SECOND REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 1283

94TH GENERAL ASSEMBLY

Reported from the Committee on Health and Mental Health, April 10, 2008, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

5271S.04C

AN ACT

To repeal sections 135.535, 135.562, 191.400, 192.014, 192.083, 208.145, 208.152, 208.215, 208.955, 376.986, and 660.062, RSMo, and to enact in lieu thereof sixty-six new sections relating to the Missouri health transformation act of 2008.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 135.535, 135.562, 191.400, 192.014, 192.083, 208.145, 208.152, 208.215, 208.955, 376.986, and 660.062, RSMo, are repealed and sixty-six new sections enacted in lieu thereof, to be known as sections 8.365, 26.850, 26.853, 26.856, 26.859, 26.900, 103.185, 135.535, 135.562, 143.116, 191.845, 191.1025, 191.1200, 191.1250, 191.1256, 191.1259, 191.1262, 191.1265, 191.1271, 191.1300, 191.1303, 191.1306, 191.1309, 191.1312, 191.1315, 191.1318, 191.1321, 191.1324, 192.083, 192.990, 196.1200, 197.551, 197.554, 197.557, 197.563, 197.566, 197.572, 197.575, 197.578, 197.581, 197.584, 197.587, 208.145, 208.149, 208.152, 208.215, 208.955, 208.1300, 208.1303, 208.1306, 208.1309, 208.1312, 208.1315, 208.1318, 208.1321, 208.1324, 208.1327, 208.1330, 208.1333, 208.1336, 208.1345, 376.025, 376.685, 376.986, 376.1600, and 376.1618, to read as follows:

8.365. The office of administration, in consultation with the department of health and senior services, shall submit a report to the governor and general assembly by December 31, 2008, detailing the opportunities for the state to implement a minimum health promotion standard for construction of state buildings or substantial renovation of state buildings. The report shall provide recommendations for creating a voluntary work group of architects, builders, engineers or

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

persons and interest groups with expertise in the field of public and environmental health for the purpose of advising the office of administration on the development of the health promotion standard that would outline architectural features designed to promote and encourage a healthier workforce and environment for those working and using the resources in state buildings. The report shall also include estimates of any additional costs or savings from incorporating such features.

26.850. Sections 26.850 to 26.859 may be cited as the "Health Cabinet and Health Policy Council Act".

26.853. 1. There is hereby created the "Missouri Health Cabinet".

2. The cabinet shall ensure that the public policy of this state relating to health is developed to promote interdepartmental collaboration and program implementation in order that services designed for health are planned, managed, and delivered in a holistic and integrated manner to improve the health of Missourians.

3. The cabinet is created in the executive office of the Governor, which shall provide administrative support and service to the cabinet.

4. The cabinet shall meet for its organizational session no later than October 1, 2008. Thereafter, the cabinet shall meet at least six times each year, with two of the meetings in different regions of the state in order to solicit input from the public and any other individual offering testimony relevant to the issues considered. Each meeting shall include a public-comment session.

5. The cabinet shall consist of six members, including the governor and the following persons:

(1) Director of the department of health and senior services;

(2) Director of the department of social services;

(3) Director of the department of mental health;

(4) Commissioner of education;

(5) Director of the department of insurance, financial institutions and professional registration.

6. The president pro tem of the senate, the speaker of the house of representatives, the chief justice of the supreme court, the attorney general, the commissioner of the office of administration, and the director of agriculture, or their appointed designees, shall serve as ex officio members of the cabinet.

7. The governor or the director of the department of health and senior services shall serve as the chairperson of the cabinet.

26.856. The cabinet shall have the following duties and responsibilities:

(1) Develop, no later than July 31, 2009, a plan to integrate services to improve health outcomes. The plan shall align public resources to support the healthy growth and development of Missourians;

(2) Develop and implement measurable outcomes that are consistent with the plan. The cabinet shall establish a baseline measurement for each outcome and regularly report on the progress made toward achieving the desired outcome;

(3) Design and implement actions that will promote collaboration, creativity, increased efficiency, information sharing, and improved service delivery between and within state governmental organizations that provide services related to health;

(4) Foster public awareness of health issues and develop new partners in the effort to improve health;

(5) Create a health impact statement for evaluating proposed legislation, requested appropriations, and programs. The impact statement shall be shared with the general assembly in their deliberative process;

(6) Identify existing and potential funding streams and resources for health programs and services, including, but not limited to, public funding, foundation and organization grants, and other forms of private funding opportunities, including public-private partnerships;

(7) Develop a health-based budget structure and nomenclature that includes all relevant departments, funding streams, and programs. The budget shall facilitate improved coordination and efficiency, explore options for and allow maximization of federal financial participation, and implement the state's vision and strategic plan;

(8) Engage in other activities that will implement improved collaboration of agencies in order to create, manage, and promote coordinated policies, programs, and service-delivery systems that support improved health outcomes;

(9) Provide an annual report by February first of each year, to

the governor, the president pro tem of the senate, the speaker of the house of representatives, and the public concerning its activities and progress towards making this state the first to reach the Healthy People 2020 goals or any updated Healthy People goals. The annual report may include recommendations for needed legislation or rulemaking authority.

26.859. The governor shall appoint a "Health Policy Council" to assist the cabinet in its tasks. This council replaces the state board of health established in section 191.400, RSMo, and the state board of senior services established in section 660.062, RSMo. The council shall include fifteen members who can provide to the cabinet the best available technical and professional research and assistance. The council shall advise the departments of health and senior services and social services in the development of rules and regulations. It shall include representatives of health policy organizations, health data collection, and analysis experts, health educators, health professionals including a minimum of one physician and one registered nurse, representatives of institutions of higher learning who train our health workforce, health facility operators, insurance providers, employers, health economist, health advocacy organizations, a health professional with focus on senior issues, consumers, wherever practicable, who have been recipients of services and programs operated or funded by state agencies.

26.900. 1. The lieutenant governor, in his or her capacity as the state's official senior advocate, shall coordinate with all of the directors of the departments in this state to review their major policies, programs, and structures in light of this state's increasingly older and more diverse population. The lieutenant governor shall establish a workgroup with representatives from leadership staff of the departments to prepare for the review required under this section.

2. The state departments shall conduct a review and develop a policy brief that highlights critical functions or issue areas that would be affected by the state's shifting demographic profile and which should be addressed within the next ten years.

3. The policy brief described under subsection 2 of this section shall be submitted to the governor, lieutenant governor, and general assembly by September 1, 2009, and updated annually thereafter.

103.185. Beginning July 1, 2009, the Missouri consolidated health care plan shall include, as part of its covered benefits, all of the preventive benefits recommended by the federal U.S. Preventive Services Task Force.

