Volume 27, Number 14
Pages 1153–1244
July 15, 2002

MATT BLUNT

SECRETARY OF STATE

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

SECRETARY OF STATE

MATT BLUNT

Administrative Rules Division

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO

Subscription fee: $56.00 per year

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

MISSOURI REGISTER
Office of the Secretary of State
Administrative Rules Division
PO Box 1767
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MISSOURI REGISTER

July 15, 2002 Vol. 27 No. 14 **Pages 1153–1244**

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

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HOW TO CITE RULES AND RSMo

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

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

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

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

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

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

FROM THIS ANGLE . . .

Rule Tips

Please watch the back page of the *Missouri Register* for our "top ten" list of rulemaking tips — these are being placed on upcoming editions of the *Register* to assist you, our rulemakers!

Please call or e-mail us at www.rules@sosmail.state.mo.us if you have any tips you would like to share with us!

Rulemaking 1-2-3, Missouri Style Classes

We enjoyed teaching our latest class on the proper steps and procedures to rulemaking at the offices of the Division of Professional Registration. Remember, if your agency needs assistance on the proper procedures for rulemaking — or if we may assist you in making this process smoother for your agency please contact us to schedule your class. Our schedule is filling up — but we still have a few openings.

Additionally, if you do not have your *new* rulemaking manual, we still have a few copies available. Contact us to receive your copy.

Still Needing your Thoughts . . .

As we look toward the future and automating our process, we have discussed the possibility of publishing the *Missouri Register* in electronic copy *only*. We respectfully request your input in this regard! What potential problems, if any, would it pose for your agency or for you personally, to have the *Missouri Register* available in *ONLY* electronic copy on our website? Drop us an e-mail or give us a call regarding this subject.

Thank you!

We would like to thank Connie Clarkston from the Department of Economic Development, Division of Professional Registration, for sharing of her time, input, and talents to assist us as an agency representative on our process of gathering information to formulate an RFP to automate the process of administrative rules. Connie has offered valuable assistance from an agency perspective to this committee. Thank you, Connie!

E-Mail Notification Service

In a previous edition of **From this Angle**, we inquired of your level of interest in an e-mail notification service (you would be notified *via* e-mail when a specific topic or subject matter has been addressed by a rulemaking filed with our office). Do you feel this service would be beneficial to you or your agency? We also would appreciate hearing from you in this regard.

Please contact us if we may assist you in any way with the rulemaking process.

Lynne C. Angle
Director, Administrative Rules

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

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

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

Title 1—OFFICE OF ADMINISTRATION
Division 10—Commissioner of Administration
Chapter 11—Travel Regulations

EMERGENCY AMENDMENT

1 CSR 10-11.010 State of Missouri Travel Regulations. The Office of Administration is amending sections (3), (15), (17) and (19), deleting section (10) and renumbering the remaining sections accordingly.

PURPOSE: These amendments reflect a change to the travel regulations for meal reimbursements and travel outside the state by privately-owned automobiles in lieu of air that could result in savings to the state.

*EMERGENCY STATEMENT: The Office of Administration finds a compelling governmental interest, which requires this emergency action. This emergency amendment is necessary to increase accountability and savings to the state at a time when the state is experiencing a significant budget shortfall. Savings as a result of this emergency amendment are needed to help address the budget shortfall. Due to the performance audit from the Office of State Auditor, dated September 25, 2001, state agencies are already aware of the recommended changes that are now being adopted. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Office of Administration believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed June 20, 2002, effective July 1, 2002, and expires February 27, 2003.*

(3) Officials and employees will be allowed travel expenses when required to travel away from their official domicile on state business. *[In instances where employees incur breakfast or evening meals when leaving and returning to their official domicile, they should indicate on their expense report that an early departure or late arrival was required to conduct state business.]* **To qualify for reimbursement for meal(s), officials and employees must be in continuous travel status for twelve (12) hours or more. Officials and employees shall indicate on their expense report the twelve (12)-hour status, if no overnight lodging is listed.** Mileage reimbursement for official use of a private motor vehicle may be claimed within the official domicile.

[(10) In certain situations (as in the metropolitan areas of Kansas City, St. Joseph, St. Louis and Springfield) where it is clearly economical or advantageous to the state, the Office of Administration may authorize reimbursement for meals for employees traveling on state business in the area, regardless of the location of their official domicile. Generally, this will include the noon meal only. This shall apply only to employees who by the nature of their jobs are required to travel and are reimbursed while on state business in their official domicile.]

[(11)] **(10)** State employees and officials may be reimbursed for travel expenses incurred for other employees or nonemployees provided the specific business reason necessary for doing so is indicated along with the names of those involved. This is intended to be used for those common types of travel situations where it is normal and practical for one (1) individual to pay for an expense rather than be divided among all individuals. Examples may be a restaurant bill or hotel charge for which a room was shared. Reimbursement for spouse expenses at an official business function requires a written justification preapproved by the commissioner of administration. This reimbursement is limited to elected officials, judges and department directors or those designated to represent them and must be for a legitimate business reason where attendance of the spouse is required to represent the state. State employees and officials may be reimbursed for expenses incurred by their spouses or other members of their families only as provided for concerning transportation to and from the airport in section (9) ((travel rule) (9)), relocation expenses in section *[(20)]* **(19)** ((travel rule) *[(20)]* **(19)**) and representing the state at an official business function in section *[(11)]* **(10)** ((travel rule) *[(11)]* **(10)**).

[(12)] **(11)** The following rules shall apply for allowances for travel in privately-owned automobiles, privately-owned and rented aircraft, and aircraft charters:

(A) For travel in privately-owned automobiles, the state mileage allowance shall be at the current rate ordered by the commissioner of administration pursuant to section 33.095, RSMo. Any changes to the mileage allowance rate will be effective on July 1. Contact your agency fiscal office for the current authorized rate. Mileage figures listed on the Monthly Expense Report Form shall be rounded to the nearest whole mile. Toll charges for bridges and turnpikes as well as parking charges will also be allowed. When more than one (1) person travels in the same automobile, only the owner of the vehicle shall be allowed mileage. The state

mileage allowance rate represents full compensation for the costs of operating your vehicle. Physical damage or loss to your private vehicle and/or its personal property contents is not covered by the state. Coverage should be obtained through personal auto insurance. Liability to others, including passengers, must be covered by your private auto policy. Refer to your policy or contact your agent for coverage specifics concerning use of your private vehicle for business activities;

(B) For travel in privately-owned or rented aircraft, the employee shall be reimbursed a mileage allowance at a rate of twenty-four and one-half cents (24 1/2¢) per mile. The mileage shall be determined by the number of air miles. When more than one (1) person travels in the same aircraft, only the employee who owned or rented the aircraft shall receive the mileage allowance;

(C) For travel in a chartered aircraft (chartered from a nonaffiliated party and piloted by the charter service), prior authorized approval shall be obtained from the Office of Administration. That approval shall be limited to a reasonable rate based upon the mileage and size of the aircraft needed. When submitted as a reimbursement request, proper receipts shall be attached to the expense report; and

(D) For travel by rented auto, the employee will be reimbursed the actual cost of the rental plus fuel. Direct billing is not allowed. Weekly car rental rates will be allowed if the cost is less than the total cost of renting at the daily rate. The State Legal Expense Fund provides liability coverage for the usage of rental vehicles for official state business. For that reason, employees will not be reimbursed for any car rental insurance incurred. Usage of rental vehicles for personal activities is not covered by the Legal Expense Fund. Employees must provide at their own expense insurance coverage for personal use of rental vehicles. The Office of Administration Risk Management Section publishes a *Guide for Drivers on State Business* which describes procedures to follow should an accident occur.

[(13)] **(12)** The following rules shall apply for allowances for travel in state-owned vehicles:

(A) Expenses for gasoline, oil, storage, washing, greasing and other necessary services will be allowable as long as proper receipts are attached to the expense report;

(B) Charges for garaging state-owned vehicles shall be allowable for officials and employees at their official domicile providing—

1. That the state has no available facilities for garaging;

2. That the garage used is not owned by the employee or immediate family;

3. That the cost of the garage rental is not included in the rental charge for the living quarters of the state official or employee; and

4. That storage is reasonable in amount, necessary and to the advantage of the state; and

(C) State-issued credit cards for state-owned vehicles shall be used with those companies that have agreed to accept the credit cards. Payments to oil companies covering credit card purchases should be listed on the warrant request. These payments must be supported by the statement received from the company and accompanied by gasoline purchase charge slips. Gasoline purchases with state credit cards will not be listed on the expense report.

[(14)] **(13)** An officer or employee whose resident city is in some place other than the city of the official domicile shall not be allowed expenses while in such resident city or mileage to travel between the resident city and the city of the official domicile. Reimbursement may be made for a meal charge within the city of residence if incurred as part of a department or agency sponsored conference or business meeting as described in section *[(15)]* **(14)** ((travel rule) *[(15)]* **(14)**). Travel expenses shall be reimbursed and computed between the travel site destination and the employee's official domicile or residence, if leaving directly from the residence, whichever is less. Any additional travel expenses incurred by reason of an employee or official choosing to reside in a place other than the city of the official domicile is not allowed. The city/town or place of official domicile must be listed on the monthly expense report.

[(15)] **(14)** No official or employee shall be allowed hotel or meals while in their city of official domicile, except as provided in *[section (10) ((travel rule) (10)) and]* this section *[(15)]* **(14)** ((travel rule) *[(15)]* **(14)**). While traveling on state business, employees and officials will not be allowed hotel expenses when it would be more economical and advantageous to the state to return to their residence. Reimbursement or direct billing may be made for agency-provided meal expenses within the city of official domicile when it is incurred as part of a department or agency required meeting or a department sponsored conference. This represents meals served to officers and employees at conferences and meetings who are interacting and conducting state business during the meal period. Direct billing and reimbursement of meals served in conjunction with agency required meetings attended by in-domicile employees shall be documented with the names of those involved or the group name with the number attending and the specific state business reason for the meeting. The state business reason can be documented in the form of an agenda, program, or other specific description.

[(16)] **(15)** The following procedures will be utilized in submitting claims for reimbursement:

(A) All claims must be prepared on a typewriter or in ink. The original shall be filed with the Office of Administration;

(B) Descriptive invoices for lodging, conference registration, airline/air charter, bus and rail transportation billed directly to the state must be submitted on a warrant request with a copy of an approved Out of State Travel Authorization Form, if applicable, attached to each invoice;

(C) Where charges for transportation, lodging, and conference registrations are not billed directly to the state, the following documentation is required for reimbursement:

1. Reimbursement for transportation must be supported by a vendor document describing the travel and a proof of payment;

2. Reimbursement for lodging must be supported with a hotel document indicating the lodging specifics and a proof of payment;

3. Reimbursement for conference registrations must be supported by a descriptive vendor document and a proof of payment;

4. Proof of payment may be in the form of a vendor receipt or a vendor marking on the invoice document that the charge has been paid. Proof of payment may also be in the form of a credit card receipt, credit card statement copy showing the charge, or a copy of a personal check that has been canceled by the bank; and

5. Fiscal personnel must verify that travel reimbursement claims are correct before submitting the claim to the Office of Administration. Primary responsibility for authenticating travel reimbursement claims rests with the department and agency directors;

(D) Any unusual expenses incurred shall be itemized on the expense report and accompanied by receipts for payment. The justification for incurring any unusual expenses shall be fully explained by letter or notation on the expense report form;

(E) Each monthly expense report shall be limited to cover expenses incurred during a one (1)-month period. The Office of Administration will not accept more than one (1) monthly expense report per individual per month. The expense reports must be rendered currently to facilitate prompt payment;

(F) Rubber stamps or facsimile signatures for the claimant on the expense report form shall not be honored unless otherwise provided by state law; and

(G) All claims for reimbursement of expenses must be itemized and attested to by the claimant and approved by the director of the department or as otherwise provided by state law.

[(17)] **(16)** The following additional rules shall apply to all travel outside the state that is necessary for the performance of official state business:

(A) All travel outside the state requires approval by the director, head of the department or their authorized representative. This rule shall not apply to members of the legislature or other legislative branch employees, judges and other judicial branch employees and elected officials of the executive branch and their employees;

(B) A copy of the approved Out of State Travel Authorization Form bearing the signature of the director, head of the department or his/her authorized representative shall be attached to the expense report for reimbursement for travel expenses incurred outside the state. The Out of State Travel Authorization Form must be the form approved by the Office of Administration and include, but not be limited to, the following information: name(s) of employee(s), destination, purpose of the trip, dates of travel, manner of transportation and estimated total expenses;

(C) Agencies shall include on one (1) Out of State Travel Authorization Form the names of all individuals requesting travel to the same place at the same date and for the same purpose. In these instances each employee must secure a copy of the authorization for submission with the monthly expense report; and

(D) Air travel shall be the primary method of transportation outside of the state unless other methods of travel are more economical or advantageous to the state. State agencies should plan their out of state travel by making advance air travel reservations to obtain the lowest convenient air fares. Air travel shall not, however, exceed coach fare for the most direct available route. Travel outside the state by commercial common carrier surface transportation, in lieu of air transportation, shall be limited to the actual cost of the surface carrier. *[Travel outside the state by privately-owned automobile, in lieu of air transportation, shall be limited to the state mileage allowance. The total mileage allowance cannot, however, exceed the highest cost coach air fare available at that time to the same destination. No meals, lodging or other travel expenses incurred as a result of taking surface transportation, in lieu of air, will be allowed.]* **Travel outside the state by privately-owned automobile, in lieu of air transportation, shall be limited to the state mileage allowance plus any actual expenses which would have been allowed or provided if taking air transportation. The total allowable expenses cannot, however, exceed the reasonable coach airfare available at that time to the same destination. Travel outside of the state by rented automobile or state car, in lieu of air transportation, shall be limited to the cost of the rented car and necessary fuel.** The Office of Administration may require a written justification for extensive travel out of state by privately-owned auto when the mileage allowance cost does not appear economical or advantageous to the state.

