:

- Public Schools (K-12);
- Public Higher Education Institutions;
- Local Governments. Local governments include a county, city, or village (which may include water treatment plants or waste water facilities), local government/public owned airport facilities (municipal, county, regional, and international); or any hospital district as defined in section 206.010, RSMo; or any sewer district as defined in section 249.010, RSMo; or any water supply districts as defined in section 247.010, RSMo; or any ambulance district as defined in section 190.010, RSMo; or any sub-district of a zoological park and museum district as defined in section 184.352, RSMo.

Application Procedures: An application for loan funds may be submitted to the department for the purpose of financing all or a portion of the cost of implementing an energy-saving project.

Loan applications will not be considered for less than ten thousand dollars ($10,000) or with a payback score of less than six (6) months.

Requests for loan financing must be made using the Division of Energy's Energy Loan Program Application Authorization Form, Fuel Use Summary Form, and Energy Conservation Measure Summary Form. Application forms and instructions are available on the department's website: https://dnr.mo.gov/energy/grants-loans.

The Application Authorization Form must be signed and dated by an authorized official. An authorized official is an individual with authority to obligate an eligible applicant to the terms of loan agreement and promissory note to repay loan proceeds.

A paper or electronic copy of the signed original Application Authorization Form and required documents may be submitted to the department's address below.

Applications received after March 31, 2025, will not be considered for a loan award for this FY2025 cycle but may be held for consideration during subsequent application cycles.

The department may request additional information as needed to determine the feasibility of a project, the project's estimated annual energy savings, and financial risks of a loan transaction. Also, an energy conservation measure has the potential of affecting other areas within the facility or system. Applicants must have no outstanding actions for violations of applicable federal, state, or local laws, ordinances, and rules.

Interest Rates: Loan principal plus two and one-half percent (2.50%) interest is to be repaid to the department in semi-annual payments not to exceed a ten- (10-) year repayment period. An administrative fee of one percent (1%) of loan principal will be added to the repayment amount.

Selection Criteria: Applications will be reviewed based on the date all information needed to determine the feasibility of the project is received.

For More Information Contact:
Missouri Department of Natural Resources
Division of Energy
Attn: Energy Loan Program
PO Box 176
1101 Riverside Drive
Jefferson City, MO 65102
Phone: 1 (855) 522-2796, Email: energy@dnr.mo.gov
Website: https://dnr.mo.gov/energy/grants-loans.

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

NOTIFICATION OF REVIEW: APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the CON applications listed below. A decision is tentatively scheduled for January 13, 2025. These applications are available for public inspection at the address shown below.

Date Filed
Project Number: Project Name
City (County)
Cost, Description

10/30/24

#6117 HS: SSM Health St. Clare Hospital
Fenton (St. Louis County)
$1,359,519, Acquire robotic surgery unit

#6118 HS: SSM Health St. Mary's - St. Louis
St. Louis (St. Louis City)
$2,397,000, Acquire robotic surgery unit

10/31/24

#6155 HS: Orthopedic & Sports Medicine Center, LLC
dba Platte City Imaging
Platte City (Platte County)
$1,186,311, Acquire MRI

#6154 HS: Heartland Regional Medical Center
St. Joseph (Buchanan County)
$5,112,000, Acquire two additional robotic surgery units

11/1/24

#6159 HS: Mercy Hospital St. Louis
St. Louis (St. Louis County)
$2,536,000, Acquire additional robotic surgery unit

#6156 HS: North Kansas City Hospital
North Kansas City (Clay County)
$3,258,638, Acquire two additional IR units

#6161 RS: La Bonne Maison Assisted Living
Sikeston (Scott County)
$0, Add 6 ALF beds

#6157 HS: The University of Kansas Hospital Authority Liberty
Liberty (Clay County)
$4,700,000, Acquire linear accelerator

#6137 DS: Scotland County Nursing Home District
Memphis (Scotland County)
$4,553,000, Establish 68-bed ICF and 28-bed RCF

#6160 HS: Missouri Baptist Medical Center
St. Louis (St. Louis County)
$2,757,992, Acquire additional MRI unit

#6158 HS: Broadway Arches – Behavioral Health Facility
St. Louis (St. Louis City)
$13,699,519, Establish 72-bed behavioral health/psychiatric hospital

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by December 4, 2024. All written requests and comments should be sent to:

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
920 Wildwood Dr.
PO Box 570
Jefferson City, MO 65102

For additional information, contact Alison Dorge at alison.dorge@health.mo.gov.

The Secretary of State is required by sections 347.141 and 359.481, RSMo, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in an editable electronic file manuscript by email to adrules.dissolutions@sos.mo.gov.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST AMERICAN COLOR TECHNOLOGY, LLC

On October 16, 2024, American Color Technology, LLC, Charter Number LC0632794, filed its notice of winding up with the Missouri Secretary of State. Said limited liability company requests that all persons and organizations who have claims against it present them immediately by letter to:

The Company
c/o Elizabeth S. Lynch, Attorney at Law
Chinnery Evans & Nail, P.C.
800 NE Vanderbilt Lane
Lee's Summit, Missouri 64064

All claims must include the following information:
1) Name and current address of the claimant;
2) The amount claimed;
3) The clear and concise statement of the facts supporting the claim; and
4) The date the claim was incurred.

NOTICE: CLAIMS AGAINST American Color Technology, LLC WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN THREE YEARS AFTER THE PUBLICATION OF THIS NOTICE.

NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST NORTHLAND NEWS OF MISSOURI, LLC

Northland News of Missouri, LLC, a Missouri limited liability company, filed its Notice of Winding up with the Missouri Secretary of State on October 16, 2024. The dissolution was effective on that date. Any and all claims against Northland News of Missouri, LLC may be sent to:

J. Brian Hill, Esq.
2900 Brooktree Lane, Suite 100
Gladstone, Missouri 64119

Each claim should include the following information:
1) The name, address and telephone number of the claimant;
2) The amount of the claim;
3) The basis for the claim;
4) Documentation supporting the claim; and
5) The date(s) on which the event(s) on which the claim is based occurred.