135.535. 1. A corporation, limited liability corporation, partnership or sole proprietorship, which moves its operations from outside Missouri or outside a distressed community into a distressed community, or which commences operations in a distressed community on or after January 1, 1999, and in either case has more than seventy-five percent of its employees at the facility in the distressed community, and which has fewer than one hundred employees for whom payroll taxes are paid, and which is a manufacturing, biomedical, medical devices, scientific research, animal research, computer software design or development, computer programming, including Internet, web hosting, and other information technology, wireless or wired or other telecommunications or a professional firm shall receive a forty percent credit against income taxes owed pursuant to chapter 143, 147 or 148, RSMo, other than taxes withheld pursuant to sections 143.191 to 143.265, RSMo, for each of the three years after such move, if approved by the department of economic development, which shall issue a certificate of eligibility if the department determines that the taxpayer is eligible for such credit. The maximum amount of credits per taxpayer set forth in this subsection shall not exceed one hundred twenty-five thousand dollars for each of the three years for which the credit is claimed. The department of economic development, by means of rule or regulation promulgated pursuant to the provisions of chapter 536, RSMo, shall assign appropriate North American Industry Classification System numbers to the companies which are eligible for the tax credits provided for in this section. Such three-year credits shall be awarded only one time to any company which moves its operations from outside of Missouri or outside of a distressed community into a distressed community or to a company which commences operations within a distressed community. A taxpayer shall file an application for certification of the tax credits for the first year in which credits are claimed and for each of the two succeeding taxable years for which credits are claimed.

2. Employees of such facilities physically working and earning wages for that work within a distressed community whose employers have been approved for tax credits pursuant to subsection 1 of this section by the department of economic development for whom payroll taxes are paid shall also be eligible to

receive a tax credit against individual income tax, imposed pursuant to chapter 143, RSMo, equal to one and one-half percent of their gross salary paid at such facility earned for each of the three years that the facility receives the tax credit provided by this section, so long as they were qualified employees of such entity. The employer shall calculate the amount of such credit and shall report the amount to the employee and the department of revenue.

3. A tax credit against income taxes owed pursuant to chapter 143, 147 or 148, RSMo, other than the taxes withheld pursuant to sections 143.191 to 143.265, RSMo, in lieu of the credit against income taxes as provided in subsection 1 of this section, may be taken by such an entity in a distressed community in an amount of forty percent of the amount of funds expended for computer equipment and its maintenance, medical laboratories and equipment, research laboratory equipment, manufacturing equipment, fiber optic equipment, high speed telecommunications, wiring or software development expense up to a maximum of seventy-five thousand dollars in tax credits for such equipment or expense per year per entity and for each of three years after commencement in or moving operations into a distressed community.

4. A corporation, partnership or sole partnership, which has no more than one hundred employees for whom payroll taxes are paid, which is already located in a distressed community and which expends funds for such equipment pursuant to subsection 3 of this section in an amount exceeding its average of the prior two years for such equipment, shall be eligible to receive a tax credit against income taxes owed pursuant to chapters 143, 147 and 148, RSMo, in an amount equal to the lesser of seventy-five thousand dollars or twenty-five percent of the funds expended for such additional equipment per such entity. Tax credits allowed pursuant to this subsection or subsection 1 of this section may be carried back to any of the three prior tax years and carried forward to any of the five tax years.

5. An existing corporation, partnership or sole proprietorship that is located within a distressed community and that relocates employees from another facility outside of the distressed community to its facility within the distressed community, and an existing business located within a distressed community that hires new employees for that facility may both be eligible for the tax credits allowed by subsections 1 and 3 of this section. To be eligible for such tax credits, such a business, during one of its tax years, shall employ within a distressed community at least twice as many employees as were employed at the beginning of that tax year. A business hiring employees shall have no more than one

hundred employees before the addition of the new employees. This subsection shall only apply to a business which is a manufacturing, biomedical, medical devices, scientific research, animal research, computer software design or development, computer programming or telecommunications business, or a professional firm.

6. Tax credits shall be approved for applicants meeting the requirements of this section in the order that such applications are received. Certificates of tax credits issued in accordance with this section may be transferred, sold or assigned by notarized endorsement which names the transferee.

7. The tax credits allowed pursuant to subsections 1, 2, 3, 4 and 5 of this section shall be for an amount of no more than ten million dollars for each year beginning in 1999. To the extent there are available tax credits remaining under the ten million dollar cap provided in this section, **[**up to one hundred thousand dollars in the**]** **such** remaining credits shall first be used for tax credits authorized under section 135.562. The total maximum credit for all entities already located in distressed communities and claiming credits pursuant to subsection 4 of this section shall be seven hundred and fifty thousand dollars. The department of economic development in approving taxpayers for the credit as provided for in subsection 6 of this section shall use information provided by the department of revenue regarding taxes paid in the previous year, or projected taxes for those entities newly established in the state, as the method of determining when this maximum will be reached and shall maintain a record of the order of approval. Any tax credit not used in the period for which the credit was approved may be carried over until the full credit has been allowed.

8. A Missouri employer relocating into a distressed community and having employees covered by a collective bargaining agreement at the facility from which it is relocating shall not be eligible for the credits in subsection 1, 3, 4 or 5 of this section, and its employees shall not be eligible for the credit in subsection 2 of this section if the relocation violates or terminates a collective bargaining agreement covering employees at the facility, unless the affected collective bargaining unit concurs with the move.

9. Notwithstanding any provision of law to the contrary, no taxpayer shall earn the tax credits allowed in this section and the tax credits otherwise allowed in section 135.110, or the tax credits, exemptions, and refund otherwise allowed in sections 135.200, 135.220, 135.225 and 135.245, respectively, for the same business for the same tax period.

135.562. 1. If any taxpayer with a federal adjusted gross income of thirty thousand dollars or less incurs costs for the purpose of making all or any portion of such taxpayer's principal dwelling accessible to an individual with a disability **or a senior** who permanently resides with the taxpayer, such taxpayer shall receive a tax credit against such taxpayer's Missouri income tax liability in an amount equal to the lesser of one hundred percent of such costs or two thousand five hundred dollars per taxpayer, per tax year. **For purposes of this section, "disability" shall have the same meaning as such term is defined in section 135.010 and "senior" shall mean a person sixty-five years of age or older.**

2. Any taxpayer with a federal adjusted gross income greater than thirty thousand dollars but less than sixty thousand dollars who incurs costs for the purpose of making all or any portion of such taxpayer's principal dwelling accessible to an individual with a disability **or senior** who permanently resides with the taxpayer shall receive a tax credit against such taxpayer's Missouri income tax liability in an amount equal to the lesser of fifty percent of such costs or two thousand five hundred dollars per taxpayer per tax year. No taxpayer shall be eligible to receive tax credits under this section in any tax year immediately following a tax year in which such taxpayer received tax credits under the provisions of this section.