[(18)] **(17)** State department directors are authorized to promulgate and enforce regulations governing travel. Departmental regulations may be more restrictive than these regulations. Departmental regulations shall not grant expenses that are not allowed under the State of Missouri Travel Regulations.

[(19)] **(18)** The commissioner of administration or an authorized representative may approve unusual travel expenses not covered by these regulations or modify procedures for the payment of travel expenses. **The commissioner of administration may make exceptions to any of these regulations deemed appropriate and in the best interests of the state.** The *[need]* **request** for reimbursement **of exception travel expenses, or** of unusual travel expenses shall be made in writing to the Office of Administration.

[(20)] **(19)** Reimbursement for recruiting and relocation expenses for new or existing employees and their families will be made in accordance with the applicable department's policy. Before submitting any recruiting or relocation expenses, departments desiring to pay such expenses shall submit their policies to the commissioner of administration for approval. If a department does not submit a policy for approval, those expenses shall be paid based upon the Office of Administration employee relocation policy distributed to each department.

AUTHORITY: section 33.090, RSMo [Supp. 1995] 2000. Original rule filed Jan. 22, 1974, effective Feb. 1, 1974. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed June 20, 2002, effective July 1, 2002, expires Feb. 27, 2003. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 90—Weights and Measures
Chapter 10—Liquefied Petroleum Gases

EMERGENCY AMENDMENT

2 CSR 90-10.040 NFPA Manual No. 58, ***Storage and Handling of Liquefied Petroleum Gases***. The department is adding section (9).

PURPOSE: The purpose of this amendment is to move the effective date of the overfill prevention device (OPD) requirement from June 30, 2002 to December 15, 2002.

EMERGENCY STATEMENT: The current demand for overfill prevention devices (OPDs) for propane cylinders is much greater than manufacturers can produce. The inability to obtain overfill prevention devices by June 30, 2002 will place propane retailers and consumers in violation of the OPD requirement. Propane retailers have commented that unless they can obtain OPDs prior to the June 30, 2002 deadline, or there is a change in the effective date of the OPD requirement, they have been advised by their legal counsel to cease cylinder filling operations. This will have a tremendous impact on the economic well being of the propane industry while also affecting the consumers ability to have their propane cylinders filled that are utilized for barbeque grills, recreational vehicles, etc. This emergency rule will delay the effective date of the OPD requirement, assist manufacturers in meeting the demand for OPDs in a legal and orderly manner and allow propane retailers and consumers to remain compliant. The Department of Agriculture believes this emergency rule is fair and equitable to all affected persons and parties. Emergency amendment filed June 20, 2002 effective June 30, 2002, expires Dec. 30, 2002.

(9) The effective date of the requirement relating to overfill protection devices in sections 2.3.1.5(a) (b) (c) and (d) of the 2001 edition of the ***National Fire Protection Association Manual 58*** **shall be postponed from June 30, 2002 until December 15, 2002.**

AUTHORITY: sections 261.023.6 and 323.020, RSMo 2000. Original rule filed Jan. 24, 1968, effective Feb. 3, 1968. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed June 20, 2002, effective June 30, 2002, expires Dec. 30, 2002.*

Title 8—DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
Division 10—Division of Employment Security
Chapter 4—Unemployment Insurance

EMERGENCY RULE

8 CSR 10-4.180 Coverage of Indian Tribes

PURPOSE: This rule implements the federally mandated coverage of Indian tribes under the Missouri Employment Security Law, Chapter 288, RSMo.

EMERGENCY STATEMENT: This rule implements federally mandated coverage of Indian tribes under the Missouri Employment Security Law. On December 21, 2000, President Clinton signed the Consolidated Appropriations Act (CAA) of 2001. The CAA amended federal law to change the way federally recognized Indian tribes are treated under the Federal Unemployment Tax Act (FUTA). Indian tribes are now treated similarly to state and local governments. The CAA amendments became effective December 21, 2000, and states are required to incorporate these federal provisions into their unemployment insurance programs by July 1, 2002.

If Missouri fails to incorporate these federal provisions concerning coverage of Indian tribes into its unemployment insurance program, the state will be out of conformity with federal law and the Secretary of the United States Department of Labor could withhold annual certification of the state's unemployment insurance program. As a result of such action by the Secretary of the United States Department of Labor, Missouri employers would lose their credits against their federal unemployment tax liabilities. The state of Missouri could also lose federal grants to administer its unemployment insurance program, and its employment services and employee training programs. Additionally, the state of Missouri could lose its ability to borrow from the federal government to maintain the solvency of state's unemployment compensation trust fund. Currently, the state of Missouri does not have sufficient general revenue to compensate for this loss of federal funding. Therefore, if the Secretary of the United States Department of Labor withheld certification of Missouri's unemployment insurance program, this vital program would cease to function. Unemployed Missouri workers would not receive needed unemployment benefit payments and Missouri employers would pay millions of dollars in additional federal unemployment taxes.

*This rule must be implemented immediately to avoid decertification of the Missouri unemployment insurance program by the United States Secretary of Labor. As a result, the Division of Employment Security finds an immediate danger to the public health, safety and/or welfare and a compelling governmental interest. 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 Division of Employment Security believes this emergency rule is fair to all interested persons and parties under the circumstances. This emergency rule was filed June 13, 2002, effective July 1, 2002, and expires December 27, 2002.*

(1) Definitions. As used in this rule, except as otherwise required for the content, the following terms shall have the meanings ascribed:

(A) Director—The administrative head of the Division of Employment Security.

(B) Division—The Division of Employment Security.

(C) Indian tribe—The meaning given to such term in section 3306 of the Federal Unemployment Tax Act (26 U.S.C. 3306).

(D) Employer—Includes any Indian tribe for which service in employment as defined in section 288.034, RSMo is performed.

(E) Employment—Includes service performed in the employ of an Indian tribe, provided such service is excluded from employment as defined in the Federal Unemployment Tax Act solely by reason of section 3306(c)(7) of the Federal Unemployment Tax Act, and is not otherwise excluded from employment under Chapter 288, RSMo. For purposes of this rule, the exclusions from employment in subsection 9 of section 288.034, RSMo shall be applicable to services performed in the employ of an Indian tribe.

(2) Benefits. Benefits based on service in employment of an Indian tribe shall be payable in the same amount, on the same terms and subject to the same conditions as benefits payable on the basis of other service subject to Chapter 288, RSMo. The provisions of subsection 3 of section 288.040, RSMo pertaining to services performed at an educational institution while in the employ of an "educational service agency" shall apply to services performed in an educational institution or educational service agency wholly owned and operated by an Indian tribe or tribal unit.

(3) Contributions. Indian tribes or tribal units (subdivisions, subsidiaries or business enterprises wholly owned by such Indian tribes) subject to this chapter shall pay contributions under the same terms and conditions as all other subject employers, unless they elect to pay into the state unemployment fund amounts equal to the amount of benefits attributable to service in the employ of the Indian tribe. An Indian tribe and all tribal units of such Indian tribe shall be jointly and severally liable for any and all contributions, payments in lieu of contributions, interest, penalties, and surcharges owed by the Indian tribe and all tribal units of such Indian tribe.

(4) Payments in Lieu of Contributions. Indian tribes electing to make payments in lieu of contributions must make such election in the same manner and under the same conditions as provided in subsection 3 of section 288.090, RSMo pertaining to state and local governments and nonprofit organizations subject to Chapter 288, RSMo. Indian tribes will determine if reimbursement for benefits paid will be elected by the tribe as a whole, by individual tribal units, or by combinations of individual tribal units. Termination of an Indian tribe's coverage pursuant to subsection (C) of this section shall terminate the election of such Indian tribe and any tribal units of such Indian tribe to make payments in lieu of contributions.

(A) Indian tribes or tribal units will be billed for the full amount of benefits attributable to service in the employ of the Indian tribe or tribal unit on the same schedule as other employing units that have elected to make payments in lieu of contributions.

(B) Any Indian tribe or tribal unit that elects to become liable for payments in lieu of contributions shall be required, prior to the effective date of its election, to post with the division a surety bond issued by a corporate surety authorized to do business in Missouri in an amount equivalent to the contributions or payments in lieu of contributions for which the Indian tribe or tribal unit was liable in the last calendar year in which it accrued contributions or payments in lieu of contributions, or one hundred thousand dollars ($100,000), whichever amount is the greater, to ensure prompt payment of all contributions or payments in lieu of contributions, interest, penalties and surcharges for which the Indian tribe or tribal unit may be, or becomes, jointly and severally liable pursuant to this chapter.

(C) Failure of the Indian tribe or tribal unit to maintain the required surety bond, including the posting of an additional surety bond or a replacement surety bond within ninety (90) days of being directed by the division, will cause services performed for such Indian tribe to not be treated as "employment" for purposes of Chapter 288, RSMo.

(D) The director may determine that any Indian tribe that loses coverage under subsection (C) of this section, may have services performed for such tribe again included as "employment" for

purposes of Chapter 288, RSMo if all contributions, payments in lieu of contributions, penalties, interest, and surcharges have been paid. Upon reinstatement of coverage under this subsection, an Indian tribe or any tribal unit may elect, in accordance with the provisions of this section, to make payments in lieu of contributions.

(E) If an Indian tribe fails to maintain the required surety bond by posting an additional surety bond or a replacement surety bond within ninety (90) days of being directed by the division, the director will immediately notify the United States Internal Revenue Service and the United States Department of Labor.

(F) Notices of surety bond deficiency to Indian tribes or their tribal units shall include information that failure to post an additional surety bond or a replacement surety bond within the prescribed time frame will cause:

1. The Indian tribe to be liable for taxes under the Federal Unemployment Tax Act;

2. The Indian tribe to be excepted from the definition of "employer," as provided in section (1) of this rule, and services in the employ of the Indian tribe, as provided in section (1) of this rule, to be excepted from "employment."

(5) Failure to Make Payments. Failure of the Indian tribe or tribal unit to make any payments required in Chapter 288, RSMo, including assessments of interest and penalty, within ninety (90) days of receipt of the bill will cause services performed for such Indian tribe to not be treated as "employment" for purposes of Chapter 288, RSMo.

(A) The director may determine that any Indian tribe that loses coverage under this section, may have services performed for such tribe again included as "employment" for purposes of Chapter 288, RSMo if all contributions, payments in lieu of contributions, penalties, interest, and surcharges have been paid.

(B) If an Indian tribe fails to make required payments (including assessments of interest and penalty) within ninety (90) days of a final notice of delinquency, the director will immediately notify the United States Internal Revenue Service and the United States Department of Labor.

(C) Notices of payment and reporting delinquency to Indian tribes or their tribal units shall include information that failure to make full payment within the prescribed time frame will cause:

1. The Indian tribe to be liable for taxes under the Federal Unemployment Tax Act;

2. The Indian tribe to be excepted from the definition of "employer," as provided in section (1) of this rule, and services in the employ of the Indian tribe, as provided in section (1) of this rule, to be excepted from "employment."

(6) Extended Benefits. Extended benefits paid that are attributable to service in the employ of an Indian tribe and not reimbursed by the federal government shall be financed in their entirety by such Indian tribe.

AUTHORITY: section 288.220, RSMo 2000. Emergency rule filed June 13, 2002, effective July 1, 2002, expires Dec. 27, 2002. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Division of Family Services
Chapter 2—Income Maintenance

EMERGENCY AMENDMENT

13 CSR 40-2.140 Limitations on Amount of Cash Payments. The division is amending section (6).

PURPOSE: This amendment expands the reasons for ineligibility for General Relief when a family meets the definition of a Temporary Assistance household to include families losing Temporary Assistance when they reach their lifetime limits and due to other prohibitions of receipt of Temporary Assistance.

EMERGENCY STATEMENT: Persons receiving benefits under the Temporary Assistance program are reaching their lifetime limits as established under 13 CSR 40-2.350. The Temporary Assistance program also has other prohibitions for receiving benefits which relate to participation in work activities and other technical requirements. It is not the intent of the General Relief program to provide benefits to persons who meet the definition of the Temporary Assistance household, but who do not qualify due to refusal to meet program requirements, due to reaching lifetime limits and the like. Funding for the General Relief program is set by the General Assembly and cannot be used to circumvent the Temporary Assistance requirements. Because Temporary Assistance lifetime limits are being reached by families beginning July 1, 2002, promulgation of this emergency amendment is necessary to preserve the government's compelling interest of conserving General Relief funds for the population it is intended to serve and preventing their use in a way that circumvents the Temporary Assistance program restrictions. A proposed amendment which covers this same material is published in this issue of the ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed June 20, 2002, effective July 1, 2002 and expires December 27, 2002.*

(6) All persons who meet the definition of *[an AFDC]* **a Temporary Assistance** household must have their eligibility explored under *[AFDC (except under emergency situations when GR orders may be utilized)]* **Temporary Assistance** before having their eligibility for GR explored. Any person whose eligibility has been explored under *[AFDC]* **Temporary Assistance** and is found to be ineligible for *[AFDC cash payments]* **Temporary Assistance** because of the following reasons shall be ineligible for GR:

(A) The person refuses to cooperate in establishing his/her eligibility for *[AFDC]* **Temporary Assistance** (this would include persons who refuse to apply for a Social Security number, *[refuse to register for Work Incentive (WIN) program]* **refuse to participate in work activities**, refuse to make an assignment of support rights, refuse to cooperate in the identification or location of absent parents**, refuse to participate in a self-sufficiency pact or an assessment pursuant to 13 CSR 40-2.370,** and the like);

(D) The available resources exceed the maximum allowed; *[or]*

(E) The children are not deprived of parental support*[.]***;**

(F) The person meets the prohibition in 13 CSR 40-2.305, 13 CSR 40-2.340, 13 CSR 40-2.345, 13 CSR 40-2.355, 13 CSR 40-2.360, or 13 CSR 40-2.365; or

(G) The person is ineligible due to the lifetime limits outlined in 13 CSR 40-2.350.