Any and all claims against Northland News of Missouri, LLC will be barred unless a proceeding to enforce such claim is commenced within three (3) years after the date this notice is published.

NOTICE TO CREDITORS AND CLAIMANTS OF ACT PARTNERS, LLC

ACT Partners, LLC, a Missouri limited liability company (the "Company") has dissolved and is in the process of winding up its affairs. On August 23, 2023, the Company filed a Notice of Winding Up with the Missouri Secretary of State pursuant to RSMo. Section 347.137. All claims against the Company should be presented in accordance with this notice. Claims should be in writing and sent to:

ACT Partners, LLC
c/o Kenneth P. Stricker
16141 Swingley Ridge Rd., Suite 109
Chesterfield, MO 63017

The claim must contain:
1) The name, address and telephone number of the claimants;
2) The amount of the claim or other relief demanded;
3) The basis of the claim and any documents related to the claim; and
4) The date(s) as of which the event(s) on which the claim is based occurred.

Any and all claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST LEGACY ASSETS, LLC

On October 17, 2024, the Company filed notice of winding up with the Missouri Secretary of State. The Company requests that all persons with claims against the Company present them immediately by letter to:

Summers Compton Wells LLC
903 S. Lindbergh Blvd., Suite 200
St. Louis, Missouri 63131

All claims must include:
1) The name and address of the claimant;
2) The amount claimed;
3) The basis for the claim; and
4) The dates(s) and event(s) on which the claim is based.

NOTICE: Because of the dissolution of the Company, any claims against the Company will be barred unless a proceeding to enforce the claim commences within three (3) years after publication of this notice.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST GATEWAY ASSETS, LLC

On October 17, 2024, the Company filed notice of winding up with the Missouri Secretary of State. The Company requests that all persons with claims against the Company present them immediately by letter to:

Summers Compton Wells LLC
903 S. Lindbergh Blvd., Suite 200
St. Louis, Missouri 63131

All claims must include:
1) The name and address of the claimant;
2) The amount claimed;
3) The basis for the claim; and
4) The dates(s) and event(s) on which the claim is based.

NOTICE: Because of the dissolution of the Company, any claims against the Company will be barred unless a proceeding to enforce the claim commences within three (3) years after publication of this notice.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST VALUE HOLDINGS, LLC

On October 17, 2024, the Company filed notice of winding up with the Missouri Secretary of State. The Company requests that all persons with claims against the Company present them immediately by letter to:

Summers Compton Wells LLC
903 S. Lindbergh Blvd., Suite 200
St. Louis, Missouri 63131

All claims must include:
1) The name and address of the claimant;
2) The amount claimed;
3) The basis for the claim; and
4) The dates(s) and event(s) on which the claim is based.

NOTICE: Because of the dissolution of the Company, any claims against the Company will be barred unless a proceeding to enforce the claim commences within three (3) years after publication of this notice.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST HEARTLAND ASSETS, LLC

On October 17, 2024, the Company filed notice of winding up with the Missouri Secretary of State. The Company requests that all persons with claims against the Company present them immediately by letter to:

Summers Compton Wells LLC
903 S. Lindbergh Blvd., Suite 200
St. Louis, Missouri 63131

All claims must include:
1) The name and address of the claimant;
2) The amount claimed;
3) The basis for the claim; and
4) The dates(s) and event(s) on which the claim is based.

NOTICE: Because of the dissolution of the Company, any claims against the Company will be barred unless a proceeding to enforce the claim commences within three (3) years after publication of this notice.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST HORIZON PLACE, LLC

On October 17, 2024, the Company filed notice of winding up with the Missouri Secretary of State. The Company requests that all persons with claims against the Company present them immediately by letter to:

Summers Compton Wells LLC
903 S. Lindbergh Blvd. Suite 200
St. Louis, Missouri 63131.

All claims must include:
1) The name and address of the claimant;
2) The amount claimed;
3) The basis for the claim; and
4) The dates(s) and event(s) on which the claim is based.

NOTICE: Because of the dissolution of the Company, any claims against the Company will be barred unless a proceeding to enforce the claim commences within three (3) years after publication of this notice.

NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST RAIL DOME CORPORATION, INC F/K/A BRANSON SCENIC RAILWAY

Rail Dome Corporation, Inc., f/k/a Branson Scenic Railway, a Missouri corporation, filed its Articles of Dissolution with the Missouri Secretary of State on October 18, 2024. Any and all claims against Rail Dome Corporation, Inc., f/k/a Branson Scenic Railway, may be sent to:

Evelyn Gwin Mangan
531 E. Bradford Parkway, Suite 302
Springfield, MO 65804

Each claim must include:
1)The name, address, and telephone number of the claimant;
2)The amount of the claim;
3)The date on which the claim arose
4)The basis for the claim; and
5)All documentation to support the claim.

A claim against the Rail Dome Corporation, Inc., f/k/a Branson Scenic Railway will be barred unless a proceeding to enforce the claim is commenced within two (2) years, after publication of the notice.

NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST CATENA TEAL, INC

On August 16, 2024, Catena Teal, Inc., a Missouri corporation (hereinafter the "Corporation"), filed its Articles of Dissolution by Voluntary Action with the Missouri Secretary of State, effective as of the date of filing by the Secretary of State. The Corporation requests that all persons and organizations with claims against it present to them immediately, by letter, to:

Attn/: Hardik Patel
1218 Westrun Dr, Ballwin
MO 63021

Each claim must include the following information:
1) The name, address, and telephone number of the claimant;
2) The amount claimed;
3) The date on which the claim arose;
4) The basis for the claim; and
5) The documentation in support of the claim.

All claims against the Corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication of this notice.