3. Tax credits issued pursuant to this section may be refundable in an amount not to exceed two thousand five hundred dollars per tax year.

4. Eligible costs for which the credit may be claimed include:

(1) Constructing entrance or exit ramps;

(2) Widening exterior or interior doorways;

(3) Widening hallways;

(4) Installing handrails or grab bars;

(5) Moving electrical outlets and switches;

(6) Installing stairway lifts;

(7) Installing or modifying fire alarms, smoke detectors, and other alerting systems;

(8) Modifying hardware of doors; **[**or**]**

(9) Modifying bathrooms**; or**

(10) Constructing additional rooms in the dwelling or structures on the property for the purpose of accommodating the senior or person with disability.

5. The tax credits allowed, including the maximum amount that may be claimed, pursuant to this section shall be reduced by an amount sufficient to offset any amount of such costs a taxpayer has already deducted from such taxpayer's federal adjusted gross income or to the extent such taxpayer has applied any other state or federal income tax credit to such costs.

6. A taxpayer shall claim a credit allowed by this section in the same taxable year as the credit is issued, and at the time such taxpayer files his or her Missouri income tax return; provided that such return is timely filed.

7. The department may, in consultation with the department of social services, promulgate such rules or regulations as are necessary to administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

8. The provisions of this section shall apply to all tax years beginning on or after January 1, 2008.

9. The provisions of this section shall expire December 31, 2013.

10. In no event shall the aggregate amount of all tax credits allowed pursuant to this section exceed **[**one hundred thousand dollars**]** **the amount of tax credits remaining unused under the program authorized under section 135.535** in any given fiscal year. The tax credits issued pursuant to this section shall be on a first-come, first-served filing basis.

143.116. 1. For all tax years beginning on or after January 1, 2009, an individual taxpayer shall be allowed a deduction from Missouri adjusted gross income in the amount equal to one hundred percent of the premium paid by the taxpayer during the taxable year for high deductible health plans established and used with a health savings account under the applicable provisions of Section 223 of the Internal Revenue Code to the extent the amount is not deducted on the taxpayer's federal income tax return for that taxable year.

2. As used in this section, the following terms shall mean:

(1) "Health savings account" or "account", shall have the same meaning as ascribed to it in 26 U.S.C. Section 223(d), as amended;

(2) "High deductible health plan", a policy or contract of health insurance or health benefit plan, as defined in section 376.1350, RSMo, that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

3. The director of the department of revenue is authorized to promulgate rules and regulations necessary to implement and administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

191.845. 1. There is hereby created in the state treasury the "Health Transformation Fund" which shall consist of all gifts, donations, transfers, and moneys appropriated by the general assembly, and bequests to the fund. The state treasurer shall be custodian of the fund and may approve disbursements from the fund in accordance with sections 30.170 and 30.180, RSMo. The fund shall be administered by the department of health and senior services.

2. Moneys in the fund shall be used for the establishment of pilot projects in the greater St. Charles and southeast bootheel areas of the state, at the same time. The pilot projects shall have the involvement of the local community health coalition to establish new approaches to expand coverage for the uninsured population in the respective communities and to create healthier populations through a single comprehensive health care plan that is focused on both of the above-named areas of the state.

3. The department shall promulgate rules setting forth the procedures and methods for implementing the provisions of this section and establish criteria for the disbursement of funds under this section.

At a minimum, such proposals shall include a plan that:

(1) Is established at the community level;

(2) Will improve population health, create a culture of health, and develop a model for providing one hundred percent health services coverage; and

(3) Provides for the submission of a feasibility study by August 2009 that identifies the infrastructure and resources needed for the implementation of the pilot projects and that analyzes the feasibility of extending the pilot projects or expanding the project state-wide.

4. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

5. Any moneys remaining in the fund as the end of the biennium shall revert to the credit of the general revenue fund, except for moneys that were gifts, donations, or bequests. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

6. Pursuant to section 23.253, RSMo, of the Missouri sunset act:

(1) The provisions of the new program authorized under this section shall sunset automatically six years after the effective date of this section unless reauthorized by an act of the general assembly; and

(2) If such program is reauthorized, the program authorized under this section shall sunset automatically twelve years after the effective date of the reauthorization of this section; and

(3) This section shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under this section is sunset.

191.1025. 1. The department of health and senior services shall develop the Missouri healthy workplace recognition program for the

purpose of granting official state recognition to employers with more than fifty employees for excellence in promoting health, wellness, and prevention. The criteria for awarding such recognition shall be developed by the department but at a minimum shall include an examination of whether the employer offers:

(1) Workplace wellness programs;

(2) Incentives for healthier lifestyles;

(3) Opportunities for active community involvement and exercise; and

(4) Encouragement of well visits with health care providers.

2. The designation to five employers each year as the healthiest place to work in Missouri shall be posted on both the department's and the state's Internet website and shall be commemorated in a plaque for the employer.

3. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

191.1200. 1. The general assembly shall appropriate four hundred thousand dollars from the health care technology fund created in section 208.975, RSMo, to the department of social services for the purpose of awarding a grant to implement an Internet web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room. The grantee shall establish a program that diverts patients presenting at an emergency room for nonemergency care to more appropriate outpatient settings as is consistent with federal law and regulations. The program shall refer the patient to an appropriate health care professional based on the

patient's health care needs and situation. The program shall provide the patient with a scheduled appointment that is timely, with an appropriate provider who is conveniently located. If the patient is uninsured and potentially eligible for MO HealthNet, the program shall connect the patient to a primary care provider, community clinic, or agency that can assist the patient with the application process. The program shall also ensure that discharged patients are connected with a community-based primary care provider and assist in scheduling any necessary follow-up visits before the patient is discharged.

2. The program shall not require a provider to pay a fee for accepting charity care patients in a Missouri public health care program.

3. The grantee shall report to the director on a quarterly basis the following information:

(1) The total number of appointments available for scheduling by specialty;

(2) The average length of time between scheduling and actual appointment;

(3) The total number of patients referred and whether the patient was insured or uninsured; and

(4) The total number of appointments resulting in visits completed and number of patients continuing services with the referring clinic.

4. The director, in consultation with the Missouri Hospital Association, or a successor organization, shall conduct an evaluation of the emergency room diversion pilot project and submit the results to the general assembly by January 15, 2009. The evaluation shall compare the number of nonemergency visits and repeat visits to hospital emergency rooms for the period before the commencement of the project and one year after the commencement, and an estimate of the costs saved from any documented reductions.