*AUTHORITY: section 207.020, RSMo [1986] **2000**. Filing dates for original rules are shown in the text of the rule. This version filed March 24, 1976. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed June 20, 2002, effective July 1, 2002, expires Dec. 27, 2002. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Division of Family Services
Chapter 2—Income Maintenance

EMERGENCY RULE

13 CSR 40-2.375 Medical Assistance for Families

PURPOSE: This emergency rule establishes the income limit for the Medical Assistance for Families program after June 30, 2002.

*EMERGENCY STATEMENT: Missouri's economic status requires emergency measures to contain cost wherever feasible. The State Fiscal Year (SFY) 2002 revenue projection is expected to be $750 million less than the original consensus revenue forecast, which was established in December 2000. The Department of Social Services has been required to withhold funds appropriated in the SFY 2002 budget in response to the shortfall in projected revenue in August 2001, December 2001, and May 2002. These withholdings have totaled $53.4 million in General Revenue funds and $24.3 million in other funds. For SFY 2003, the state is projecting general revenue will be $56 million less than actual net collections in SFY 2001. This does not take into account the impact of inflation. Assuming this projection is accurate, the state will have less money to operate than two (2) years ago while it must fund mandatory items such as Medicaid caseload growth. In order to meet SFY 2003 projected revenues, the 91st General Assembly, in House Bill 1111, approved core reductions to the Medical Assistance for Families program, totaling $22.8 million. Beginning July 1, 2002 Medicaid coverage for Medical Assistance for Families is modified so that the income limit is reduced from one hundred percent (100%) of the federal poverty level to seventy-seven percent (77%) of the federal poverty level. An Emergency Rule is necessary to preserve a compelling governmental interest. The Department of Social Services (DSS), Division of Family Services and Division of Medical Services must modify spending through certain programs to more closely align expenditures with available revenues for SFY 2003. Through HB 1111, the legislature has acted. DSS is required to implement the actions of the legislature. The actions of the legislature are made clear through language in the bill, dollars appropriated and any subsequent letters of intent issued to clarify the legislature's actions. In SFY 2003, DSS must cut spending in identified programs, to preserve the compelling governmental interest reflected in the actions of the legislature that are designed to achieve a balanced state budget. The majority of these spending cuts must be implemented effective July 1, 2002 to give the greatest opportunity to achieve the savings projected through these program cuts or reductions for SFY 2003. The necessary projected savings cannot be acquired through the regular rulemaking process and, thus, requires emergency rulemaking. Promulgation of this emergency rule is necessary to preserve the compelling governmental interest to achieve a balanced state budget for SFY 2003. 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 division believes this emergency rule is fair to all interested persons and parties under the circumstances. This emergency rule was filed June 7, 2002, effective July 1, 2002 and expires December 27, 2002.*

(1) The income limit for persons to be eligible for the Medical Assistance for Families program established pursuant to section 208.145, RSMo is at or below seventy-seven percent (77%) of the federal poverty level for the household size.

(2) The standard work expense for persons with earned income shall be ninety dollars ($90).

*AUTHORITY: sections 208.145 and 207.020, RSMo 2000. Emergency rule filed June 7, 2002, effective July 1, 2002, expires Dec. 27, 2002. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Division of Family Services
Chapter 30—Permanency Planning for Children

EMERGENCY RULE

13 CSR 40-30.030 Attorney Fees and Guardian *Ad Litem* Fees in Subsidized Adoption and Guardianship Cases

*PURPOSE: This rule establishes fees for attorneys and guardians **ad litem** who provide services in subsidized adoption and subsidized guardianship cases.*

*EMERGENCY STATEMENT: The division has determined that an emergency rule is necessary to establish fees for attorneys and guardians **ad litem** who provide services in subsidized adoption and subsidized guardianship cases. In fulfilling its responsibility of ensuring that children in foster care achieve permanency, the division finds it necessary in certain cases to initiate adoption or guardianship proceedings in order to provide a permanent plan for these children. Ensuring that adequate representation of the prospective adoptive parents or guardians is provided in these cases is a vital part of this process. The division finds that an immediate danger to the health, safety and welfare to the citizens of Missouri exists inasmuch as there presently is no rule in effect to provide a fair and equitable procedure for the payment of fees to attorneys to provide essential representation in subsidized adoption and subsidized guardianship cases. Having an established procedure for payment of fees in subsidized adoption and subsidized guardianship cases will assist the courts, the agency and all interested parties, including attorneys, by assuring that a just compensation is awarded under the criteria established. The division finds that this emergency rule is necessary to preserve a compelling governmental interest in achieving permanency for children that requires an early effective date and certifies that the reasons supporting this finding are as follows: 1) it will help to promote fiscal responsibility by conserving monetary resources allocated for representation and assistance; 2) it will provide necessary guidance to the courts in determining how compensation will be provided; 3) it will enable all attorneys and guardians **ad litem** involved in such cases to know what compensation to expect; and 4) it will help ensure that the best interest of the children are protected by enabling attorneys and guardians **ad litem** to be provided fair compensation for their services in these cases. Without this emergency rule, there is a danger that compensation to attorneys and guardians **ad litem** will be unequal throughout the state and that the rights of all parties, including the best interest of the children, will not be adequately safeguarded through effective representation and assistance. 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 circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The division believes the emergency rule is fair to all interested persons and parties under the circumstances. This emergency rule was filed on June 13, 2002, effective June 24, 2002, and expires December 20, 2002.*

(1) If permanency for the children requires that children be adopted or placed under a guardianship, the children's prospective adoptive parents/guardians shall be provided representation in such cases which shall include counsel, investigative, expert and other services to ensure adequate representation. Representation shall be

provided for any person(s) who have been identified as a prospective adoptive resource for a child who is eligible for the Missouri Adoption Subsidy program. A family is considered to be a prospective adoptive resource when it has been identified as a potential resource for a child via an adoption staffing held by the case manager of the child who is available for adoption. A child is considered eligible for the Missouri Adoption Subsidy program when he or she is or has been in the custody of the Division of Family Services or one (1) of the following agencies: Department of Mental Health, Division of Youth Services or a licensed child-placing agency.

(2) Payment for attorney representation shall be made as provided below.

(A) Hourly Rate. Any attorney shall, at the conclusion of the representation (i.e., the conclusion of trial or at the conclusion of any appeal, or both at the conclusion of the hearing and at the conclusion of appeal), be compensated at a rate not exceeding one hundred dollars ($100) per hour for time expended in court and seventy-five dollars ($75) per hour for time reasonably expended out of court, unless the court determines that a higher rate of not in excess of one hundred dollars ($100) per hour is justified for the area where the services were performed or by reason of the nature of the services performed. Attorneys may be reimbursed for expenses reasonably incurred, including the costs of transcripts authorized by the court.

(B) Maximum Amounts. The compensation to be paid for representation at an adoption hearing shall not exceed one thousand five hundred dollars ($1,500) for uncontested matters and three thousand dollars ($3,000) for contested matters. For representation in an appellate court, the compensation shall not exceed two thousand five hundred dollars ($2,500) at one hundred dollars ($100) per hour. The compensation to be paid for representation for a guardianship action shall not exceed five hundred dollars ($500) as budgeted by the state legislature.

(C) Waiving Maximum Amounts. Payment in excess of any maximum amount provided in subsection (2)(B) may be made for extended or complex representation whenever the court in which the representation was rendered certifies that the amount of the excess payment is necessary to provide fair compensation and the payment is approved by the court. At any time an attorney believes that the cost of representation will surpass the limit of three thousand dollars ($3,000), they must provide written documentation to the Division of Family Services, as to why they do not think that the case will be completed under the current maximum fee.

(D) Disclosure of Fees. The amounts paid to particular attorneys or groups of attorneys shall be available as public records. However, the identity of parties, including parents, children, foster parents and anyone whose confidentiality is established in Chapter 210 or 211, RSMo, shall not be publicly available.

(E) Filing Claims. A separate claim for compensation and reimbursement shall be made to the adoptive parent for each case. Each claim shall be supported by a sworn written statement specifying the time expended, services rendered, and expenses incurred while the case was pending before the court, and the compensation and reimbursement applied for or received in the same case from any other source. The Division of Family Services may agree to the claim, may negotiate the claim with the applying attorney, or may deny the claim in which case the attorney shall apply to the court to determine the compensation and reimbursement to be paid to the attorney.

(F) New Hearings. For purposes of compensation and other payments authorized by this section, an order by a trial or appellate court granting a new trial shall be deemed to initiate a new case.

(3) Payment for Guardian *Ad Litem*. Children involved in adoption or guardianship cases are entitled to a guardian *ad litem*. The fees for the guardian *ad item* shall be paid in the maximum amount of five hundred dollars ($500) at seventy-five dollars ($75) per hour.

AUTHORITY: section 207.020, RSMo 2000. Emergency rule filed June 13, 2002, effective June 24, 2002, expires Dec. 20, 2002. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 4—Conditions of Recipient Participation, Rights and Responsibilities

EMERGENCY AMENDMENT

13 CSR 70-4.090 Uninsured Parents' Health Insurance Program. The division is amending sections (2), (6), (7), and (8) and deleting sections (3) and (4).

PURPOSE: This emergency amendment establishes who will be eligible for the Uninsured Parents' Health Insurance Program after June 30, 2002.

EMERGENCY STATEMENT: Missouri's economic status requires emergency measures to contain costs wherever feasible. For SFY 2003, the state is projecting general revenue will be $56 million less than actual net collections in SFY 2001. This does not take into account the impact of inflation. Assuming this projection is accurate, the state will have less money to operate than two (2) years ago while it must fund mandatory items such as Medicaid caseload growth. In order to meet the SFY 2003 projected revenue, the 91st General Assembly in House Bill 1111 approved core reductions to services for uninsured parents totaling $6.3 million. Beginning July 1, 2002, Medicaid coverage for low-income parents is to be modified as follows: noncustodial parents' coverage is eliminated; Parents' Fair Share participants' coverage is eliminated; extended transitional benefits coverage is reduced from two (2) additional years beyond transitional coverage to one (1) additional year for qualifying parents with income eligibility reduced from below three hundred percent (300%) to one hundred percent (100%) of the federal poverty level; and women's health services is reduced from two (2) years to one (1) year. An emergency amendment is necessary to preserve a compelling governmental interest. The Department of Social Services (DSS), Division of Medical Services must modify spending through certain programs to more closely align expenditures with available revenues for SFY 2003. Through HB 1111, the legislature has acted. DSS is required to implement the actions of the legislature, as they are reflected in the bill. The actions of the legislature are made clear through language in the bill, dollars appropriated and any subsequent letters of intent issued to clarify the legislature's actions. In SFY 2003, DSS must cut spending in identified programs, to preserve the compelling governmental interest reflected in the actions of the legislature that are designed to achieve a balanced state budget. The majority of these spending cuts must be implemented effective July 1, 2002 to give the greatest opportunity to achieve the savings projected through these program cuts or reductions for SFY 2003. The necessary projected savings cannot be acquired through the regular rulemaking process and, thus, requires emergency rulemaking. Promulgation of this emergency amendment is necessary to preserve the compelling governmental interest to achieve a balanced state budget for SFY 2003. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The division believes this emergency amendment is*

fair to all interested persons and parties under the circumstances. This emergency amendment was filed June 7, 2002, effective July 1, 2002 and expires December 27, 2002.

(2) The following uninsured individuals shall be eligible to receive medical services to the extent and in the manner provided in this regulation:

(A) Individuals losing transitional medical assistance (TMA) who would not otherwise be insured or Medicaid eligible, with *[gross]* **net** income **at or** below *[three hundred percent (300%)]* **one hundred percent (100%)** of the federal poverty level for the household size—

1. Eligibility for the Uninsured Parents' Health Insurance Program for individuals losing TMA ends *[twenty-four (24)]* **twelve (12)** months after TMA eligibility ends; and

2. After coverage ends, the individuals with a child eligible for MC+ have the option of staying in the MC+ health plan, where managed care is available, if the parents pay the cost of the state's cost for the time period covered by the Missouri Medicaid Section 1115 Health Care Reform Demonstration Proposal as approved by the Health Care Financing Administration;

[(B) Uninsured non-custodial parents with income at or below one hundred twenty-five percent (125%) of the federal poverty level for the household size who are current in paying their child support—

1. Eligibility for the Uninsured Parents' Health Insurance Program for uninsured non-custodial parents with income below one hundred twenty-five percent (125%) of the federal poverty level ends after twenty-four (24) total months, the months can be non-consecutive; and

2. Child support refers to a legally obligated dollar amount established by court or administrative order;

(C) Uninsured non-custodial parents who are actively participating in Missouri's Parents' Fair Share Program;

(D) Uninsured custodial parents with family income at or below one hundred percent (100%) of the federal poverty level for the household size; and]

[(E)] **(B)** Uninsured women who do not qualify for other medical assistance benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage, will continue to be eligible for family planning and limited testing of sexually transmitted diseases (EWH), regardless of income, for *[twenty-four (24)]* **twelve (12)** consecutive months *[after the pregnancy ends]*.