NOTICE OF DISSOLUTION AND WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST COTTAGES OF LIBERAL, L.P.

On September 30, 2024, Cottages of Liberal, L.P. filed a Certificate of Cancellation with the Missouri Secretary of State. All claims against the partnership should be sent in writing by mail to:

Stacee Cohn Bright
7920 Ward Parkway, Suite 205
Kansas City, Missouri 64114

Each claim should include:
1) The name, address and phone number of the claimant;
2) The claim amount;
3) The basis of the claim;
4) The date the claim arose; and
5) The documentation of the claim.

Claims against the partnership will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication this notice.

NOTICE OF CORPORATE DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST JAVA JOJO LTD

On September 3, 2024, Java Jojo Ltd filed Articles of Dissolution with the Missouri Secretary of State. All claims against the corporation should be sent in writing by mail to:

Stacee Cohn Bright
7920 Ward Parkway, Suite 205
Kansas City, Missouri 64114

Each claim should include:
1) The name, address and phone number of the claimant;
2) The claim amount;
3) The basis of the claim;
4) The date the claim arose; and
5) The documentation of the claim.

Claims against the corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication this notice.

NOTICE TO CREDITORS AND CLAIMANTS OF ROCHESTER COOLER, LLC

Rochester Cooler, LLC, a Missouri limited liability company (the "Company") has dissolved and is in the process of winding up its affairs. On October 22, 2024, the Company filed a Notice of Winding Up with the Missouri Secretary of State pursuant to RSMo. Section 347.137. All claims against the Company should be presented in accordance with this notice. Claims should be in writing and sent to:

Rochester Cooler, LLC
c/o Branding Iron Holdings, LLC
1682 Sauget Business Blvd.
Sauget, IL 62206

The claim must contain:
1) The name, address and telephone number of the claimants;
2) The amount of the claim or other relief demanded;
3) The basis of the claim and any documents related to the claim; and
4) The date(s) as of which the event(s) on which the claim is based occurred.

Any and all claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND ALL CLAIMANTS AGAINST FARMINGTON DEPOT, LLC

On October 10, 2024, Farmington Depot, LLC, a Missouri limited liability company, filed its Articles of Termination for Limited Liability Company with the Missouri Secretary of State. You are hereby notified that if you believe you have a claim against Farmington Depot, LLC, you must submit a summary in writing of the circumstances surrounding your claim to:

Farmington Depot, LLC
c/o Dr. Timothy R. McMann
4009 Big Timber Drive
Farmington, MO 63640

The summary of your claim must include the following information:
1) The name, address and telephone number of the claimant;
2) The amount of the claim;
3) The date on which the event on which the claim is based occurred; and
4) A brief description of the nature of the debt or the basis for the claim.

All claims against Farmington Depot, LLC will be barred unless the proceeding to enforce the claim is commenced within three (3) years after publication of this Notice.

NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND ALL CLAIMANTS AGAINST U.S. IMPORT/EXPORT CONNECTION, LLC

On October 10, 2024, U.S. Import/Export Connection, LLC, a Missouri limited liability company, filed its Articles of Termination for Limited Liability Company with the Missouri Secretary of State. You are hereby notified that if you believe you have a claim against U.S. Import/Export Connection, LLC, you must submit a summary in writing of the circumstances surrounding your claim to:

U.S. Import/Export Connection, LLC
c/o Dr. Timothy R. McMann
4009 Big Timber Drive
Farmington, MO 63640

The summary of your claim must include the following information:
1) The name, address and telephone number of the claimant;
2) The amount of the claim;
3) The date on which the event on which the claim is based occurred; and
4) A brief description of the nature of the debt or the basis for the claim.

All claims against U.S. Import/Export Connection, LLC will be barred unless the proceeding to enforce the claim is commenced within three (3) years after publication of this Notice.

NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND ALL CLAIMANTS AGAINST McMANN PROPERTIES, LLC

On October 10, 2024, McMann Properties, LLC, a Missouri limited liability company, filed its Articles of Termination for Limited Liability Company with the Missouri Secretary of State. You are hereby notified that if you believe you have a claim against McMann Properties, LLC, you must submit a summary in writing of the circumstances surrounding your claim to:

McMann Properties, LLC
c/o Dr. Timothy R. McMann
4009 Big Timber Drive
Farmington, MO 63640

The summary of your claim must include the following information:
1) The name, address and telephone number of the claimant;
2) The amount of the claim;
3) The date on which the event on which the claim is based occurred; and
4) A brief description of the nature of the debt or the basis for the claim.

All claims against McMann Properties, LLC will be barred unless the proceeding to enforce the claim is commenced within three (3) years after publication of this Notice.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST ROO ENTERPRISES, LLC

On October 22, 2024, ROO ENTERPRISES, LLC, a Missouri limited liability company filed its Notice of Winding Up with the Missouri Secretary of State. Roo Enterprises, LLC, hereby requests that all persons and organizations with claims against it present them immediately by letter to:

Steven Riley
1404 190th Street
Des Moines, Iowa 50273

All claims must include the following information:
1) The name and address of the claimant;
2) The amount claimed;
3) The date on which the claim arose;
4) The basis for the claim; and
5) Any documentation in support of the claim.

NOTICE: Because of the dissolution of Roo Enterprises, LLC, all claims against Roo Enterprises, LLC will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication date of the notices authorized by Section 347.141 RSMo.

NOTICE OF DISSOLUTION AND WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST WEST KANSAS APARTMENTS, L.P.

On 9/30/2024, West Kansas Apartments, L.P. filed a Certificate of Cancellation with the Missouri Secretary of State. All claims against the partnership should be sent in writing by mail to:

Stacee Cohn Bright
7920 Ward Parkway, Suite 205
Kansas City, Missouri 64114

Each claim should include:
1) The name, address and phone number of the claimant;
2) The claim amount;
3) The basis of the claim;
4) The date the claim arose; and
5) The documentation of the claim.