191.1250. As used in sections 191.1250 to 191.1277, the following terms shall mean:

(1) "Chronic condition", any regularly recurring, potentially life-threatening medical condition that requires regular supervision by a primary care physician and/or medical specialist;

(2) "Department", the department of health and senior services;

(3) "EMR" or "electronic medical record", refers to a patient's medical history that is stored in real-time using information technology and which can be amended, updated, or supplemented by the patient or the physician using the electronic medical record;

(4) "HIPAA", the federal "Health Insurance Portability and Accountability Act of 1996";

(5) "Originating site", a place where a patient may receive health care via telehealth. An originating site may include:

(a) A licensed inpatient center;

(b) An ambulatory surgical center;

(c) Any practice location, office, or clinic of a licensed health care professional;

(d) A skilled nursing facility;

(e) A residential treatment facility;

(f) A home health agency;

(g) A diagnostic laboratory or imaging center;

(h) An assisted living facility;

(i) A school-based health program;

(j) A mobile clinic;

(k) A mental health clinic;

(l) A rehabilitation or other therapeutic health setting;

(m) The patient's residence;

(n) The patient's place of employment; or

(o) The patient's then-current location if the patient is away from the patient's residence or place of employment;

(6) "Telehealth", the use of telephonic and other electronic means of communications to provide and support health care delivery, diagnosis, consultation, and treatment when distance separates the patient and the health care provider;

(7) "Telehealth practitioner", a person who is a licensed health care professional and who utilizes telehealth to diagnose, consult with, or treat patients without having conducted an in-person consultation with a particular patient.

191.1256. Sections 191.1250 to 191.1277 do not:

(1) Alter the scope of practice of any health care practitioner; or

(2) Limit a patient's right to choose in-person contact with a health care practitioner for the delivery of health care services for

which telehealth is available.

191.1259. The delivery of health care via telehealth is recognized and encouraged as a safe, practical and necessary practice in this state. No health care provider or operator of an originating site shall be disciplined for or discouraged from participating in sections 191.1250 to 191.1277. In using telehealth procedures, health care providers and operators of originating sites shall comply with all applicable federal and state guidelines and shall follow established federal and state rules regarding security, confidentiality and privacy protections for health care information.

191.1262. Although the use of telehealth is strongly encouraged, nothing in sections 191.1250 to 191.1277 requires a health insurer, health maintenance organization, managed care organization, provider service organization or MO HealthNet, except as provided in section 208.670, RSMo, to include telehealth within the scope of the plan or policy offered by that entity.

191.1265. Only telehealth practitioners qualified under sections 191.1250 to 191.1277 may practice telehealth care in this state. Telehealth practitioners may reside outside this state but shall be licensed by the division of professional registration.

191.1271. By January 1, 2009, the department shall promulgate quality control rules and regulations to be used in removing and improving the services of telehealth practitioners. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

191.1300. As used in sections 191.1300 to 191.1324, the following terms shall mean:

(1) "Center", the Missouri center for health information management and evaluation within the department of health and senior

services;

(2) "Council", the health policy council created under section 26.859, RSMo;

(3) "Department", the department of health and senior services;

(4) "Inpatient quality indicators" and "Patient-safety indicators", as defined by the Centers for Medicare and Medicaid Services, the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states;

(5) "Provider", licensed physicians and other providers as required by rules promulgate by the department.

191.1303. 1. The Missouri center for health information management and evaluation, within the department of health and senior services, shall establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics. The center shall be staffed with public health experts, biostatisticians, information system analysts, health policy experts, economists, and other staff necessary to carry out its functions.

2. The comprehensive health information system operated by the center shall identify the best available data sources and coordinate the compilation of extant health-related data and statistics and purposefully collect data on:

(1) The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality;

(2) The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state;

(3) Environmental, social, and other health hazards;

(4) Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status;

(5) Health resources, including physicians, dentists, nurses, and other health professionals, by specialty and type of practice and acute,

long-term care and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities;

(6) Utilization of health care by type of provider;

(7) Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care;

(8) Family formation, growth, and dissolution;

(9) The extent of public and private health insurance coverage in this state; and

(10) The quality of care provided by various health care providers.

191.1306. 1. In order to produce comparable and uniform health information and statistics for the development of policy recommendations, the department shall perform the following functions:

(1) Coordinate the activities of state departments involved in the design and implementation of the comprehensive health information system;

(2) Undertake research, development, and evaluation respecting the comprehensive health information system;

(3) Review the statistical activities of state departments to ensure that they are consistent with the comprehensive health information system;

(4) Develop written agreements with local, state, and federal agencies for the sharing of health-care-related data or using the facilities and services of such agencies. State departments and agencies, local health councils, and other entities under state contract shall assist the center in obtaining, compiling, and transferring health-care-related data maintained by state and local agencies. Written agreements must specify the types, methods, and periodicity of data exchanges and specify the types of data that will be transferred to the center;

(5) Establish by rule the types of data collected, compiled, processed, used, or shared. Decisions regarding center data sets should be made based on consultation with the health policy council created under section 26.859, RSMo, and other public and private users

regarding the types of data which should be collected and their uses. The center shall establish standardized means for collecting health information and statistics under laws and rules administered by the department;

(6) Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state departments in collecting and compiling health-care-related data. The department shall periodically review ongoing health care data collections of other state department and agencies to determine if the collections are being conducted in accordance with the established minimum sets of data;

(7) Establish advisory standards to ensure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private organizations;

(8) Prescribe standards for the publication of health-care-related data reported under sections 191.1300 to 191.1324 which ensure the reporting of accurate, valid, reliable, complete, and comparable data. Such standards should include advisory warnings to users of the data regarding the status and quality of any data reported by or available from the center;

(9) Prescribe standards for the maintenance and preservation of the center's data. This should include methods for archiving data, retrieval of archived data, and data editing and verification;

(10) Ensure that strict quality control measures are maintained for the dissemination of data through publications, studies, or user requests;

(11) Develop, in conjunction with the council, and implement a long-range plan for making available health care quality measures and financial data that will allow consumers to compare health care services. The health care quality measures and financial data the department shall make available shall include, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The department shall submit the initial plan to the governor, the president of the Senate, and the speaker of the house of representatives by January 1, 2010, and shall update the plan and report on the status of its implementation annually thereafter. The department shall also make the plan and status report

available to the public on its Internet website, to be entitled "Missourihealthfinder.com".