(3) *[Uninsured parents identified in subsections (2)(B), (2)(C) or (2)(D) who had health insurance in the six (6) months prior to the month of application shall not be eligible for coverage under this rule until six (6) months after coverage was dropped.*

(4) The six (6)-month period of ineligibility would not apply to parents who lose health insurance due to:

(A) Loss of employment due to factors other than voluntary termination;

(B) Employment with a new employer that does not provide an option for coverage;

(C) Expiration of the Consolidated Budget Reconciliation Act (COBRA) coverage period;

(D) Lapse of health insurance when the lifetime maximum benefits under their private health insurance have been exhausted; or

(E) Lapse of health insurance when maintained by an individual other than the parent, individual losing TMA, or women who qualify for EWH.]

[(5)] **(3)** Beneficiaries covered in section (2) of this rule shall be eligible for service(s) from the date their application is received. No service(s) will be covered prior to the date the application is received.

[(6)] **(4)** The following services are covered for beneficiaries of the Uninsured Parents' Health Insurance Program if they are medically necessary:

(A) Inpatient hospital services;

(B) Outpatient hospital services;

(C) Emergency room services;

(D) Ambulatory surgical center, birthing center;

(E) Physician, advanced practice nurse, and certified nurse midwife services;

(F) Maternity benefits for inpatient hospital and certified nurse midwife. The health plan shall provide coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo. A shorter length of hospital stay for services related to maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. The health plan is to provide coverage for post-discharge care to the mother and her newborn. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization and be documented in the patient's medical record. The first post-discharge visit shall occur within twenty-four (24) to forty-eight (48) hours. Post-discharge care shall consist of a minimum of two (2) visits at least one (1) of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physician assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. If the health plan intends to use another nationally recognized medical organization's guidelines, the state agency must approve prior to implementation of its use;

(G) Family planning services;

(H) Pharmacy benefits;

(I) Dental services to treat trauma *[or disease]*;

(J) Laboratory, radiology and other diagnostic services;

(K) Prenatal case management;

(L) Hearing aids and related services;

(M) Eye exams and services to treat trauma or disease (one (1) pair of glasses after cataract surgery only);

(N) Home health services;

(O) Emergent (ground or air) transportation;

(P) Non-emergent transportation only for members in ME Code 78 Parents' Fair Share;

(Q) Mental health and substance abuse services;

(R) Services of other providers when referred by the health plan's primary care provider;

(S) Hospice services;

(T) Durable medical equipment (including but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs and walkers, diabetes supplies and equipment);

(U) Diabetes self-management training for persons with gestational, Type I or Type II diabetes;

(V) Services provided by local health agencies (may be provided by the health plan or through an arrangement between the local health agency and the health plan)—

1. Screening, diagnosis, and treatment of sexually transmitted diseases;

2. HIV screening and diagnostic services;

3. Screening, diagnosis, and treatment of tuberculosis; and

(W) Emergency medical services. Emergency medical services are defined as those health care items and services furnished or required to evaluate or stabilize a sudden and unforeseen situation or occurrence or a sudden onset of a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent lay person, possessing average knowledge of health and medicine, to result in:

1. Placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part; or

4. Serious harm to a member or others due to an alcohol or drug abuse emergency; or

5. Injury to self or bodily harm to others; or

6. With respect to a pregnant woman who is having contractions: a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

[(7)] **(5)** Individuals losing TMA*[, uninsured non-custodial parent(s) with family income at or below one hundred twenty-five percent (125%) of the federal poverty level who are current in paying their child support and uninsured custodial parent(s) with family income at or below one hundred percent (100%) of the federal poverty level]* shall owe a ten dollar ($10) co-payment for certain professional services and a five dollar ($5) co-payment in addition to the recipient portion of the professional dispensing fee for pharmacy services required by 13 CSR 70-4.051.

(A) Providers may request payment of the mandatory co-payment(s) prior to or after service delivery.

(B) The co-payment amount shall be deducted from the Medicaid maximum allowable amount for fee-for-service claims reimbursed by the Division of Medical Services.

(C) Service(s) may not be denied for failure to pay the mandatory co-payment(s).

(D) When a mandatory co-payment is not paid, the Medicaid provider will have the following options:

1. Forego the co-payment entirely;

2. Make arrangements for future payment with the recipient; or

3. File a claim with the Division of Medical Services to report the non-payment of the mandatory co-payment(s) and secure payment for the service from the Division of Medical Services.

(E) When the Division of Medical Services receives a claim from a Medicaid fee-for-service provider for non-payment of the mandatory co-payment, the division shall send a notice to the recipient—

1. Requesting that the recipient reimburse the Division of Medical Services for the mandatory co-payment made on their behalf;

2. Requesting information from the recipient to determine if the mandatory co-payment was not made because there has been a change in the financial situation of the family; and

3. Advising the recipient of the possible loss of coverage for up to six (6) months if the recipient fails to pay three (3) co-payments in one (1) year.

(F) The recipient will be allowed fourteen (14) calendar days to respond. If the recipient indicated there has been a change in the financial situation of the family, the state shall redetermine eligibility—

1. If the eligibility redetermination places the recipient in a non-mandatory co-payment category, there will be no co-payment due; or

2. If the eligibility redetermination does not place the recipient in a non-mandatory co-payment category another notice will be sent to the recipient about the mandatory co-payment provision of the program which shall include the number of co-payments that have not been paid and how many may not be paid before a recipient is terminated from the program.

(G) Notice of non-payment of mandatory co-payment(s) sent to the recipient during the course of a year shall establish a pattern of not meeting the mandatory cost sharing requirement of the program. The process to terminate eligibility shall proceed with the third failure to pay a mandatory co-payment in any one (1) year or until one (1) or more of the three (3) delinquent mandatory co-payments is made. Coverage shall begin again only after payment of one (1) or more of the three (3) co-payments or passage of six (6) months time whichever occurs first. Health care coverage shall not be retroactive.

1. A year starts at the time a co-payment is reported not paid to the Division of Medical Services;

2. Payment of a delinquent co-payment or co-payments will eliminate the failure to pay a mandatory co-payment or co-payments.

(H) Recipient(s) shall have access to a fair hearing process to appeal the disenrollment decision.

(I) If the recipient fails to pay the mandatory co-payments three (3) times within a year and is disenrolled from coverage the recipient shall not be eligible for coverage for six (6) months after the department provides notice to the recipient of disenrollment for failure to pay mandatory co-payments or until one (1) or more of the three (3) delinquent mandatory co-payments is paid. Coverage shall begin again only after payment of one (1) or more of the three (3) co-payments or passage of six (6) months whichever occurs first. Coverage shall not be retroactive.

[(8)] **(6)** *[Uninsured non-custodial parents who are actively participating in Missouri's Parents' Fair Share Program and u]***U**ninsured women who do not qualify for other benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage are not required to pay a co-payment for services.

*[(9)]***(7)** The Department of Social Services, Division of Medical Services shall provide for granting an opportunity for a fair hearing to any applicant or recipient whose claim for benefits under the Missouri Medicaid Section 1115 Health Care Reform Demonstration Proposal is denied or disenrollment for failure to pay mandatory co-payments has been determined by the Division of Medical Services. There are established positions of state hearing officer within the Department of Social Services, Division of Legal Services in order to comply with all pertinent federal and state law and regulations. The state hearing officers shall have authority to conduct state level hearings of an appeal nature and

shall serve as direct representative of the director of the Division of Medicaid Services.

*AUTHORITY: sections 208.040, **RSMo Supp. 2001,** 208.201 and 660.017, RSMo 2000. Emergency rule filed Sept. 13, 1999, effective Sept. 23, 1999, terminated Oct. 15, 1999. Original rule filed Aug. 16, 1999, effective March 30, 2000. Amended: Filed March 29, 2001, effective Oct. 30, 2001. Emergency amendment filed June 7, 2002, effective July 1, 2002, expires Dec. 27, 2002. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.040 Inpatient Hospital and Outpatient Hospital Settlements. The division is amending section (1) and subsections (2)(E), (4)(A), (4)(C)–(E) and adding subsection (4)(F).

PURPOSE: This amendment amends section (1) and subsections (2)(E), (4)(A), (4)(C)–(E) and adds (4)(F). The proposed changes eliminate final or amended settlements for outpatient hospital services for cost reports ending after December 31, 1998 for hospitals reimbursed under the prospective outpatient methodology authorized in 13 CSR 70-15.160.

*EMERGENCY STATEMENT: The Division of Medical Services finds an immediate danger to public health and welfare which requires emergency actions. If this emergency rule is not enacted, it will cause significant cash flow shortages and financial strain on all hospitals which service more than eight hundred fifty thousand (850,000) Medicaid recipients. This will, in turn, result in an adverse impact on the health and welfare of those in need of medical care and treatment. A proposed amendment, which covers the same material, is 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 Medical Services Division believes this emergency amendment to be fair to all interested persons and parties under the circumstances. The emergency amendment was filed June 20, 2002, effective July 1, 2002, and expires February 27, 2003.*

(1) General. This regulation defines the specific procedures used to calculate inpatient and outpatient settlements for Missouri in-state hospitals participating in the Missouri Medicaid program. Although inpatient and outpatient settlements are calculated at the same time, an overpayment for outpatient services shall not be offset against an underpayment for inpatient services. **Outpatient settlements shall not be determined for cost report periods ending after December 31, 1998 except for recently closed hospitals and new hospitals as provided for in subsection (4)(E).**

(2) Definitions.

(E) Outpatient services/cost. Reimbursable outpatient services or costs are services or costs that are provided prior to the patient being admitted to the hospital. Only outpatient services or cost which are reimbursed on a percentage of charge as defined in *[13 CSR 70-15.010]* **13 CSR 70-15.160** will be included in the final settlement, unless they are excluded elsewhere in this regulation.

(4) Outpatient Hospital Settlements, Provider Based Rural Health Clinic (PBRHC) settlements or Provider Based Federally Qualified Health Centers (PBFQHC) settlements will be calculated after the division receives the Medicare/Medicaid cost report with a NPR from the hospital fiscal intermediary.

(A) The Division of Medical Services shall adjust the hospital's outpatient Medicaid payments, PBRHC or PBFQHC Medicaid payments to conform with the percent of cost paid on an interim basis under *[13 CSR 70-15.010(13)(A)]* **13 CSR 70-15.160** for the appropriate time period (except for those hospitals that qualify under subsection (4)(B), whose payments will be based on the percent of cost in paragraph (4)(A)1., 2., or 3.) for—

1. Services prior to January 5, 1994, the lower of eighty percent (80%) of the outpatient share of the costs from subsection (4)(D), or eighty percent (80%) of the outpatient charges from paragraph (4)(C)1.;

2. Services after January 4, 1994 and prior to April 1, 1998, the lower of ninety percent (90%) of the outpatient share of the cost from subsection (4)(D), or ninety percent (90%) of the outpatient charge from paragraph (4)(C)1.;

3. Services after March 31, 1998, **included in cost reports ending prior to January 1, 1999,** the lower of one hundred percent (100%) of the outpatient share of the cost from subsection (4)(D), or one hundred percent (100%) of the outpatient charge from paragraph (4)(C)1.; and

4. PBRHC and PBFQHC shall be reimbursed one hundred percent (100%) of its share of the cost in paragraph (4)(E)2.

(C) The Medicaid charges used to determine the cost, and the payments used to determine the settlement will be—

1. For outpatient services the charges and payments extracted from the Medicaid outpatient claims history for reimbursable services paid on a percentage basis under *[13 CSR 70-15.010]* **13 CSR 70-15.160**.

2. For PBRHC and PBFQHC the charges and payments will be for services billed under 13 CSR 70-94.020.

(D) The Medicaid hospital's outpatient, cost will be determined by multiplying the overall outpatient cost-to-charge ratio, determined in accordance with paragraph (4)(D)1., by the Medicaid charges from paragraphs (4)(C)1. To this product will be added the Medicaid outpatient share of GME. The GME will be determined using the methodology on worksheet E-3 part IV from the Medicare/Medicaid cost report (HCFA 2552-92) by substituting Medicaid data in place of Medicare data.

1. The overall outpatient cost-to-charge ratio will be determined by multiplying the reported total outpatient charges for each ancillary cost center, excluding PBRHC or PBFQHC, on the supplemental worksheet C column 10 (HCFA 2552-83) or substitute schedule by the appropriate cost-to-charge ratio from worksheet C (HCFA 2552-92) column 7 part I of the fiscal intermediary's audited Medicare/Medicaid cost report to determine the outpatient cost for each cost center reimbursed on a percentage of charge basis by Medicaid under *[13 CSR 70-15.010]* **13 CSR 70-15.160**. Total the outpatient costs from each cost center and total the outpatient charges from each cost center. Divide the total outpatient costs by the total outpatient charges to arrive at the overall outpatient cost-to-charge ratio.