Claims against the partnership will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication this notice.

NOTICE OF WINDING UP FOR LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST KOCH FAMILY INVESTMENTS, LLC

Koch Family Investments, LLC, a Missouri limited liability company, filed its Notice of Winding Up for a Limited Liability Company with the Missouri Secretary of State on this 24th day of October, 2024. Any and all claims against Koch Family Investments, LLC may be sent to:

Steven P. Kuenzel, Jr.
PO Box 228
Washington, MO 63090

Each claim should include the following information:
1) The name, address and telephone number of the claimant;
2) The amount of the claim;
3) The basis of the claim;
4) The date(s) on which the event(s) on which the claim is based occurred; and
5) Any documentation related to the claim.

Any and all claims against Koch Family Investments, LLC will be barred unless a proceeding to enforce such claim is commenced within three (3) years after the date this notice is published.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST L&A MARINA, LLC

On October 30, 2024, L&A Marina LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up with the Missouri Secretary of State. The Company requests that all persons and organizations who have claims against it present them immediately by letter to:

Kyle Hertel, Lathrop GPM LLP
2345 Grand Boulevard, Suite 2200
Kansas City, MO 64108

All claims must include the following information:
1) The name and address of the claimant;
2) The amount claimed;
3) The date on which the claim arose;
4) The basis for the claim; and
5) Any documentation in support of the claim.

All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the date of publication of this notice.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST L&A BRAZILIA ACQ, LLC

On October 30, 2024, L&A Brazilia ACQ LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up with the Missouri Secretary of State. The Company requests that all persons and organizations who have claims against it present them immediately by letter to:

Kyle Hertel, Lathrop GPM LLP
2345 Grand Boulevard, Suite 2200
Kansas City, MO 64108

All claims must include the following information:
1) The name and address of the claimant;
2) The amount claimed;
3) The date on which the claim arose;
4) The basis for the claim; and
5) Any documentation in support of the claim.

All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the date of publication of this notice.

NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS AGAINST L&A 326 HANLEY, LLC

On October 30, 2024, L&A 326 Hanley LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up with the Missouri Secretary of State. The Company requests that all persons and organizations who have claims against it present them immediately by letter to:

Kyle Hertel, Lathrop GPM LLP
2345 Grand Boulevard, Suite 2200
Kansas City, MO 64108.

All claims must include the following information:
1) The name and address of the claimant;
2) The amount claimed;
3) The date on which the claim arose;
4) The basis for the claim; and
5) Any documentation in support of the claim.

All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the date of publication of this notice.

NOTICE OF CANCELLATION TO CREDITORS OF AND CLAIMANTS AGAINST FERGUSON MEDICAL GROUP, L.P.

Ferguson Medical Group, L.P. a Missouri limited partnership, filed its notice of cancellation with the Missouri Secretary of State on October 21, 2024. If you believe you have a claim against the company, you must submit a written claim to:

Blanton, Nickell, Collins, Douglas, Hanschen, & Peters, LLC
c/o Thomas W. Collins
PO Box 805, 219 S. Kingshighway
Sikeston, Missouri, 63801

Claims must include:
1) The name, address, and telephone number of the claimant;
2) The amount claimed;
3) The basis of the claim;
4) The date on which the claim arose; and
5) Any documentation in support of the claim.

All claims against Ferguson Medical Group, L.P. will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the date of the publication of this notice.

NOTICE OF CORPORATION DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST PDQ TOWER SERVICES, INC

On October 31, 2024, PDQ TOWER SERVICES, INC., a Missouri corporation, Charter Number 00510684, filed its Articles of Dissolution by Voluntary Action with the Missouri Secretary of State. All persons or organizations having claims against PDQ TOWER SERVICES, INC., are required to present them immediately in writing to:

Andrew S. Felker, Attorney at Law
CHINNERY EVANS & NAIL, P.C.
800 NE Vanderbilt Lane
Lee's Summit, MO 64064

Each claim must contain the following information:
1) Name and current address of the claimant.
2) A clear and concise statement of the facts supporting the claim.
3) The date the claim was incurred.
4) The amount of money or alternate relief demanded.

NOTE: CLAIMS AGAINST PDQ TOWER SERVICES, INC., WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN TWO (2) YEARS AFTER THE PUBLICATION OF THIS NOTICE.