2. As part of the plan required under subdivision (11) of subsection 1 of this section, the department shall identify the process and timeframes for implementation, any barriers to implementation, and recommendations of changes in the law that may be enacted by the general assembly to eliminate the barriers. As preliminary elements of the plan, the department shall:

(1) Make available patient-safety indicators, inpatient quality indicators, and performance outcome and patient charge data collected from health care facilities as already required by state and federal law and regulation. The department shall determine which conditions, procedures, health care quality measures, and patient charge data to disclose based upon input from the council. When determining which conditions and procedures are to be disclosed, the council and the department shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which health care quality measures to disclose, the department:

(a) Shall consider such factors as volume of cases; average patient charges; average length of stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable;

(b) May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states;

When determining which patient charge data to disclose, the department shall consider such measures as average charge, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission, among others;

(2) Make available performance measures, benefit design, and premium cost data from health benefit plans licensed under chapter 376, RSMo. The department shall determine which health care quality

measures and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the department shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copayments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network. Health benefit plans shall make available to the department any such data or information that is not currently reported to the department; and

(3) Determine the method and format for public disclosure of data reported pursuant to this paragraph. The department shall make its determination based upon input from the council. At a minimum, the data shall be made available on the department's Missourihealthfinder Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website shall include such additional information as is determined necessary to ensure that the website enhances informed decision-making among consumers and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider. The data specified in subdivision (1) of this subsection shall be released no later than January 1, 2011, for the reporting of infection rates for those entities not currently reporting infection rates, and no later than October 1, 2010, for mortality rates and complication rates. The data specified in subdivision (2) of this subsection shall be released no later than October 1, 2011.

3. The department shall administer, manage, and monitor grants contracts to not-for-profit organizations, regional health information organizations, public health departments, or state agencies that submit proposals for planning, implementation, or training projects to advance the development of a health information network. Any grant contract shall be evaluated to ensure the effective outcome of the health information project.

4. The department shall initiate, oversee, manage, and evaluate the integration of health care data from each state agency that collects, stores, and reports on health care issues and make that data available to any health care practitioner through a state health information network.

5. This section does not confer on the department the power to demand or require that a health care provider or professional furnish information, records of interviews, written reports, statements, notes, memoranda, or data other than as expressly required by law.

6. Nothing in this section shall limit, restrict, affect, or control the collection, analysis, release, or publication of data by any state agency pursuant to its statutory authority, duties, or responsibilities.

191.1309. The center shall provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and compiled by the center. The center shall also provide the following additional technical assistance services:

(1) Establish procedures identifying the circumstances under which, the places at which, the persons from whom, and the methods by which a person may secure data from the center, including procedures governing requests, the ordering of requests, timeframes for handling requests, and other procedures necessary to facilitate the use of the center's data. To the extent possible, the center should provide current data timely in response to requests from public or private agencies;

(2) Provide assistance to data sources and users in the areas of database design, survey design, sampling procedures, statistical interpretation, and data access to promote improved health-care-related data sets;

(3) Identify health care data gaps and provide technical assistance to other public or private organizations for meeting documented health care data needs;

(4) Assist other organizations in developing statistical abstracts of their data sets that could be used by the center;

(5) Provide statistical support to state departments with regard to the use of databases maintained by the center;

(6) To the extent possible, respond to multiple requests for information not currently collected by the center or available from

other sources by initiating data collection;

(7) Maintain detailed information on data maintained by other local, state, federal, and private agencies in order to advise those who use the center of potential sources of data which are requested but which are not available from the center;

(8) Respond to requests for data which are not available in published form by initiating special computer runs on data sets available to the center; and

(9) Monitor innovations in health information technology, informatics, and the exchange of health information and maintain a repository of technical resources to support the development of a health information network.

191.1312. The center shall provide for the widespread dissemination of data which it collects and analyzes. The center shall have the following publication, reporting, and special study functions:

(1) The center shall publish and make available periodically to agencies and individuals health statistics publications of general interest, including health plan consumer reports and health maintenance organization member satisfaction surveys; publications providing health statistics on topical health policy issues; publications that provide health status profiles of the people in this state; and other topical health statistics publications;

(2) The center shall publish, make available, and disseminate, promptly and as widely as practicable, the results of special health surveys, health care research, and health care evaluations conducted or supported under this section. Any publication by the center must include a statement of the limitations on the quality, accuracy, and completeness of the data;

(3) The center shall provide indexing, abstracting, translation, publication, and other services leading to a more effective and timely dissemination of health care statistics;

(4) The center shall be responsible for publishing and disseminating an annual report on the center's activities; and

(5) The center shall be responsible, to the extent resources are available, for conducting a variety of special studies and surveys to expand the health care information and statistics available for health policy analyses, particularly for the review of public policy issues. The

center shall develop a process by which users of the center's data are periodically surveyed regarding critical data needs and the results of the survey considered in determining which special surveys or studies will be conducted. The center shall select problems in health care for research, policy analyses, or special data collections on the basis of their local, regional, or state importance; the unique potential for definitive research on the problem; and opportunities for application of the study findings.

191.1315. 1. There is hereby created in the state treasury the "Missourihealthfinder Fund" which shall consist of all gifts, donations, transfers, and moneys appropriated by the general assembly, and bequests to the fund. The state treasurer shall be custodian of the fund and may approve disbursements from the fund in accordance with sections 30.170 and 30.180, RSMo. The fund shall be administered by the department of health and senior services.

2. Moneys in the fund shall be used for the administration of section 191.1300 to 191.1324. The center may charge such reasonable fees for services as the department prescribes by rule. The established fees may not exceed the reasonable cost for such services. Fees collected may not be used to offset annual appropriations from the general revenue fund. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

3. Any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund, except for moneys that were gifts, donations, or bequests. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

191.1318. 1. The health policy council created in section 26.859,

RSMo, shall assist the center in reviewing the comprehensive health information system, including the identification, collection, standardization, sharing, and coordination of health-related data, fraud and abuse data, and professional and facility licensing data among federal, state, local, and private entities and to recommend improvements for purposes of public health, policy analysis, and transparency of consumer health care information. The council may create an advisory panel to carry out the duties of sections 191.1300 to 191.1325 and seek consultation with recommendations from the department, representing other state and local agencies, state universities, business and health coalitions, local health councils, professional health-care-related associations, consumers, and purchasers.