(E) The Medicaid outpatient final settlement **for cost reports ending prior to January 1, 1999, unless the hospital closed prior to July 1, 2002,** will determine either an overpayment or an underpayment for the hospital's outpatient services *[and PBRHC or PBFQHC]*.

1. The outpatient Medicaid cost determined in subsection (4)(D) is multiplied by the percent of cost allowed in paragraph (4)(A)1., 2., or 3., to determine the reimbursable cost for outpatient services. (If a cost report covers both periods the outpatient Medicaid charges will be split to determine the reimbursable cost for each time period.) From this cost subtract the outpatient payments made on a percentage of charge basis under *[13 CSR 70-15.010]* **13 CSR 70-15.160** for the time period. (Medicaid payments include the actual payment by Medicaid, third party payments, coinsurance and deductibles.) The difference is either an

overpayment (negative amount) due from provider or underpayment (positive amount) due to provider; *[and]*

2. *[For PBRHC or PBFQHC services multiply the PBRHC or PBFQHC Medicaid charges from paragraph (4)(C)2., by the cost center's cost-to-charge ratio to determine PBRHC or PBFQHC cost. From this cost, the PBRHC or PBFQHC payments associated with charges from paragraph (4)(C)2., are subtracted. The difference is either an overpayment (negative amount) due from provider or underpayment (positive amount) due to provider.]* **Closed facilities. Hospitals which closed after January 1, 1999 but before July 1, 2002 will have final settlements for cost reports ending during this time period calculated in accordance with 13 CSR 70-15.040(4)(E)1.; and**

3. New hospitals which do not have a fourth, fifth, and sixth prior year cost report necessary for establishment of a prospective rate will have final settlement calculated for their initial three (3) cost report periods.

(F) The Medicaid PBRHC or PBFQHC final settlement will determine either an overpayment or an underpayment for the hospital's PBRHC or PBFQHC services. For PBRHC or PBFQHC services multiply the PBRHC or PBFQHC Medicaid charges from paragraph (4)(C)2., by the cost center's cost-to-charge ratio to determine PBRHC or PBFQHC cost. From this cost, the PBRHC or PBFQHC payments associated with charges from paragraph (4)(C)2., are subtracted. The difference is either an overpayment (negative amount) due from provider or an underpayment (positive amount) due to provider.

*AUTHORITY: sections 208.152, 208.153, 208.201, **RSMo** 2000 and 208.471, RSMo **Supp. 2001**. Original rule filed June 2, 1994, effective Dec. 30, 1994. For intervening history, please consult the **Code of State Regulations**. Amended: Filed June 14, 2002. Emergency amendment filed June 20, 2002, effective July 1, 2002, expires Feb. 27, 2003.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

EMERGENCY RULE

13 CSR 70-15.160 Prospective Outpatient Hospital Services Reimbursement Methodology

PURPOSE: This rule establishes a prospective outpatient reimbursement methodology for hospitals in place of the current retrospective reimbursement methodology. This rule establishes the methodology for setting a hospital's prospective outpatient payment percentage for hospital services effective July 1, 2002.

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

*EMERGENCY STATEMENT: The Division of Medical Services finds an immediate danger to public health and welfare which requires emergency actions. If this emergency rule is not enacted, it will cause significant cash flow shortages and financial strain on all hospitals which service more than eight hundred fifty thousand (850,000) Medicaid recipients. This will, in turn, result in an adverse impact on the health and welfare of those in need of medical care and treatment. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The Medical Services Division believes this emergency rule to be fair to all interested persons and parties under the circumstances. The emergency rule was filed June 20, 2002, effective July 1, 2002, and expires February 27, 2003.*

(1) Prospective Outpatient Hospital Services Reimbursement Percentage for Hospitals Located Within Missouri.

(A) Outpatient hospital services shall be reimbursed on a prospective outpatient payment percentage effective July 1, 2002 except for services identified in subsection (1)(C). The prospective outpatient payment percentage will be calculated using the Medicaid over-all outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports regressed to the current State Fiscal Year (SFY). (If the current SFY is 2003 the fourth, fifth and sixth prior year cost reports would be the cost report filed in calendar year 1997, 1998 and 1999.) The prospective outpatient payment percentage shall not exceed one hundred percent (100%) except for nominal charge providers and shall not be less than twenty percent (20%).

(B) Outpatient cost-to-charge ratios will be as determined in the desk review of the base year cost reports.

(C) Outpatient hospital services reimbursement limited by rule.

1. All services provided to General Relief (GR) recipients will be reimbursed from the Medicaid fee schedule in accordance with provisions of 13 CSR 70-2.020.

2. Effective for dates of service September 1, 1985, and annually updated, certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.

3. Services of hospital-based physicians and certified registered nurse anesthetists shall be billed on an HCFA-1500 professional claim form, which is incorporated by reference as part of this rule, and reimbursed from a Medicaid fee schedule or the billed charge, if less.

4. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed under Title XVIII.

(2) Exempt Hospitals. Medicaid providers which do not have a fourth, fifth and sixth prior year cost report.

(A) Interim Payment Percentage. An interim outpatient payment percentage for new Medicaid hospital providers will be set at seventy-five percent (75%) for the first three (3) state fiscal years in which the hospital operates. The cost reports for these three (3) years will have a cost settlement calculated in accordance with 13 CSR 70-15.040.

(B) Outpatient Percentage. The outpatient payment percentage for the fourth and fifth year in which the hospital operates will be based on the overall Medicaid cost-to-charge ratio from its fourth prior year cost report.

(3) Closed Facilities. Hospitals which closed after January 1, 1999 but before July 1, 2002 will have final settlements for cost reports ending during this time period calculated in accordance with 13 CSR 70-15.040.

(4) Definitions.

(A) Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve (12)-month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.

(B) Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report.

(C) Effective date.

1. The plan effective date shall be July 1, 2002.

2. New prospective outpatient payment percentages will be effective July 1 of each SFY.

(5) Out-of-State Outpatient Reimbursement.

(A) Out-of-state outpatient hospital services and services of federally-operated hospitals located within Missouri will be reimbursed by Missouri Medicaid at sixty percent (60%) of usual and customary charges as billed by the provider for covered services with the exception for services in subsection (1)(C).

AUTHORITY: sections 208.152, 208.153, 208.201, RSMo 2000 and 208.471, RSMo Supp. 2001. Original rule filed June 14, 2002. Emergency rule filed June 20, 2002, effective July 1, 2002, expires Feb. 27, 2003.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

EMERGENCY RULE

13 CSR 70-15.170 Enhanced Disproportionate Share Payment to Trauma Hospitals for the Cost of Care to the Uninsured Provided by Physicians Not Employed by the Hospital

PURPOSE: This rule establishes an enhanced disproportionate share payment, beginning in State Fiscal Year (SFY) 2003, to not-for-profit hospital, designated as a trauma hospital(s), in a county with more than one million residents, and within five miles of an international airport for the cost of the care to the uninsured provided at the trauma hospital by physicians not employed by the hospital.

*EMERGENCY STATEMENT: Individual and mass casualty events present special challenges to health care systems and professionals. Promulgation of this emergency rule is necessary to preserve the compelling governmental interest of allocating funding necessary to maintain the current level of hospital trauma coverage and prepare adequately for any potential mass casualty event by establishing an enhanced disproportionate share payment for not-for-profit hospitals, designated as a trauma hospital, in a county with more than one (1) million residents, and within five (5) miles of an international airport. 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 division believes this emergency rule is fair to all interested persons and parties under the circumstances. The emergency rule was filed June 20, 2002, effective July 1, 2002, expires February 27, 2003.*

(1) General Reimbursement Principles. Beginning in State Fiscal Year (SFY) 2003, not-for-profit hospital(s) which reimburse(s) physicians not employed by the hospital to provide emergency department services for the uninsured that has a trauma center designation, in a county with more than one (1) million residents, and within five (5) miles of an international airport shall receive an additional disproportionate share payment for the net cost of those physician services.

(2) Definitions.

(A) Trauma hospital. A trauma center designated by the Missouri Department of Health and Senior Services.

(B) Uninsured patients. Uninsured patients are patients not covered under any other government entitlement program, who have no health insurance, and do not have sufficient financial resources to pay for emergency department services.

(C) Disproportionate share payment. A disproportionate share payment is a payment to hospitals that serve a disproportionate number of low-income patients as defined in federal law.

(3) Payment Computation. The enhanced disproportionate share payment for each state fiscal year shall be computed using the net cost of services for the hospital's most recent fiscal year ending in the calendar year prior to July 1. The enhanced disproportionate share payment shall be computed as of July 1 and paid to the hospital in quarterly installments.

(A) Payment shall not be made unless the qualifying hospital files an application for the enhanced disproportionate share payment ninety (90) days prior to the July 1 start of the state fiscal year. However, application for SFY 2003 must be made by August 31, 2002. The completed application must include a summary of physician charges for emergency department services provided to uninsured patients, any payments received by the physician, and the net payment by the hospital.

(B) The enhanced disproportionate share payment shall be computed as a percentage of the hospital's net payment to the physician. The net payment to the physician shall be calculated as the cost of physician services in the emergency department to uninsured patients, less any payments made by the uninsured patient, less any amount paid by any other third party. The enhanced disproportionate share payment percentage may be up to one hundred percent (100%), subject to availability of funds for SFY 2003. Any payments received directly by the physician must not be included in the charge to the hospital for providing the service.

AUTHORITY: sections 208.152, 208.153 and 208.201, RSMo 2000. Emergency rule filed June 20, 2002, effective July 1, 2002, expires Feb. 27, 2003.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 20—Pharmacy Program

EMERGENCY AMENDMENT

13 CSR 70-20.031 List of Excludable Drugs for Which Prior Authorization is Required. The division is amending section (3).

PURPOSE: This amendment establishes a more timely notification to providers regarding products requiring prior authorization in order for them to be reimbursable under the Missouri Medicaid Pharmacy Program.

EMERGENCY STATEMENT: Expansion of prior authorization of drugs in medical assistance programs across the country has been recognized as a prudent cost containment measure. Missouri's economic status calls for emergency measures to contain cost

wherever feasible. The State Fiscal Year (SFY) 2002 revenue projection is expected to be $750 million less than the original consensus revenue forecast, which was established in December 2000. The Department of Social Services has been required to withhold funds appropriated in the SFY 2002 budget in response to the shortfall in projected revenues in August 2001, December 2001, and May 2002. These withholdings have totaled $53.4 million in General Revenue funds and $24.3 million in other state funds. For SFY 2003, the state is projecting general revenue will be $56 million less than actual net collections in SFY 2001. This does not take into account the impact of inflation. Assuming this projection is accurate, the state will have less money to operate than two years ago while it must fund mandatory items such as Medicaid caseload growth. In the SFY 2003 budget, the Department of Social Services' appropriation indicates cost containment in pharmacy costs in the Medical Assistance Program of over $100 million (state and federal funds), including $35.5 million in savings through the prior authorization of new drugs. Achieving cost containment necessary through prior authorization requires an effective date for this amendment in advance of that which can be obtained through the regular rulemaking process. Promulgation of this emergency amendment is necessary to preserve the compelling governmental interest of maximizing pharmacy cost containment to reduce expenditures to match projected actual revenues in SFY 2002 and to achieve a balanced state budget for SFY 2003. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed June 7, 2002, effective July 1, 2002, and expires December 27, 2002.*

(3) List of drugs or categories of excludable drugs which are restricted to require prior authorization for certain specified indications*[—]* **shall be made available through the Department of Social Services, Division of Medical Services website at www.dss.state.mo.us/dms, provider bulletins, and updates to the provider manual.**

[Drug or Category of Drug	*Allowed Indications*
Amphetamines	*Attention Deficit Hyperactivity Disorder Narcolepsy*
Barbiturates (with the exception of phenobarbital and mephobarbital and methabarbital which do not require prior authorization)	*All medically accepted uses*
Isotretinoin	*Noncosmetic uses*
Orlistat	*Dyslipidemia*
Retinoic Acid, topical	*Noncosmetic uses]*

*AUTHORITY: sections 208.153 and 208.201, RSMo [1994] **2000**. Original rule filed Dec. 13, 1991, effective Aug. 6, 1992. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed June 7, 2002, effective July 1, 2002, expires Dec. 27, 2002. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 20—Pharmacy Program

EMERGENCY AMENDMENT

13 CSR 70-20.032 List of Drugs Excluded From Coverage Under the Missouri Medicaid Pharmacy Program. The division is amending section (2).

PURPOSE: This amendment establishes a more timely notification to providers regarding products for which reimbursement is not available through the Missouri Medicaid Pharmacy Program.