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*. Citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year – 48 (2023) and 49 (2024). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				47 MoReg 1457
	DEPARTMENT OF AGRICULTURE				
2 CSR 70-25.005	Plant Industries		49 MoReg 848	49 MoReg 1518	
2 CSR 70-25.010	Plant Industries		49 MoReg 848	49 MoReg 1518	
2 CSR 70-25.020	Plant Industries		49 MoReg 850	49 MoReg 1518	
2 CSR 70-25.030	Plant Industries		49 MoReg 851	49 MoReg 1518	
2 CSR 70-25.050	Plant Industries		49 MoReg 851	49 MoReg 1519	
2 CSR 70-25.060	Plant Industries		49 MoReg 852	49 MoReg 1519	
2 CSR 70-25.070	Plant Industries		49 MoReg 853	49 MoReg 1519	
2 CSR 70-25.080	Plant Industries		49 MoReg 854	49 MoReg 1520	
2 CSR 70-25.090	Plant Industries		49 MoReg 854	49 MoReg 1520	
2 CSR 70-25.100	Plant Industries		49 MoReg 855	49 MoReg 1520	
2 CSR 70-25.110	Plant Industries		49 MoReg 857	49 MoReg 1520	
2 CSR 70-25.120	Plant Industries		49 MoReg 864	49 MoReg 1524	
2 CSR 70-25.130	Plant Industries		49 MoReg 865	49 MoReg 1524	
2 CSR 70-25.140	Plant Industries		49 MoReg 866	49 MoReg 1524	
2 CSR 70-25.150	Plant Industries		49 MoReg 866	49 MoReg 1525	
2 CSR 70-25.153	Plant Industries		49 MoReg 870	49 MoReg 1525	
2 CSR 70-25.156	Plant Industries		49 MoReg 871	49 MoReg 1525	
2 CSR 70-25.160	Plant Industries		49 MoReg 873R	49 MoReg 1525	
2 CSR 70-25.170	Plant Industries		49 MoReg 873	49 MoReg 1526	
2 CSR 70-25.180	Plant Industries		49 MoReg 873	49 MoReg 1526	
2 CSR 80-2.001	State Milk Board		49 MoReg 1571		
2 CSR 80-2.002	State Milk Board		49 MoReg 1571		
2 CSR 80-2.004	State Milk Board		49 MoReg 1572		
2 CSR 80-5.010	State Milk Board		49 MoReg 1493		
2 CSR 90-10.011	Weights, Measures and Consumer Protection		49 MoReg 874	49 MoReg 1619	
2 CSR 90-10.012	Weights, Measures and Consumer Protection		49 MoReg 874	49 MoReg 1619	
2 CSR 90-10.020	Weights, Measures and Consumer Protection		49 MoReg 875	49 MoReg 1619	
2 CSR 90-10.040	Weights, Measures and Consumer Protection		49 MoReg 876	49 MoReg 1619	
2 CSR 90-30.040	Weights, Measures and Consumer Protection		49 MoReg 1441		
2 CSR 90-36.005	Weights, Measures and Consumer Protection		49 MoReg 603	49 MoReg 1455	
2 CSR 90-36.010	Weights, Measures and Consumer Protection		49 MoReg 604	49 MoReg 1455	
2 CSR 90-36.015	Weights, Measures and Consumer Protection		49 MoReg 605	49 MoReg 1456	
	DEPARTMENT OF CONSERVATION				
3 CSR 10-5.210	Conservation Commission		49 MoReg 731	49 MoReg 1305	
3 CSR 10-5.430	Conservation Commission		49 MoReg 955	49 MoReg 1526	
3 CSR 10-5.435	Conservation Commission		49 MoReg 957	49 MoReg 1527	
3 CSR 10-5.440	Conservation Commission		49 MoReg 959	49 MoReg 1527	
3 CSR 10-5.445	Conservation Commission		49 MoReg 961	49 MoReg 1527	
3 CSR 10-5.540	Conservation Commission		49 MoReg 963	49 MoReg 1528	
3 CSR 10-5.545	Conservation Commission		49 MoReg 965	49 MoReg 1528	
3 CSR 10-5.551	Conservation Commission		49 MoReg 967	49 MoReg 1529	
3 CSR 10-5.552	Conservation Commission		49 MoReg 969	49 MoReg 1530	
3 CSR 10-5.554	Conservation Commission		49 MoReg 971	49 MoReg 1530	
3 CSR 10-5.559	Conservation Commission		49 MoReg 973	49 MoReg 1530	
3 CSR 10-5.560	Conservation Commission		49 MoReg 973	49 MoReg 1530	
3 CSR 10-5.565	Conservation Commission		49 MoReg 975	49 MoReg 1531	
3 CSR 10-5.567	Conservation Commission		49 MoReg 977	49 MoReg 1532	
3 CSR 10-5.570	Conservation Commission		49 MoReg 979	49 MoReg 1532	
3 CSR 10-5.576	Conservation Commission		49 MoReg 981	49 MoReg 1532	
3 CSR 10-5.579	Conservation Commission		49 MoReg 983	49 MoReg 1533	
3 CSR 10-5.580	Conservation Commission		49 MoReg 985	49 MoReg 1533	
3 CSR 10-5.605	Conservation Commission		49 MoReg 987	49 MoReg 1533	
3 CSR 10-5.710	Conservation Commission		49 MoReg 1493		
3 CSR 10-6.415	Conservation Commission		49 MoReg 1495		
3 CSR 10-6.535	Conservation Commission		49 MoReg 1495		
3 CSR 10-6.550	Conservation Commission		49 MoReg 1496		
3 CSR 10-7.410	Conservation Commission		49 MoReg 1496		
3 CSR 10-7.412	Conservation Commission		49 MoReg 1496		
3 CSR 10-7.450	Conservation Commission		49 MoReg 1497		
3 CSR 10-7.705	Conservation Commission		49 MoReg 1497		
3 CSR 10-7.710	Conservation Commission		49 MoReg 1498		
3 CSR 10-7.900	Conservation Commission		49 MoReg 793	49 MoReg 1305	
3 CSR 10-9.565	Conservation Commission		49 MoReg 1500		
3 CSR 10-11.115	Conservation Commission		49 MoReg 1502		
3 CSR 10-11.180	Conservation Commission		49 MoReg 1502		
3 CSR 10-11.186	Conservation Commission		49 MoReg 1503		
3 CSR 10-11.205	Conservation Commission		49 MoReg 1504		
3 CSR 10-12.110	Conservation Commission		49 MoReg 1504		
3 CSR 10-12.140	Conservation Commission				
	DEPARTMENT OF ECONOMIC DEVELOPMENT				