2. The council's duties include, but are not limited to, the following:

(1) To develop a mission statement, goals, and a plan of action for the identification, collection, standardization, sharing, and coordination of health-related data across federal, state, and local government and private sector entities;

(2) To develop a review process to ensure cooperative planning among agencies that collect or maintain health-related data; and

(3) To create ad hoc issue-oriented technical workgroups on an as-needed basis to make recommendations to the committee;

191.1321. 1. The department shall require the submission by health care facilities, licensed under chapters 197 and 198, RSMo, and health insurers under chapter 376, RSMo, of data necessary to carry out the department's duties. Specifications for data to be collected under this section shall be developed by the department with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the department. The data submitted shall consist of the following:

(1) Data submitted by health care facilities, including the facilities as licensed under chapters 197 and 198, RSMo, shall include, but are not limited to: case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed

hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, with patient and provider-specific identifiers included, actual charge data by diagnostic groups, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. The department shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the department for all data submitted as required by this section. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information. Reported data elements shall be reported electronically. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

(2) Data to be submitted by health care providers may include, but are not limited to: professional organization and specialty board affiliations, Medicare and Mo HealthNet participation, types of services offered to patients, amount of revenue and expenses of the health care provider, and such other data which are reasonably necessary to study utilization patterns. Data submitted shall be certified by the appropriate duly authorized representative or employee of the health care provider so that the information submitted is true and accurate.

(3) Data to be submitted by health insurers may include, but are not limited to: claims, premium, administration, and financial information. Data submitted shall be certified by the chief financial officer, an appropriate and duly authorized representative, or an employee of the insurer that the information submitted is true and accurate.

(4) Data required to be submitted by health care facilities, health care providers, or health insurers shall not include specific provider contract reimbursement information. However, such specific provider reimbursement data shall be reasonably available for onsite inspection

by the department as is necessary to carry out the department's regulatory duties. Any such data obtained by the department as a result of onsite inspections may not be used by the state for purposes of direct provider contracting and are confidential.

(5) A requirement to submit data shall be adopted by rule if the submission of data is being required of all members of any type of health care facility, health care provider, or health insurer. Rules are not required, however, for the submission of data for a special study mandated by the general assembly or when information is being requested for a single health care facility, health care provider, or health insurer.

2. The department shall, by rule, after consulting with appropriate professional and governmental advisory bodies and holding public hearings and considering existing and proposed systems of accounting and reporting utilized by health care facilities, specify a uniform system of financial reporting for each type of facility based on a uniform chart of accounts developed after considering any chart of accounts developed by the national association for such facilities and generally accepted accounting principles. Such systems shall, to the extent feasible, use existing accounting systems and shall minimize the paperwork required of facilities. This provision shall not be construed to authorize the department to require health care facilities to adopt a uniform accounting system. As a part of such uniform system of financial reporting, the department may require the filing of any information relating to the cost to the provider and the charge to the consumer of any service provided in such facility, except the cost of a physician's services which is billed independently of the facility.

3. When more than one licensed facility is operated by the reporting organization, the information required by this section shall be reported for each facility separately.

4. Within one hundred twenty days after the end of its fiscal year, each health care facility, excluding continuing care facilities and long-term care facilities under chapter 198, RSMo, shall file with the department, on forms adopted by the department and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which

are certified to be complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. Every long-term care facility shall submit to the department, in a format designated by the department, a statistical profile of the long-term care residents. The department shall review these statistical profiles and develop recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings.

5. In addition to information submitted in accordance with subsection 4 of this section, each long-term care facility shall track and file with the department, on a form adopted by the department, data related to each resident's admission, discharge, or conversion to MO HealthNet; health and functional status; plan of care; and other information pertinent to the resident's placement in a long-term care facility.

6. The department may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of this section.

7. Portions of patient records obtained or generated by the department containing the name, residence or business address, telephone number, social security or other identifying number, or photograph of any person or the spouse, relative, or guardian of such person, or any other identifying information which is patient-specific or otherwise identifies the patient, either directly or indirectly, are confidential.

8. The identity of any health care provider, health care facility, or health insurer who submits any data which is proprietary business information to the department pursuant to the provisions of this section shall remain confidential. As used in this section, "proprietary business information" shall include, but not be limited to, information relating to specific provider contract reimbursement information; information relating to security measures, systems, or procedures; and information concerning bids or other contractual data, the disclosure of which would impair efforts to contract for goods or services on favorable terms or would injure the affected entity's ability to compete in the marketplace. Such proprietary business information may be used in published analyses and reports or otherwise made available for

public disclosure in such manner as to preserve the confidentiality of the identity of the provider.

9. No health care facility, health care provider, health insurer, or other reporting entity or its employees or agents shall be held liable for civil damages or subject to criminal penalties either for the reporting of patient data to the department or for the release of such data by the department as authorized by this chapter.

10. The department shall be the primary source for collection and dissemination of health care data. No other department of state government may gather data from a health care provider licensed or regulated in this state without first determining if the data is currently being collected by the department and affirmatively demonstrating that it would be more cost-effective for a department of state government other than the department to gather the health care data. The director shall ensure that health care data collected by the divisions within the department is coordinated. It is the express intent of the general assembly that all health care data be collected by a single source within the department and that other divisions within the department, and all other agencies of state government, obtain data for analysis, regulation, and public dissemination purposes from that single source. Confidential information may be released to other governmental entities or to parties contracting with the department to perform department duties or functions as needed in connection with the performance of the duties of the receiving entity. The receiving entity or party shall retain the confidentiality of such information as provided for herein.

11. The department shall cooperate with local health councils with regard to health care data collection and dissemination and shall cooperate with state agencies in any efforts to establish an integrated health care database.

12. It is the policy of this state that philanthropic support for health care should be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system.

13. For purposes of determining reasonable costs of services furnished by health care facilities, unrestricted grants, gifts, and income from endowments shall not be deducted from any operating

costs of such health care facilities, and, in addition, the following items shall not be deducted from any operating costs of such health care facilities:

(1) An unrestricted grant or gift, or income from such a grant or gift, which is not available for use as operating funds because of its designation by the health care facility's governing board;

(2) A grant or similar payment which is made by a governmental entity and which is not available, under the terms of the grant or payment, for use as operating funds;

(3) The sale or mortgage of any real estate or other capital assets of the health care facility which the health care facility acquired through a gift or grant and which is not available for use as operating funds under the terms of the gift or grant or because of its designation by the health care facility's governing board, except for recovery of the appropriate share of gains and losses realized from the disposal of depreciable assets.