EMERGENCY STATEMENT: The State Fiscal Year (SFY) 2002 revenue projection is expected to be $750 million less than the original consensus revenue forecast, which was established in December 2000. The Department of Social Services has been required to withhold funds appropriated in the SFY 2002 budget in response to the shortfall in projected revenues in August 2001, December 2001, and May 2002. These withholdings have totaled $53.4 million in General Revenue funds and $24.3 million in other state funds. For SFY 2003, the state is projecting general revenue will be $56 million less than actual net collections in SFY 2001. This does not take into account the impact of inflation. Assuming this projection is accurate, the state will have less money to operate than two years ago while it must fund mandatory items such as Medicaid caseload growth. In the SFY 2003 budget, the Department of Social Services' appropriation indicates cost containment in pharmacy costs in the Medical Assistance Program of over $100 million (state and federal funds), including $6.5 million in savings through the exclusion of reimbursement of most over the counter drugs. Achieving cost containment necessary through the exclusion of reimbursement of most over-the-counter drugs requires an effective date for this amendment in advance of that which can be obtained through the regular rulemaking process. Promulgation of this emergency amendment is necessary to preserve the compelling governmental interest of maximizing pharmacy cost containment to reduce expenditures to match projected actual revenues in SFY 2002 and to achieve a balanced state budget for SFY 2003. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed June 7, 2002, effective July 1, 2002, and expires December 27, 2002.*

(2) List of drugs or classes which are excluded from reimbursement through the Missouri Medicaid Pharmacy Program *[—]* **shall be made available through the Department of Social Services, Division of Medical Services website at www.dss.state.mo.us/dms, provider bulletins, and updates to the provider manual.**

[Drug or Category	*Exceptions—Reimbursable*
Drugs used to promote fertility	
Drugs used to promote weight loss	
Drugs used to promote hair growth	
Drugs used for cosmetic purposes	
Nonlegend vitamins, multivitamins and minerals, adult	*Children's Chewable Multivitamins* *Calcium Preparations* *Iron Preparations*

Drugs used to promote smoking cessation	
Nonlegend lotions, shampoos and medicated soaps	
Nonlegend acne preparations	
Nonlegend weight control products	
Nonlegend ophthalmic products	*Artificial tear products* *Eyewash products* *Ocular lubricants*
Contact lens products	
Nonlegend oral analgesics	*All nonlegend strengths and dosage forms of:* *Acetaminophen* *Aspirin* *Buffered Aspirin* *Ibuprofen* *Naproxen sodium*
Nonlegend stimulant products	
Nonlegend external analgesic products	
Nonlegend hemorrhoidal products	
Halazepam	
Prazepam	
Estazolam	
Quazepam]	

*AUTHORITY: sections 208.153 and 208.201, RSMo [1994] **2000**. Original rule filed Dec. 13, 1991, effective Aug. 6, 1992. Amended: Filed June 30, 2000, effective Feb. 28, 2001. Emergency amendment filed June 7, 2002, effective July 1, 2002, expires Dec. 27, 2002. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 20—Pharmacy Program

EMERGENCY AMENDMENT

13 CSR 70-20.034 List of Non-Excludable Drugs for Which Prior Authorization Is Required. The division is amending section (2).

PURPOSE: This amendment establishes a more timely notification to providers regarding products requiring prior authorization in order for them to be reimbursable under the Missouri Medicaid Pharmacy Program.

*EMERGENCY STATEMENT: Expansion of prior authorization of drugs in medical assistance programs across the country has been recognized as a prudent cost containment measure. Missouri's economic status calls for emergency measures to contain cost wherever feasible. The State Fiscal Year (SFY) 2002 revenue projection is expected to be $750 million less than the original consensus revenue forecast, which was established in December 2000. The Department of Social Services has been required to withhold funds appropriated in the SFY 2002 budget in response to the shortfall in projected revenues in August 2001, December 2001, and May 2002. These withholdings have totaled $53.4 million in General Revenue funds and $24.3 million in other state funds. For SFY 2003, the state is projecting general revenue will be $56 million less than actual net collections in SFY 2001. This does not take into account the impact of inflation. Assuming this projection is accurate, the state will have less money to operate than two (2) years ago while it must fund mandatory items such as Medicaid caseload growth. In the SFY 2003 budget, the Department of Social Services' appropriation indicates cost containment in pharmacy costs in the Medical Assistance Program of over $100 million (state and federal funds), including $35.5 million in savings through the prior authorization of new drugs. Achieving cost containment necessary through prior authorization requires an effective date for this amendment in advance of that which can be obtained through the regular rulemaking process. Promulgation of this emergency amendment is necessary to preserve the compelling governmental interest of maximizing pharmacy cost containment to reduce expenditures to match projected actual revenues in SFY 2002 and to achieve a balanced state budget for SFY 2003. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed June 7, 2002, effective July 1, 2002, and expires December 27, 2002.*

(2) List of drugs or categories of drugs which are restricted to require prior authorization for certain specified indications*[—]* **shall be made available through the Department of Social Services, Division of Medical Services website at www.dss.state.mo.us/dms, provider bulletins, and updates to the provider manual.**

[Drug or Category of Drug	*Allowed Indications*
Abortifacients	*Termination of pregnancy resulting from an act of rape or incest or when necessary to protect the life of the mother*
Butorphanol, nasal spray	*Override of quantity restriction allowed for medically accepted uses*
Drugs used to treat sexual dysfunction	*Sexual dysfunction*
Histamine 2 Receptor Antagonists	*Medically accepted uses*
Ketorolac, oral	*Short term treatment of moderately severe acute pain following injection of same entity*
Linezolid, oral	*Medically accepted uses*
Modafanil	*Narcolepsy*
Proton Pump Inhibitors	*Medically accepted uses]*

*AUTHORITY: sections 208.152, 208.153 and 208.201, RSMo [1994] **2000**. Emergency rule filed Nov. 21, 2000, effective Dec. 1, 2000, expired May 29, 2001. Original rule filed June 29, 2000, effective Feb. 28, 2001. Emergency amendment filed June 7, 2002, effective July 1, 2002, expires Dec. 27, 2002. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 20—Pharmacy Program

EMERGENCY RULE

13 CSR 70-20.320 Pharmacy Reimbursement Allowance

PURPOSE: The purpose of this rule is to establish Pharmacy Federal Reimbursement Allowance and to determine the formula for the amount of allowance each pharmacy is required to pay for the privilege of providing outpatient prescription drugs.

EMERGENCY STATEMENT: Missouri's economic status calls for emergency measures to contain cost wherever feasible. The State Fiscal Year (SFY) 2002 revenue projection is expected to be $750 million less than the original consensus revenue forecast, which was established in December 2000. The Department of Social Services has been required to withhold funds appropriated in the SFY 2002 budget in response to the shortfall in projected revenues in August 2001, December 2001, and May 2002. These withholdings have totaled $53.4 million in General Revenue funds and $24.3 million in other state funds. For SFY 2003, the state is projecting general revenue will be $56 million less than actual net collections in SFY 2001. This does not take into account the impact of inflation. Assuming this projection is accurate, the state will have less money to operate than two (2) years ago while it must fund mandatory items such as Medicaid caseload growth. In the SFY 2003 budget, the Department of Social Services' appropriation includes net gain of $31.5 million as a result of the pharmacy tax. If this program does not become operational July 1, 2002, the State would have to come up with the difference in General Revenue funds. Promulgation of this emergency rule is necessary to preserve the compelling governmental interest of implementing those actions taken by the executive and being implemented by the Department of Social Services to maximize revenue to achieve a balanced state budget for SFY 2003. 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 division believes this emergency rule is fair to all interested persons and parties under the circumstances. This emergency rule was filed June 20, 2002, effective July 1, 2002 and expires February 27, 2003.*

(1) Pharmacy Reimbursement Allowance (PRA). PRA shall be assessed as described in this section.

(A) Definitions.

1. Department—Department of Social Services.

2. Director—director of Department of Social Services.

3. Division—Division of Medical Services.

4. Monthly Gross Retail Prescription Receipts—For ease of administration for the department as well as the industry, this shall be an annual amount. The basis of tax for fiscal year 2003 will be the prescription sales for calendar year 2001.

(B) Each pharmacy engaging in the business of providing outpatient prescription drugs in Missouri to the general public shall pay a Pharmacy Reimbursement Allowance (PRA).

1. The PRA owed for existing pharmacies shall be calculated by multiplying the pharmacy's total gross retail prescription receipts by the tax rate determined by the department.

2. The PRA shall be divided by and collected over the number of months for which the PRA is effective.

3. The initial PRA owed by a newly licensed pharmacy shall be calculated by estimating the total prescription sales and multiplying the estimate by the tax rate determined by the department.

4. If a pharmacy ceases to provide outpatient prescription drugs to the general public, the pharmacy is not required to pay the PRA during the time it did not provide outpatient prescription drugs.

5. If the pharmacy reopens, it shall resume paying the PRA. It shall owe the same PRA as it did prior to closing, if the PRA has not changed per section (1)(B)1.

(C) Each pharmacy shall submit an affidavit to the department with the following information:

1. Pharmacy Name
2. Contact
3. Telephone Number
4. Address
5. Federal Tax ID Number
6. Medicaid Pharmacy Number (If applicable)
7. Pharmacy Sales (Total)
8. Medicaid Pharmacy Sales
9. Number of Paid Medicaid Prescriptions

(D) The department shall prepare a confirmation schedule of the information provided by each pharmacy and the amount of PRA that is due from the pharmacy.

(E) Each pharmacy shall review the information prepared by the department and the amount of Pharmacy Reimbursement Allowance calculated by the department to verify that the information is correct.

1. If the information supplied by the department is incorrect, the facility, within thirty (30) calendar days of receiving the confirmation schedule must notify the division and explain the correction.

2. If the division does not receive corrected information within thirty (30) calendar days, it will be assumed to be correct, unless the pharmacy files a protest in accordance with subsection (2)(D) of this regulation.

(2) Payment of the PRA.

(A) Offset.

1. Each pharmacy may request that their Pharmacy Reimbursement Allowance be offset against any Missouri Medicaid payment due to that pharmacy.

A. A statement authorizing the offset must be on file with the division before any offset may be made relative to the pharmacy reimbursement allowance by the pharmacy.

B. Assessments shall be allocated and deducted over the applicable service period.

C. Any balance due after the offset shall be remitted to the Director of the Department of Revenue and be deposited in the state treasury to the credit of the Pharmacy Reimbursement Allowance Fund.

D. If the remittance is not received before the next Medicaid payment cycle, the division shall offset the balance due from that check.

(B) Check.

1. If no offset has been authorized by the pharmacy, the division will begin collecting the pharmacy reimbursement allowance on the first day of each month for the preceding months.

2. The PFR shall be remitted by the pharmacy to the department. The remittance shall be made payable to the Director of the Department of Revenue and be deposited in the state treasury to the credit of the Pharmacy Reimbursement Allowance Fund.

(C) Failure to pay the PFR.

1. If a pharmacy fails to pay its PFR within thirty (30) days of notice, the PFR shall be delinquent.

2. For any delinquent PFR, the department may—

A. Proceed to enforce the state's lien of the property of the pharmacy;

B. May cancel or refuse to issue, extend or reinstate the Medicaid provider agreement; or

C. May seek denial, suspension or revocation of license granted under Chapter 198, RSMo.

3. The new owner, as a result of a change in ownership, shall have his/her PFR paid by the same method the previous owner elected.

(D) Each pharmacy, upon receiving written notice of the final determination of its Pharmacy Reimbursement Allowance may file a protest with the director of the department setting forth the grounds on which the protest is based, within thirty (30) days from the date of receipt of written notice from the department. The director of the department shall reconsider the determination and, if the pharmacy so requested, grant the pharmacy a hearing to be held within forty-five (45) days after the protest was filed, unless extended by agreement between the pharmacy and the director. The director shall issue a final decision within forty-five (45) days of the completion of the hearing. After a final decision by the director, a pharmacy's appeal of the director's final decision shall be to the Administrative Hearing Commission in accordance with sections 208.156, RSMo 2000 and 621.055, RSMo Supp. 2001.

(E) PFR Rates.

1. The PFR tax rates will be done in bands and will be determined by the ratio of paid Medicaid claims to total prescription sales.

2. The maximum rate shall be six percent (6%).

3. Adjustments will be made to the tax rate if the average Medicaid prescription charge for an individual entity is statistically different than that of the other entities in the assigned tax band.

AUTHORITY: section 208.201, RSMo 2000. Emergency rule filed June 20, 2002, effective July 1, 2002, expires Feb. 27, 2003.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 35—Dental Program

EMERGENCY AMENDMENT

13 CSR 70-35.010 Dental Benefits and Limitations, Medicaid Program. The division is amending sections (1), (4), (7), (8), and (9).

PURPOSE: This emergency amendment changes the adult dental benefits and limitations of the Missouri Medicaid program to reflect the provisions of the State Fiscal Year 2003 budget as passed by the 91st General Assembly and signed by the governor.

*EMERGENCY STATEMENT: Missouri's economic status requires emergency measures to contain costs wherever feasible. For SFY 2003, the state is projecting general revenue will be $56 million less than actual net collections in SFY 2001. This does not take into account the impact of inflation. Assuming this projection is accurate, the state will have less money to operate than two (2) years ago while it must fund mandatory items such as Medicaid caseload growth. In order to meet the SFY 2003 projected revenue, the 91st General Assembly in House Bill 1111 approved core reductions to adult dental services. Beginning July 1, 2002, Medicaid coverage for adults (not children) is eliminated with the exception of dentures and treatment of trauma to the mouth or teeth as a result of injury. An emergency amendment is necessary to preserve the compelling governmental interest effectuating the changes reflected through the appropriations process. The Department of Social Services (DSS), Division of Medical Services must modify spending as provided for in HB 1111 to more closely align expenditures with available revenues for SFY 2003. DSS is required to implement the actions of the legislature and the governor. These actions are made clear through the bill, dollars appropriated and any subsequent letters of intent issued to clarify the legislature's actions. In SFY 2003, DSS must cut spending in identified programs, to preserve the compelling governmental interest reflected in the actions of the legislature that are designed to achieve a balanced state budget. The majority of these spending cuts must be implemented effective July 1, 2002 to give the greatest opportunity to achieve the savings projected through these program cuts or reductions for SFY 2003. The necessary projected savings cannot be acquired through the regular rulemaking process and, thus, requires emergency rulemaking. Promulgation of this emergency amendment is necessary to preserve the compelling governmental interest to modify spending to conform to monies appropriated. 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 June 27, 2002, effective July 7, 2002 and expires February 27, 2003.*

(1) Administration. The Missouri Medicaid dental program shall be administered by the Division of Medical Services, Department of Social Services. The dental services covered and not covered, the limitations under which services are covered and the maximum allowable fees for all covered services shall be determined by the Division of Medical Services **and shall be made available through the Department of Social Services, Division of Medical Services website at www.dss.state.mo.us/dms, provider bulletins, and updates to the provider manual**. Dental services covered by the Missouri Medicaid program shall include only those which are clearly shown to be medically necessary. The division reserves the right to effect changes in services, limitations and fees with proper notification to Medicaid dental providers.