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 20-100.110	Division of Learning Service		49 MoReg 731	49 MoReg 1533	
5 CSR 20-200.180	Division of Learning Services		49 MoReg 876	49 MoReg 1533	
5 CSR 20-400.125	Division of Learning Services		49 MoReg 1391		
5 CSR 20-400.610	Division of Learning Services		49 MoReg 877	49 MoReg 1534	
5 CSR 20-400.650	Division of Learning Services		49 MoReg 879	49 MoReg 1534	
5 CSR 20-400.660	Division of Learning Services		49 MoReg 880	49 MoReg 1534	
5 CSR 20-400.670	Division of Learning Services		49 MoReg 882	49 MoReg 1534	
5 CSR 20-500.130	Division of Learning Services		49 MoReg 1051	This Issue	
5 CSR 20-500.170	Division of Learning Services		49 MoReg 1052	This Issue	
5 CSR 20-500.180	Division of Learning Services		49 MoReg 1052	This Issue	
5 CSR 20-500.190	Division of Learning Services		49 MoReg 1053	This Issue	
5 CSR 20-500.200	Division of Learning Services		49 MoReg 1054	This Issue	
5 CSR 30-660.090	Division of Financial and Administrative Services		49 MoReg 607R 49 MoReg 1504R	49 MoReg 1456W	
	DEPARTMENT OF HIGHER EDUCATION AND WORKFORCE DEVELOPMENT				
	MISSOURI DEPARTMENT OF TRANSPORTATION				
7 CSR 10-4.020	Missouri Highways and Transportation Commission	49 MoReg 1699	49 MoReg 1704		
7 CSR 10-25.020	Missouri Highways and Transportation Commission		49 MoReg 1393		
	DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS				
	DEPARTMENT OF MENTAL HEALTH				
	DEPARTMENT OF NATURAL RESOURCES				
10 CSR 10-6.060	Director's Office		49 MoReg 1054		
10 CSR 10-6.065	Director's Office		49 MoReg 1067		
10 CSR 10-6.110	Director's Office		49 MoReg 1082		
10 CSR 10-6.241	Director's Office		49 MoReg 1094		
10 CSR 10-6.250	Director's Office		49 MoReg 1103		
10 CSR 10-6.255	Director's Office		49 MoReg 1115		
10 CSR 10-6.261	Director's Office		49 MoReg 1572		
10 CSR 20-6.030	Clean Water Commission		49 MoReg 1121		
10 CSR 20-8.130	Clean Water Commission		49 MoReg 1123		
10 CSR 20-8.200	Clean Water Commission		49 MoReg 1125		
10 CSR 23-1.010	Well Installation		49 MoReg 607	49 MoReg 1456	
10 CSR 23-1.140	Well Installation		49 MoReg 608	49 MoReg 1456	
10 CSR 23-3.030	Well Installation		49 MoReg 608	49 MoReg 1456	
10 CSR 23-3.050	Well Installation		49 MoReg 612	49 MoReg 1458	
10 CSR 23-3.080	Well Installation		49 MoReg 612	49 MoReg 1459	
10 CSR 23-3.090	Well Installation		49 MoReg 615	49 MoReg 1460	
10 CSR 23-3.110	Well Installation		49 MoReg 631	49 MoReg 1460	
10 CSR 23-4.060	Well Installation		49 MoReg 632	49 MoReg 1460	
10 CSR 23-5.050	Well Installation		49 MoReg 633	49 MoReg 1460	
10 CSR 25-3.260	Hazardous Waste Management Commission		49 MoReg 1267		
10 CSR 25-4.261	Hazardous Waste Management Commission		49 MoReg 1270		
10 CSR 25-5.262	Hazardous Waste Management Commission		49 MoReg 1271		
10 CSR 25-7.264	Hazardous Waste Management Commission		49 MoReg 1274		
10 CSR 25-7.265	Hazardous Waste Management Commission		49 MoReg 1276		
10 CSR 25-7.266	Hazardous Waste Management Commission		49 MoReg 1278		
10 CSR 25-7.268	Hazardous Waste Management Commission		49 MoReg 1278		
10 CSR 25-7.270	Hazardous Waste Management Commission		49 MoReg 1279		
10 CSR 25-11.279	Hazardous Waste Management Commission		49 MoReg 1281		
10 CSR 25-12.010	Hazardous Waste Management Commission		49 MoReg 1284		
10 CSR 25-12.020	Hazardous Waste Management Commission		49 MoReg 1290		
10 CSR 25-16.273	Hazardous Waste Management Commission		49 MoReg 1291		
10 CSR 40-10.025	Missouri Mining Commission		49 MoReg 884	This Issue	
10 CSR 90-2.070	State Parks		49 MoReg 1399		
10 CSR 140-2.020	Division of Energy		49 MoReg 1400		This Issue
	DEPARTMENT OF PUBLIC SAFETY				
11 CSR 30-1.010	Office of the Director		49 MoReg 987	This Issue	
11 CSR 30-8.010	Office of the Director		49 MoReg 987R	This Issue R	
11 CSR 30-8.020	Office of the Director		49 MoReg 988R	This Issue R	
11 CSR 30-8.030	Office of the Director		49 MoReg 988R	This Issue R	
11 CSR 30-8.040	Office of the Director		49 MoReg 988R	This Issue R	
11 CSR 30-19.010	Office of the Director		49 MoReg 988	This Issue	
11 CSR 40-2.025	Division of Fire Safety		49 MoReg 1505		
11 CSR 40-6.020	Division of Fire Safety		49 MoReg 1505		
11 CSR 40-6.025	Division of Fire Safety		49 MoReg 1506		
11 CSR 40-6.031	Division of Fire Safety		49 MoReg 1506		
11 CSR 40-6.033	Division of Fire Safety		49 MoReg 1509		
11 CSR 40-6.060	Division of Fire Safety		49 MoReg 1509		
11 CSR 40-6.065	Division of Fire Safety		49 MoReg 1512		
11 CSR 45-13.030	Missouri Gaming Commission		49 MoReg 1442		
11 CSR 45-30.135	Missouri Gaming Commission		49 MoReg 1442		
11 CSR 45-30.280	Missouri Gaming Commission		49 MoReg 1443		
11 CSR 45-30.610	Missouri Gaming Commission		49 MoReg 1443		
11 CSR 50-2.010	Missouri State Highway Patrol		49 MoReg 1293	This Issue	
11 CSR 50-2.020	Missouri State Highway Patrol		49 MoReg 1294	This Issue	
11 CSR 50-2.060	Missouri State Highway Patrol		49 MoReg 1294	This Issue	
11 CSR 50-2.070	Missouri State Highway Patrol		49 MoReg 1295	This Issue	
11 CSR 50-2.090	Missouri State Highway Patrol		49 MoReg 1295	This Issue	