191.1324. 1. The department shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to:

(1) The financial status of any health care facility or facilities subject to the provisions of adverse events sections;

(2) The impact of uncompensated charity care on health care facilities and health care providers;

(3) The state's role in assisting to fund indigent care;

(4) In conjunction with the department of insurance, financial institutions and professional registration, the availability and affordability of health insurance for small businesses;

(5) Total health care expenditures in the state according to the sources of payment and the type of expenditure;

(6) The quality of health services, using techniques such as small area analysis, severity adjustments, and risk-adjusted mortality rates;

(7) The development of physician information systems which are capable of providing data for health care consumers taking into account the amount of resources consumed, including such information at licensed facilities under chapter 197, RSMo, and the outcomes

produced in the delivery of care;

(8) The collection of a statistically valid sample of data on the retail prices charged by pharmacies for the one hundred most frequently prescribed medicines from any pharmacy licensed by this state as a special study authorized by the general assembly to be performed by the department quarterly. If the drug is available generically, price data shall be reported for the generic drug and price data of a brand-named drug for which the generic drug is the equivalent shall be reported. The department shall make available on its Missourihealthfinder Internet website for each pharmacy, no later than October 1, 2009, drug prices for a 30-day supply at a standard dose. The data collected shall be reported for each drug by pharmacy and by metropolitan statistical area or region and updated quarterly;

(9) The use of emergency department services by patient acuity level and the implication of increasing hospital cost by providing nonurgent care in emergency departments. The department shall submit an annual report based on this monitoring and assessment to the governor, the speaker of the House of Representatives, and the president of the Senate with the first report due January 1, 2011; and

(10) The making available on its Missourihealthfinder Internet website beginning no later than October 1, 2011, and in a hard-copy format upon request, of patient charge, volumes, length of stay, and performance indicators collected from health care facilities pursuant to subdivision (1) of subsection 1 of section 191.1321 for specific medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the department. In making the determination of specific medical conditions, surgeries, and procedures to include, the department shall consider such factors as volume, severity of the illness, urgency of admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the department. The website shall also provide an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region,

definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. Such public data shall be updated quarterly. The department shall submit an annual status report on the collection of data and publication of health care quality measures to the governor, the speaker of the House of Representatives, and the president of the Senate with the first status report due January 1, 2011.

2. The department may assess annually the caesarean section rate in state hospitals using the analysis methodology that the department determines most appropriate. The data from this assessment shall be published periodically on the department's Internet website.

3. The department may also prepare such summaries and compilations or other supplementary reports based on the information analyzed by the department under this section, as will advance the purposes its duties.

4. (1) The department shall conduct data-based studies and evaluations and make recommendations to the general assembly and the governor concerning exemptions, the effectiveness of limitations of referrals, restrictions on investment interests and compensation arrangements, and the effectiveness of public disclosure. Such analysis shall include, but need not be limited to, utilization of services, cost of care, quality of care, and access to care. The department may require the submission of data necessary to carry out this duty, which may include, but need not be limited to, data concerning ownership, Medicare and MO HealthNet, charity care, types of services offered to patients, revenues and expenses, patient-encounter data, and other data reasonably necessary to study utilization patterns and the impact of health care provider ownership interests in health-care-related entities on the cost, quality, and accessibility of health care.

(2) The department may collect such data from any health facility or licensed health care provider as a special study.

5. The department shall develop and implement a strategy for the adoption and use of electronic health records, including the development of an electronic health information network for the sharing of electronic health records among health care facilities, health care providers, and health insurers. The department may develop rules

to facilitate the functionality and protect the confidentiality of electronic health records. The department shall report to the governor, the speaker of the House of Representatives, and the president of the Senate on legislative recommendations to protect the confidentiality of electronic health records.

192.083. There is hereby established in the department of health and senior services an "Office of Minority Health". The office of minority health shall monitor the progress of all programs in the department for their impact on eliminating the health status disparity between minorities and the general population and shall:

(1) Address new issues related to minority health;

(2) Instill cultural sensitivity and awareness into all existing programs of the department of health and senior services;

(3) Develop health education programs specifically for minorities;

(4) Promote constituency development;

(5) Coordinate programs provided by other agencies;

(6) Develop culturally sensitive health education materials;

(7) Seek extramural funding for programs;

(8) Develop resources within communities **through solicitation of proposals from community programs and organizations representing minorities to develop culturally-appropriate solutions and services relating to health and wellness**;

(9) Establish interagency communication to assure that agreements are established and carried out;

(10) Ensure that personnel within the department of health and senior services have cultural understanding and sensitivity;

(11) Ensure that all programs are designed to be responsive to unique needs of minorities;

(12) Provide necessary health and medical information, data, and staff resources to the Missouri minority health issues task force;

(13) Review all programs of the department, their impact on the health status of minorities;

(14) Assist in the design of programs targeted specifically to improving the health of minorities;

(15) Develop programs that can attract other public and private funds;

(16) Analyze federal and state legislation for its impact on the health

status of minorities;

(17) Advise the director of the department of health and senior services on health matters that affect minorities;

(18) Coordinate the development of educational programs designed to reduce the incidence of disease in the minority population**; and**

(19) Solicit proposals from faith-based organizations on initiatives to educate citizens on the value of personal responsibility and wellness.

192.990. 1. To support the successful and growing collaboration of community volunteers and pro bono services by providers throughout Missouri in meeting the primary care health needs of many uninsured people in the state, there is created the "Missouri Free Clinics Fund" to be administered by the department of health and senior services for use by clinics in the Missouri free clinics association, or any successor organization. For a one-time funding appropriation of five hundred thousand dollars from the general assembly, subject to appropriation, the department shall disburse funds via contracts in accordance with applicable guidelines, policies, and requirements established by the department to add services into existing clinics. Grant support will be limited to capacity building projects for existing clinics.

2. For purposes of this section, "capacity building projects" means activities that improve an organization's ability to achieve its mission by providing existing clinics an opportunity to increase their infrastructure and bolster their sustainability in order to serve a greater number of people in a more effective manner. Such activities may include efforts to improve a clinic's ability to deliver services by covering operating expenses, sustaining or increasing service levels, or stabilizing finances.

3. The state treasurer shall be custodian of the fund and may approve disbursements from the fund in accordance with sections 30.170 and 30.180, RSMo.

4. The department shall promulgate rules setting forth the procedures and methods for implementing the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this

section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

5. Any moneys remaining in the fund at the end of the biennium shall revert to the credit of the general revenue fund, except for moneys that were gifts, donations, or bequests. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

6. Pursuant to section 23.253, RSMo, of the Missouri sunset act:

(1) The provisions of the new program authorized under this section shall sunset automatically six years after the effective date of this section unless reauthorized by an act of the general assembly; and

(2) If such program is reauthorized, the program authorized under this section shall sunset automatically twelve years after the effective date of the reauthorization of this section; and

(3) This section shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under this section is sunset.

196.1200. 1. There is hereby established in the state treasury the "Tobacco Use Prevention and Cessation Trust Fund" to be held separate and apart from all other public moneys and funds of the state, including but not limited to the tobacco securitization settlement trust fund established in section 8.550, RSMo. The state treasurer shall deposit into the fund the first five million dollars received from the strategic contribution payments received from the account provided under subsection IX(c)(2) of the master settlement agreement, as defined in section 196.1000, beginning in fiscal year 2009 and in perpetuity thereafter. All moneys in the fund shall be used for the purposes of this section only. Notwithstanding the provisions of section 33.080, RSMo, to the contrary, the moneys in the fund shall not revert to the credit of general revenue at the end of the biennium.