(4) Prior Authorization. Prior authorization shall be required in the following *[two (2)]* case*[s: a)]***:** initial placement or replacement of all full dentures (upper, lower or both) *[and b) placement or replacement of all partial dentures]*. When prior authorization is required, the form provided by the Division of Medical Services or its contracted agent shall be used. The dental service shall not be started until written approval has been received. Telephone approval shall not be given. Prior authorization shall be effective for a period of one hundred twenty (120) days from the date of written approval. Prior authorization approves the medical necessity of the requested dental service. It shall not guarantee payment for that service as the patient must be a Medicaid-eligible recipient on the date the service is performed. The division reserves the right to request documentation regarding any specific request for prior authorization.

(7) Dental Certification. A dental certification form as provided by the Division of Medical Services or its contracted agent shall be completed in the case of any denture*[, partial or full, except for those flipper-type partials identified in the Dental Services Provider Manual]*. This completed form shall be attached to the claim and the request for prior authorization.

(8) Dental Manual. A *Medicaid Dental Manual* shall be produced by the Division of Medical Services and *[shall be distributed to all dental providers participating in the Missouri Medicaid program. It shall contain a list of covered and noncovered services, the limitations under which services are covered and other pertinent data to supplement this rule. The Health Care Financing Administration's Common Procedure Coding System (HCPCS) Level 1, 2 or 3 procedure codes, which includes a modification of the American Dental Association's (ADA) Code on Dental Procedures and Nomenclature shall be used in the manual.]* **made available through the Department of Social Services, Division of**

Medical Services website at www.dss.state.mo.us/dms, provider bulletins, and updates to the provider manual. Maximum allowable fees by the Missouri Medicaid Dental Program shall be *[published in]* **made available through the Department of Social Services, Division of Medical Services website at www.dss.state.mo.us/dms,** provider manuals and bulletins.

(9) Services, Covered and Noncovered. The list shown in this section represents the groupings of medically necessary services covered by the Missouri Medicaid program. **Only dentures and treatment of trauma to the mouth or teeth as a result of injury are covered dental services for Medicaid-eligible adults.** The *Medicaid Dental Manual* shall provide the detailed listing of procedure codes and pricing information.

[(A) Anesthesia. General anesthesia administered in the office is a covered service. General anesthesia administered in the hospital for dental care is payable to the hospital. Local anesthesia is not paid under a separate procedure code and is included in the treatment fee. Nitrous oxide is not covered;

(B) Crowns, Bridges, Inlays. A crown of chrome or stainless steel is a covered item. A crown of polycarbonate material is a covered item for an anterior tooth. Crowns of other materials are not covered. Cast restorations indicated by an early periodic screening diagnosis and treatment (EPSDT) screen are covered;]

[(C)] **(A)** Full Dentures. One (1) upper full denture, one (1) lower full denture, or one (1) complete set (upper and lower) of full dentures is covered. A full denture must be constructed of acrylic material and must meet the following criteria: full arch impression, bite registration, each tooth set individually in wax, try-in of teeth set individually in wax before denture processing, insertion of the processed denture and six (6)-month follow-up adjustments, to be a covered item. Service in the case of any full denture is not completed and shall not be claimed until the denture is placed. Noncovered items include temporary full dentures, full overdentures and immediate placement full dentures;

[(D) Partial Dentures. A partial denture shall replace permanent teeth and must be constructed of acrylic material to be a covered item. Service in the case of any partial denture is not completed and shall not be claimed until the denture is placed. Noncovered items include temporary partial dentures and partial overdentures. Immediate placement partial dentures are noncovered except for those flipper-type partials identified in the Dental Services Provider Manual under procedure codes D5820, D5820W5, D5820W6, D5820W9, D5821, D5821W5, D5821W6, D5821W9;

(E) Denture Adjustment and Repair. Denture adjustment is a covered service but not to the originating dentist of a new denture until six (6) months after the denture is placed. Repair of a broken denture may be accomplished on the same date of service as denture duplication or reline;

(F) Denture Duplication and Reline. Duplication of a partial or full denture is a covered service. Reline of a partial or full denture, either chair-side or laboratory, is covered. Duplications and relines are not covered within twelve (12) months of initial placement of an original denture. Additional denture relines or duplications are limited to once within three (3) years from the date of the last preceding reline or duplication. Denture duplication or reline may be accomplished on the same date of service as repair of a broken denture;]

[(G)] **(B)** Emergency Treatment. Emergency dental care does not require prior authorization and is covered whether performed by a licensed dentist or a licensed dentist specialist. Emergency care is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention re**a**sonably could be expected to result in—placing the patient's health in serious jeopardy or serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Emergency care not listed in the *Medicaid Dental Manual* shall be explained on the claim. An emergency oral examination is not paid under a separate procedure code and is included in the treatment fee. Palliative treatment on the same date of service as other dental care on the same tooth is not covered. Denture dental services are not *[subject to]* **considered** emergency treatment *[consideration]*;

[(H) Examinations, Visits, Consultations. An initial oral examination in the office is covered. Subsequent office medical services are covered. A professional visit to a nursing home is covered and shall include the fee for an oral examination. A professional visit to a hospital is covered and shall include the fee for an oral examination. A consultation by a dentist is a covered service and shall include the fee for an oral examination;

(I) Extractions. Extraction fees for permanent and deciduous teeth, as listed in the Medicaid Dental Manual, apply whether the service is performed in the office, hospital or ambulatory surgical center. Preoperative X rays involving extractions may be covered but postoperative X rays are not covered;

(J) Preventive Treatment. Fluoride treatment may be covered but is limited to the application of stannous fluoride or acid phosphate fluoride. Sodium fluoride treatments are not covered. Fluoride treatment shall include both the upper and lower arch and shall be a separate service from prophylaxis. Fluoride treatment for recipients under age twenty-one (21) is covered. Fluoride treatment for recipients age twenty-one (21) and over is limited to individuals with rampant caries, or those who are undergoing radiation therapy to head and neck, or those with diminished salivary flow, or individuals who are mentally retarded or have cemental or roof surface caries secondary to gingival recession. For recipients ages five through twenty (5–20), topical application of sealants as outlined in Section 19 of the Medicaid Dental Manual is covered. Dietary planning, oral hygiene instruction and training in preventive dental care are not covered;]

[(K)] **(C)** Hospital Dental Care. Dental services provided in an inpatient hospital or an outpatient hospital place of service are subject to the same general benefits and limitations applicable to all dental services and all are not selectively restricted based on place of service;

[(L) Injections. Procedure codes for the injections which are covered shall be shown in Section 19 of the Dental Manual;

(M) Oral Surgery (or Other Qualified Dentist Specialist). Oral surgery is limited to medically necessary care. Cosmetic oral surgeries shall not be paid. Procedures as covered for a certified oral surgeon (or other qualified dentist specialist) shall be indicated in the Medicaid Dental Manual. A medically necessary oral surgery procedure not specifically listed in the Medicaid Dental Manual may be billed using the procedure code identified in the dental manual as Unspecified. The Unspecified procedure must be explained on the claim form.

(N) Orthodontic Treatment/Space Management Therapy. Medically necessary minor orthodontic appliances for interceptive and oral development as listed in the Medicaid Dental Manual are covered. Fixed space maintainers are covered for the premature loss of deciduous teeth. Medically necessary orthodontic treatment and space maintainers for recipients under age twenty-one (21) is

covered when indicated by an EPSDT screen and prior authorized;

(O) Periodontic Treatment. A gingivectomy or gingivoplasty is allowed for epileptic patients on Dilantin therapy, or medically necessary drug-induced hyperplasia. Limited occlusal adjustment is covered when it is necessary as emergency treatment. Other periodontic procedures are not covered;

(P) Prophylaxis (Preventive). Prophylaxis may be a covered service for the upper arch, the lower arch or both arches. Prophylaxis shall be a separate service from fluoride treatment and shall include scaling and polishing of the teeth;

(Q) Pulp Treatment (Endodontic). A pulpotomy on deciduous teeth is covered and shall include complete amputation of the vital coronal nerve, with placement of a suitable drug over the remaining exposed tissue. The fee excludes final restoration. Pulp vitality tests and pulp caps are not covered;

(R) Restorations (Fillings). Fees for any restorative care listed in the Medicaid Dental Manual apply whether the service is performed in the office, hospital, ambulatory surgical center or nursing facility. Amalgam fillings are covered for Class I, Class II and Class V restorations on posterior teeth. A maximum fee shall apply for any one (1) posterior tooth and shall include polishing, local anesthesia and treatment base. Silicate cement, acrylic or composite fillings are not covered for Class I and Class II restorations but are covered for Class III, Class IV and Class V restorations on anterior teeth. A maximum fee shall apply for any one (1) anterior tooth and shall include polishing, local anesthesia and treatment base. Fillings of other materials are not covered, except when a sedative filling is necessary as emergency treatment. X rays may be covered;

(S) Root Canal Therapy (Endodontic). Root canal therapy is a covered service for permanent teeth. The fee excludes final restoration but includes all in treatment X rays. Pre-operative and postoperative X rays may be reimbursed. An apicoectomy is a covered service for permanent teeth but not on the same day as a root canal. Excluding a pulpotomy, other endodontic procedures are not covered; and

(T) X rays. X rays shall not be submitted routinely with a request for prior authorization or with a claim, unless the practitioner shall have been specifically requested to submit X rays. X rays shall be taken at the discretion of the dental practitioner. Films which are not of diagnostic value shall not be claimed. X rays to be covered shall be of the intraoral type, except when a panoramic-type film is required. A preoperative full-mouth X-ray survey of permanent or deciduous teeth, or mixed dentition, is covered as described in the Medicaid Dental Manual. Medically necessary X rays of an edentulous mouth are covered.]

*AUTHORITY: sections 208.152, [RSMo Cum Supp. 1990,] 208.153, [RSMo Cum. Supp. 1991] and 208.201, RSMo [Supp. 1987] **2000**. This rule was previously filed as 13 CSR 40-81.040. Original rule filed Jan. 21, 1964, effective Jan. 31, 1964. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 27, 2002, effective July 7, 2002, expires Feb. 27, 2003.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 40—Optical Program

EMERGENCY AMENDMENT

13 CSR 70-40.010 Optical Care Benefits and Limitations—Medicaid Program. The division is amending sections (1), (4), (6), (7), and (8).

PURPOSE: This emergency amendment reflects a change in adult optical services. Eyeglasses will no longer be covered for adults, except one pair following cataract surgery.

*EMERGENCY STATEMENT: Missouri's economic status requires emergency measures to contain costs wherever feasible. For SFY 2003, the state is projecting general revenue will be $56 million less than actual net collections in SFY 2001. This does not take into account the impact of inflation. Assuming this projection is accurate, the state will have less money to operate than two (2) years ago while it must fund mandatory items such as Medicaid caseload growth. In order to meet the SFY 2003 projected revenue, the 91st General Assembly in House Bill 1111 approved core reductions to adult optical services. Beginning July 1, 2002, eyeglasses will no longer be covered for adults (not children), except one (1) pair following cataract surgery. An emergency amendment is necessary to preserve the compelling governmental interest effectuating the changes reflected through the appropriation process. The Department of Social Services (DSS), Division of Medical Services must modify spending as provided for in HB 1111 to more closely align expenditures with available revenues for SFY 2003. DSS is required to implement the actions of the legislature and the Governor. These actions are made clear through the bill, dollars appropriated and any subsequent letters of intent issued to clarify the legislature's actions. In SFY 2003, DSS must cut spending in identified programs, to preserve the compelling governmental interest reflected in the actions of the legislature that are designed to achieve a balanced state budget. The majority of these spending cuts must be implemented effective July 1, 2002 to give the greatest opportunity to achieve the savings projected through these program cuts or reductions for SFY 2003. The necessary projected savings cannot be acquired through the regular rulemaking process and, thus, requires emergency rulemaking. Promulgation of this emergency amendment is necessary to preserve the compelling governmental interest to modify spending to conform to monies appropriated. 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 June 27, 2002, effective July 7, 2002 and expires February 27, 2003.*

(1) Administration. The Optical Care program shall be administered by the Division of *[Family]* **Medical** Services, Department of Social Services. The optical care services covered and not covered, the program limitations and the maximum allowable fees for all covered services shall be determined by the Division of *[Family]* **Medical** Services **and shall be made available through the Department of Social Services, Division of Medical Services website at www.dss.state.mo.us/dms, provider bulletins, and updates to the provider manual**. Services covered shall include only those which are clearly shown to be medically necessary.