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
11 CSR 50-2.100	Missouri State Highway Patrol		49 MoReg 1296	This Issue	
11 CSR 50-2.110	Missouri State Highway Patrol		49 MoReg 1296	This Issue	
11 CSR 50-2.120	Missouri State Highway Patrol		49 MoReg 1297	This Issue	
11 CSR 50-2.140	Missouri State Highway Patrol		49 MoReg 1299	This Issue	
11 CSR 70-2.010	Division of Alcohol and Tobacco Control		49 MoReg 1345		
11 CSR 70-2.020	Division of Alcohol and Tobacco Control		49 MoReg 1345		
11 CSR 70-2.050	Division of Alcohol and Tobacco Control		49 MoReg 1346		
11 CSR 70-2.060	Division of Alcohol and Tobacco Control		49 MoReg 1346		
11 CSR 70-2.120	Division of Alcohol and Tobacco Control		49 MoReg 1444		
11 CSR 70-2.130	Division of Alcohol and Tobacco Control		49 MoReg 1575		
11 CSR 70-2.140	Division of Alcohol and Tobacco Control		49 MoReg 1347		
11 CSR 70-2.240	Division of Alcohol and Tobacco Control		49 MoReg 1347		
11 CSR 70-2.270	Division of Alcohol and Tobacco Control		49 MoReg 1349		
11 CSR 90-4.010	Missouri 911 Service Board		49 MoReg 793	49 MoReg 1461	
11 CSR 90-4.020	Missouri 911 Service Board		49 MoReg 794	49 MoReg 1461	
11 CSR 90-4.030	Missouri 911 Service Board		49 MoReg 794	49 MoReg 1461	
11 CSR 90-4.040	Missouri 911 Service Board		49 MoReg 794	49 MoReg 1461	
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12 CSR 10-24.325	Director of Revenue		49 MoReg 736	49 MoReg 1534	
12 CSR 10-24.330	Director of Revenue		48 MoReg 1544	49 MoReg 101	
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15 CSR 30-51.172	Secretary of State	This Issue	This Issue		
15 CSR 30-51.174	Secretary of State	This Issue	This Issue		
15 CSR 30-120.010	Secretary of State *moved to 20 CSR 1140-120.010*				49 MoReg 1467
15 CSR 30-120.020	Secretary of State *moved to 20 CSR 1140-120.020*				49 MoReg 1467
15 CSR 30-120.030	Secretary of State *moved to 20 CSR 1140-120.030*				49 MoReg 1467
15 CSR 30-120.040	Secretary of State *moved to 20 CSR 1140-120.040*				49 MoReg 1467
15 CSR 30-120.050	Secretary of State *moved to 20 CSR 1140-120.050*				49 MoReg 1467
15 CSR 30-120.060	Secretary of State *moved to 20 CSR 1140-120.060*				49 MoReg 1467

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
15 CSR 30-120.070	Secretary of State *moved to 20 CSR 1140-120.070*				49 MoReg 1467
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16 CSR 10-1.040	The Public School Retirement System of Missouri		49 MoReg 1708		
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19 CSR 60-50.430	Missouri Health Facilities Review Committee		49 MoReg 815	49 MoReg 1464	
19 CSR 60-50.440	Missouri Health Facilities Review Committee		49 MoReg 818	49 MoReg 1464	
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20 CSR	Sovereign Immunity Limits				49 MoReg 45
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20 CSR 1140-120.030	Division of Finance *formerly 15 CSR 30-120.030*		49 MoReg 1606R		49 MoReg 1467
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20 CSR 1140-120.050	Division of Finance *formerly 15 CSR 30-120.050*				49 MoReg 1468 49 MoReg 1467
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20 CSR 1140-120.070	Division of Finance *formerly 15 CSR 30-120.070*				49 MoReg 1468 49 MoReg 1467
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20 CSR 2063-1.015	Behavior Analyst Advisory Board		49 MoReg 1143	49 MoReg 1624	
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20 CSR 4240-10.155	Public Service Commission		49 MoReg 1609		

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20 CSR 4240-20.015	Public Service Commission		49 MoReg 1615R		
20 CSR 4240-20.017	Public Service Commission		49 MoReg 1615R		
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20 CSR 4240-40.016	Public Service Commission		49 MoReg 1616R		
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22 CSR 10-2.047	Health Care Plan	This Issue	This Issue		
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22 CSR 10-2.090	Health Care Plan	This Issue	This Issue		
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22 CSR 10-3.020	Health Care Plan	This Issue	This Issue		
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22 CSR 10-3.058	Health Care Plan	This Issue	This Issue		
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Division of Alcohol and Tobacco Control				
11 CSR 70-2.010	Definitions	49 MoReg 601	April 5, 2024	Jan. 15, 2025
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13 CSR 35-38.010	Adoption and Guardianship Subsidy	49 MoReg 1043	June 25, 2024	Feb. 27, 2025
13 CSR 35-71.015	Background Checks for Personnel of Residential Care Facilities and Child Placing Agencies	This Issue	Nov. 7, 2024	May 5, 2025
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13 CSR 70-15.010	Inpatient Hospital Services Reimbursement Methodology	49 MoReg 1329	Aug. 9, 2024	Feb. 27, 2025
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	49 MoReg 1334	Aug. 9, 2024	Feb. 27, 2025
13 CSR 70-15.160	Outpatient Hospital Services Reimbursement Methodology	This Issue	Oct. 30, 2024	April 27, 2025
13 CSR 70-15.230	Upper Payment Limit (UPL) Payment Methodology	49 MoReg 1341	Aug. 9, 2024	Feb. 27, 2025
13 CSR 70-25.160	Doula Services	49 MoReg 1489	Sept. 30, 2024	March 28, 2025
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15 CSR 30-51.170	Dishonest or Unethical Business Practices by Broker-Dealers and Agents	This Issue	Nov. 6, 2024	May 4, 2025
15 CSR 30-51.172	Dishonest or Unethical Business Practices by Investment Advisers and Investment Adviser Representatives	This Issue	Nov. 6, 2024	May 4, 2025
15 CSR 30-51.174	Fraudulent Practices of Investment Advisers and Investment Adviser Representatives	This Issue	Nov. 6, 2024	May 4, 2025
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19 CSR 30-1.002	Schedules of Controlled Substances	49 MoReg 1557	Oct. 8, 2024	April 5, 2025
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20 CSR 2120-2.106	Preneed Funeral Contract Audit Fee Waiver	49 MoReg 789	May 14, 2024	Feb. 20, 2025
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20 CSR 2197-2.010	Application for Licensure	49 MoReg 952	July 1, 2024	Feb. 27, 2025
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20 CSR 2232-1.040	Fees	49 MoReg 1049	Sept. 1, 2024	Jan. 31, 2025
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22 CSR 10-2.020	General Membership Provisions	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-2.025	Rule for Participating Higher Education Entity Entry into the Missouri Consolidated Health Care Plan	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-2.046	PPO 750 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-2.047	PPO 1250 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-2.053	Health Savings Account Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-2.075	Review and Appeals Procedure	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-2.089	Pharmacy Employer Group Waiver Plan for Medicare Primary Members	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-2.090	Pharmacy Benefit Summary	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-2.140	Strive for Wellness® Health Center Provisions, Charges, and Services	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-3.020	General Membership Provisions	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-3.055	Health Savings Account Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-3.058	PPO 750 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-3.059	PPO 1250 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-3.075	Review and Appeals Procedure	This Issue	Jan. 1, 2025	June 29, 2025
22 CSR 10-3.090	Pharmacy Benefit Summary	This Issue	Jan. 1, 2025	June 29, 2025

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo.

ORDER	SUBJECT MATTER	FILED DATE	PUBLICATION
	2024		
24-15	Orders state offices to be closed on Friday, November 29, 2024	November 7, 2024	Next Issue
24-14	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to ongoing and forecasted severe storm systems	November 5, 2024	Next Issue
24-13	Declares a drought alert for 88 Missouri counties in accordance with the Missouri Drought Mitigation and Response Plan and orders the director of the Department of Natural Resources to activate and designate a chairperson for the Drought Assessment Committee	October 29, 2024	This Issue
24-12	Revokes the rescission of Executive Order 97-97	October 24, 2024	This Issue
24-11	Rescinds 177 executive orders that are no longer necessary or applicable to the operations of the government	October 23, 2024	This Issue
24-10	Directs the Department of Health and Senior Services to address foods containing unregulated psychoactive cannabis products and the Department of Public Safety Division of Alcohol and Tobacco to amend regulations on unregulated psychoactive cannabis products	August 1, 2024	49 MoReg 1343
24-09	Orders executive branch state offices closed on Friday, July 5, 2024	July 1, 2024	49 MoReg 1188
24-08	Extends Executive Order 24-06 and the State of Emergency until July 31, 2024	June 26, 2024	49 MoReg 1187
24-07	Extends Executive Order 23-06 and the State of Emergency until June 30, 2024	May 30, 2024	49 MoReg 954
24-06	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to forecasted severe storm systems	May 2, 2024	49 MoReg 847
24-05	Extends Executive Order 23-05 to address drought-response efforts until September 1, 2024	April 26, 2024	49 MoReg 792
24-04	Designates members of his staff to have supervisory authority over departments, divisions and agencies of state government	February 29, 2024	49 MoReg 447
24-03	Declares a State of Emergency and declares Missouri will implement the Emergency Mutual Aid Compact (EMAC) agreement with the State of Texas to provide support with border operations	February 20, 2024	49 MoReg 446
24-02	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to forecasted winter storm systems	January 11, 2024	49 MoReg 270
24-01	Orders the Dept. of Agriculture to establish rules regarding acquisitions of agricultural land by foreign businesses	January 2, 2024	49 MoReg 136
	2023		
23-10	Extends Executive Order 23-05 to address drought-response efforts until May 1, 2024	November 17, 2023	48 MoReg 2267
23-09	Orders state offices to be closed on Friday, November 24, 2023	November 9, 2023	48 MoReg 2149
23-08	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to forecasted severe storm systems	August 5, 2023	48 MoReg 1684
23-07	Designates members of his staff to have supervisory authority over departments, divisions and agencies of state government	July 28, 2023	48 MoReg 1595
23-06	Rescinds Executive Order 17-20	June 29, 2023	48 MoReg 1423

ORDER	SUBJECT MATTER	FILED DATE	PUBLICATION
23-05	Declares drought alerts for 60 Missouri counties in accordance with the Missouri Drought Mitigation and Response Plan	May 31, 2023	48 MoReg 1179
23-04	Designates members of the governor's staff as having supervisory authority over each department, division, or agency of state government	April 14, 2023	48 MoReg 911
23-03	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to severe storm systems	March 31, 2023	48 MoReg 795
23-02	Extends Executive Order 22-08, the State of Emergency, and waivers until February 28, 2023	January 24, 2023	48 MoReg 433
23-01	Orders the commencement of the Missourians Aging with Dignity Initiative, with directives to support all citizens as they age	January 19, 2023	48 MoReg 431

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Rulemaking Classes

Are you new to rulemaking or in need of a refresher course to assist you in filing rules or understanding the rulemaking process?

The Administrative Rules Division offers group and individual classes for rule drafting and preparation of rule packets. Please call Curtis at (573) 751-2022 or email curtis.treat@sos.mo.gov to schedule a class.

We offer both in-person and virtual classes.

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