(4) Types of Service Reimbursed by Medicaid for Each Profession.

(A) Optometrist or Optometric Clinic.

1. Eye examinations.
2. Eyeglasses **for adults, only following cataract surgery**.
3. Artificial eyes.
4. Special ophthalmological services.

(B) Opticians or Optical Dispensers.

1. Eyeglasses **for adults, only following cataract surgery**.
2. Artificial eyes.

(D) Physicians (MD or DO).

1. Eye examinations.
2. Eyeglasses **for adults, only following cataract surgery**.
3. Artificial eyes.
4. Special ophthalmological services.

(6) Covered Services.

(C) Glasses (frames and lenses, under 4.00 diopters **for adults, only following cataract surgery**).

[(D) Frames.

(E) Temple.

(F) Lenses, single vision.

(G) Lenses, bifocal, Kryptok.

(H) Lenses, bifocal, Flat top.

(I) Lenses, bifocal, Executive.

(J) Lenses, trifocal.]

[(K)] **(D)** Lenses, cataract.

[(L)] **(E)** Special frames (prior authorization required).

[(M)] **(F)** Special lens (medical necessity required).

[(N)] **(G)** Miscellaneous repairs (medical necessity required).

[(O)] **(H)** Scleral shell, stock or custom.

[(P)] **(I)** Artificial eye, stock or custom.

[(Q)] **(J)** Artificial eye, refitting.

[(R)] **(K)** Artificial eye prosthesis check/polishing/cleaning.

[(S)] **(L)** Rose I and Rose II tints (medical necessity required).

[(T)] **(M)** Photochromatic (prior authorization required).

[(U)] **(N)** Orthoptic and/or pleoptic training, with continuing optometric direction and evaluation (visual therapy/training) (prior authorization required).

[(V)] **(O)** Fitting of contact lens for treatment of disease, including supply of lens (therapeutic bandage lens) (medical necessity required).

[(W)] **(P)** Visual field examination with optometric diagnostic evaluation; tangent screen, Autoplot or equivalent (prior authorization required).

[(X)] **(Q)** Electro-oculography, with medical diagnostic evaluation (prior authorization required).

[(Y)] **(R)** Visually evoked potential (response) study, with medical diagnostic evaluation (prior authorization required).

[(Z)] **(S)** Quantitative perimetry, for example, several isopters on Goldmann perimeter or equivalent (prior authorization required).

[(AA)] **(T)** Static and kinetic perimetry or equivalent.

[(BB)] **(U)** Serial tonometry with optometric diagnostic evaluation (separate procedure), one (1) or more sessions, same day.

[(CC)] **(V)** Tonography with optometric diagnostic evaluation, recording indentation tonometer method or perilimbal suction method.

[(DD)] **(W)** Color vision examination, extended, for example, anomaloscope or equivalent.

[(EE)] **(X)** Dark adaptation examination, with optometric diagnostic evaluation.

(7) Program Limitations.

[(D) Eyeglasses are covered by Medicaid when the prescription is at least 0.75 diopters for one (1) eye or 0.75 diopters for each eye.

(E) Only one (1) pair of eyeglasses is allowed every two (2) years (within any twenty-four (24)-month period of time) for all Medicaid recipients regardless of age.

(F) All claims for eyeglasses or lenses must contain the prescription and the name of the prescribing physician (MD or DO) or optometrist (OD).

(G) The original eyeglass prescription and laboratory invoices listing costs for optical materials, lenses and/or frames provided; and the charge for grinding, edging or assembling of glasses must be kept on file by the provider for five (5) years and furnished to DOSS upon request.

(H) Special frames are covered under the Missouri Medicaid program if they are required for medical reasons and are prior authorized by DOSS. Special frames may be authorized if the patient requires special lenses (over 4.00 diopters for one (1) eye or over 4.00 diopters for each eye and are extra thick or heavy), the structure of the patient's face requires special frames (a very large face, wide-set eyes) or the patient needs glasses with pads because of nose surgery. The Prior Authorization Request Form must be completed and signed by the prescribing physician or optometrist.

(I) Special lenses are covered under the Missouri Medicaid program if they are medically justified and the prescription is plus or minus 4.00 diopters for one (1) eye or 4.00 diopters for each eye, cataract lenses or special bifocal lenses (for example, plastic Executive lenses). A Medical Necessity Form stating the reason special lenses are required must be completed and signed by the prescribing physician or optometrist and attached to the claim form.

(J) Plastic lenses may be dispensed under the Missouri Medicaid program. Reimbursement will be at the same rate as comparable glass lenses. Additional payment will be allowed for plastic lenses that meet the definition of special lenses and are medically justified.

(K) Photochromatic lenses are covered only if medically necessary and prior authorized by the DOSS Medical Consultant. The Prior Authorization Request Form must be completed and signed by the prescribing physician or Optometrist.

(L) Tinted lenses (Rose I and Rose II) are covered if medically necessary. A Medical Necessity Form completed and signed by the prescribing physician or optometrist must be attached to the claim form for the glasses.

(M) Replacement of optical materials and repairs in excess of program limitations may be covered if medically necessary or required for employment training, or educational purposes as follows:

1. Replacement of complete eyeglasses (frames and lenses)—Prior authorization required.

A. Lenses and frames broken (recipient must show provider the broken glasses or Medicaid will not pay for the glasses).

B. Lost.

C. Destroyed.

D. Stolen.

E. Repair of existing glasses would exceed the Medicaid allowable amount for new frames and lenses;

2. Lenses—Medical Necessity Form required.

A. Scratched.

B. Broken.

C. Prescription change or at least 0.50 diopters or greater (old and new prescription must appear on the Medical Necessity and claim forms); or

3. Frames—Prior authorization required. Temples, fronts or both broken and repair would exceed the Medicaid allowable amount for new frames.

(N) Repair of frames or replacement of parts of frames (temples) are covered as follows (Medical Necessity Form required):

1. The cost of the repairs do not exceed the Medicaid allowable amount for new frames; and

2. Repair would provide a serviceable frame for the recipient.

(O) Temples may never be billed in addition to complete new eyeglasses and new frames.

[(P)] **(D)** Prior authorization is required for all optical services for Missouri Medicaid recipients residing in a nursing home, boarding home or domiciliary home when the service is provided in the nursing home. The provider must submit a Prior

Authorization Request Form to DOSS before the service is provided in order for Medicaid payment to be made.

[(Q)] **(E)** An eye refraction is included in the reimbursement for a comprehensive or limited eye examination. Because the eye refraction is not covered by Medicare but is covered by Medicaid, providers may bill Medicaid for an eye refraction when the patient has Medicare and Medicaid coverage.

[(R)] **(F)** Eyeglasses may be covered by Medicaid for *[a prescription of less than 0.75 diopters if medically necessary. A Medical Necessity Form must be completed by the prescribing physician or optometrist and attached to the claim form. Eyeglasses less than 0.75 diopters will be approved for the following reasons:]* **adults following cataract surgery.**

[1. Child under age eighteen (18) who requires glasses for school performances;

2. Visual acuity 20/40 or less; or

3. Protective eyewear for persons with sight in only one (1) eye.]

[(S)] **(G)** Any warranties extended by optical companies for optical materials to private-pay patients must also apply to those same materials dispensed to Medicaid recipients.

[(T)] **(H)** Medicaid allows one (1) artificial eye per eye (one (1) left and one (1) right) within a five (5)-year period. If the artificial eye is lost, destroyed, cracked or deteriorated, payment will be allowed for replacement if a Medical Necessity Form is completed and attached to the claim.

[(U)] **(I)** Optometrist may be reimbursed for visual therapy training when there is a prognosis for substantial improvement or correction of an ocular or vision condition. These conditions include amblyopia, eccentric (nonfoveal) monocular fixation, suppression, inadequate motor or sensory fusion and strabismus (squint). Orthoptic and pleoptic training must be prior authorized by the DOSS Optometric Consultant. The number of training sessions are limited to one (1) per day, two (2) per week and a maximum of twenty (20) sessions may be requested on the Prior Authorization Request Form. If the patient shows significant improvement after the initial twenty (20) sessions and the optometrist feels that further progress could be made, DOSS may grant prior authorization for additional training sessions not to exceed a total of forty (40) sessions.

[(V)] **(J)** Fitting of contact lens for treatment of disease, including supply of lens (therapeutic bandage lens) is covered if it is prescribed by a physician, (MD or DO), as a bandage to cover a diseased condition of the eye, such as a bandage over an abrasion of the skin. The lens must be plain with no corrective power. Diagnosis for which the lens should be reimbursed are Bullous Kerotopathy, Corneal Ulcers, Ocular Pemphigoid and other corneal exposure problems. A Medical Necessity Form completed and signed by the prescribing physician must be attached to the claim form.

[(W)] **(K)** Visual field examination with optometric diagnosis evaluation, tangent screen, Autoplot or equivalent, are covered when performed by an optometrist and prior authorized by DOSS. The following criteria will be considered in granting prior authorization:

1. Elevated intraocular pressure;
2. Best corrected visual acuity of 20/40 or less in either eye;
3. Headaches not attributed to refractive error; and
4. Reduction of confrontation fields.

[(X)] **(L)** Quantitative perimetry, for example, several isopters on Goldmann perimeter, or equivalent is covered.

[(Y)] **(M)** Serial tonometry with optometric diagnostic evaluation (separate procedure), one (1) or more sessions on the same day is covered when performed by an optometrist. Routine tonometry is included in the reimbursement for a comprehensive examination and cannot be billed separately.

(8) Noncovered Services.

(W) Eyeglasses for adults, except one (1) pair following cataract surgery.

AUTHORITY: section 207.020, RSMo [1986] 2000. This rule was previously filed as 13 CSR 40-81.170. Emergency rule filed April 10, 1981, effective April 20, 1981, expired July 10, 1981. Original rule filed April 10, 1981, effective July 11, 1981. Emergency amendment filed June 27, 2002, effective July 7, 2002, expires Feb. 27, 2003.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20—Division of Environmental Health and Communicable Disease Prevention
Chapter 20—Communicable Diseases

EMERGENCY AMENDMENT

19 CSR 20-20.040 Measures for the Control of Communicable, Environmental and Occupational Diseases. This emergency amendment deletes section (6).

PURPOSE: This amendment is to remove the sunset clause on this rule in order to continue to define investigative and control measures for communicable, environmental, and occupational diseases.

EMERGENCY STATEMENT: Section 192.020 mandates that the Missouri Department of Health and Senior Services (DHSS) safeguard the health of the people in the state and all its subdivisions; study the causes and prevention of diseases; designate those diseases which are infectious, contagious, communicable or dangerous; and make such orders, findings, rules and regulations to prevent the entrance and spread of such infectious, contagious and communicable disease into this state. This rule gives the director the legal means necessary to control, investigate, or both, any disease or condition listed in 19 CSR 20-20.020 that is a threat to the public health. This rule is a continuation of the longstanding, well proven, public health tools that have served the people for many decades to monitor and prevent outbreaks and control the spread of disease. The methods of investigation and control of communicable disease as listed in this rule are well established in the field of epidemiology and infectious diseases and are based on the recommendations and guidance from the Department of Health and Human Services, Centers for Disease Control and Prevention. These methods serve to protect the health of Missouri citizens against infectious, contagious and communicable diseases transmittable by contact with persons infected or harboring such diseases. In 2001, 46 (provisional) institutional and community outbreaks and 30,786 cases of such diseases were reported in Missouri that required investigation and follow-up by the department and/or local health authority. Further, since September 11, 2001 and the following anthrax bioterrorist events, this rule provides additional protection for the public health and safety of Missouri citizens by setting forth the measures to prevent, investigate, and control illnesses associated with agents of bioterrorism. Without this rule, the citizens of Missouri are vulnerable to acts of bioterrorism in addition to infectious, contagious, and communicable diseases that are controllable through the application of current principles of infectious diseases control. Currently there is a sunset clause which provides that this rule is due to expire on June 30, 2002. As this rule is necessary for the continued implementation and administration of section 192.020, RSMo, the Missouri Department of Health and Senior Services finds an immediate danger to the public health and welfare and a compelling government interest, which requires emergency action to remove this sunset clause. A proposed amendment which covers the same material, is

*published in this issue of the **Missouri Register**. The scope of this rule is limited to the circumstances creating the emergency and complies with the protection extended in the **Missouri** and the **United States Constitutions**. The Commission believes this emergency rule is fair to all interested persons and parties under the circumstances. This emergency amendment was filed June 13, 2002, effective July 1, 2002, and expires December 27, 2002.*

[(6) This rule will expire on June 30, 2002.]

*AUTHORITY: section 192.006[.1] and 192.020, RSMo [1994] **2000**. This rule was previously filed as 13 CSR 50-101.050. Original rule filed July 15, 1948, effective Sept. 13, 1948. Rescinded and readopted: Filed Dec. 11, 1981, effective May 13, 1982. Amended: Filed Sept. 16, 1982, effective Jan. 14, 1983. Amended: Filed March 21, 1984, effective July 15, 1984. Amended: Filed June 2, 1988, effective Aug. 25, 1988. Amended: Filed Nov. 15, 1989, effective Feb. 11, 1990. Amended: Filed Aug. 14, 1992, effective April 8, 1993. Amended: Filed Sept. 15, 1995, effective April 30, 1996. Emergency amendment filed June 13, 2002, effective July 1, 2002, expires Dec. 27, 2002. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*