2. Moneys in the tobacco use prevention and cessation trust fund shall be used strategically, in cooperation with other governmental and not-for-profit entities, for a comprehensive tobacco control program for the purpose of tobacco prevention and cessation.

3. Moneys shall be allocated consistently with the Center for Disease Control and Prevention, or it successor agency's, best practices and guidelines for state tobacco control programs and as determined by the department of health and senior services.

4. The department of health and senior services shall promulgate such rules and regulations as are necessary to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

197.551. As used in sections 197.551 to 197.587, the following terms shall mean:

(1) "Identifiable information", information that is presented in a form and manner that allows the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information includes any individually identifiable health information, as defined in federal regulations promulgated under Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as amended;

(2) "Nonidentifiable information", information presented in a form and manner that prevents the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information shall be de-identified consistent with the federal regulations promulgated under Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as amended;

(3) "Patient safety organization", any entity which:

(a) Is organized as an independent not-for-profit corporation

under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and applicable state law governing not-for-profit corporations;

(b) Meets the statutory and regulatory criteria for certification as a patient safety organization under the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended, and regulations promulgated thereunder;

(c) Has a governing board that includes representatives of hospitals, physicians, and a federally recognized quality improvement organization that contracts with the federal government to review medical necessity and quality assurance in the Medicare program;

(d) Conducts, as the organization's primary activity, efforts to improve patient safety and the quality of health care delivery;

(e) Collects and analyzes patient safety work product that is submitted by providers;

(f) Develops and disseminates evidence-based information to providers with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices;

(g) Utilizes patient safety work product to carry out activities limited to those described under this section and for the purposes of encouraging a culture of safety and of providing direct feedback and assistance to providers to effectively minimize patient risk;

(h) Maintains confidentiality with respect to identifiable information pursuant to federal and state law and regulations;

(i) Implements appropriate security measures with respect to patient safety work product;

(j) Submits, if authorized by its governing board and certified by federal law and regulation, nonidentifiable information to a national patient safety database;

(k) Provides technical support to health care providers in the collection, submission, and analysis of data and patient safety activities as described in sections 197.554 and 197.566; and

(l) May establish a formula for fees or assessments for the performance of activities as described in sections 197.554 and 197.566;

(4) "Patient safety work product", as defined in federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299h-21, et seq., as

amended;

(5) "Provider", as defined in federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended;

(6) "Reportable incident", an occurrence of a serious reportable event in health care as such event is defined in subdivision (9) of this subsection;

(7) "Reportable incident prevention plan", a written plan that:

(a) Defines, based on a root cause analysis, specific changes in organizational policies and procedures designed to reduce the risk of similar incidents occurring in the future or that provides a rationale that no such changes are warranted;

(b) Sets deadlines for the implementation of such changes;

(c) Establishes who is responsible for making the changes; and

(d) Provides a mechanism for evaluating the effectiveness of such changes;

(8) "Root cause analysis", a structured process for identifying basic or causal factors that underlie variation in performance, including but not limited to the occurrence or possible occurrence of a reportable incident. A root cause analysis focuses primarily on systems and processes rather than individual performance and progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determines after analysis that no such improvement opportunities existed; and

(9) "Serious reportable event in health care", an occurrence of one or more of the actions or outcomes included in the list of serious adverse events in health care as initially defined by the National Quality Forum in its March 2002 report and subsequently updated by the National Quality Forum, including all criteria established for identifying such events.

197.554. 1. Effective six months after the effective date of initial federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., a hospital shall report each reportable incident to a patient safety organization. The hospital's initial report of the incident shall

be submitted to the patient safety organization no later than the close of business on the next business day following discovery of the incident. The initial report shall include a description of immediate actions to be taken by the hospital to minimize the risk of harm to patients and prevent a reoccurrence and verification that the hospital's patient safety and performance improvement review processes are responding to the reportable incident. The hospital shall, within forty-five days after the incident occurs, submit a completed root cause analysis and a reportable incident prevention plan to the patient safety organization.

2. Upon request of the hospital, a patient safety organization may provide technical assistance in the development of a root cause analysis or reportable incident prevention plan relating to a reportable incident.

3. All hospitals shall establish a policy whereby the patient or the patient's legally authorized representative is notified of the occurrence of a serious reportable event in health care as defined in subdivision (10) of section 197.551. Such notification shall be provided not later than seven days after the hospital or its agent becomes aware of the occurrence. The time, date, participants, and content of the notification shall be documented in the patient's medical record. The provision of notice to a patient under this section shall not, in any action or proceeding, be considered an acknowledgment or admission of liability.

197.557. Pursuant to paragraphs (f) and (g) of subdivision (4) of section 197.551 and 42 U.S.C. Section 299b-21, et seq., the patient safety organization shall assess the information provided regarding the reportable incident and furnish the hospital with a report of its findings and recommendations as to how to prevent future incidents.

197.563. 1. The provisions of sections 197.551 to 197.587 shall not be construed to:

(1) Restrict the availability of information gleaned from original sources;

(2) Limit the disclosure or use of information from original sources regarding a reportable incident to:

(a) State or federal agencies or law enforcement under law or regulation; or

(b) Health care facility accreditation agencies.

2. Nothing in sections 197.551 to 197.566 shall modify the duty of a hospital to report disciplinary actions or medical malpractice actions against a health care professional under law.

197.566. 1. The patient safety organization shall publish an annual report to the public on reportable incidents. The first report shall include twelve months of reported data and shall be published not more than fifteen months after the date data collection begins. The report shall indicate the number of reportable events by the then current National Quality Forum category of reportable incident and rate per patient encounter by region and by category of reportable incident, as such categories are established by the National Quality Forum in defining reportable incidents, and may identify reportable incidents by type of facility. The report for the previous year shall be made public no later than April thirtieth. For purposes of the annual report, the state shall be divided into no fewer than three regions, with the St. Louis metropolitan statistical area being one of the regions.

2. The patient safety organization as defined in this section shall report semi-annually to the health policy council created in section 26.859, RSMo.

197.572. No person shall disclose the actions, decisions, proceedings, discussions, or deliberations occurring at a meeting of a patient safety organization except to the extent necessary to carry out one or more of the purposes of a patient safety organization. A meeting of the patient safety organization shall include any meetings of the patient safety organization; its staff; its governing board; any and all committees, work groups, and task forces of the patient safety organization, whether or not formally appointed by the governing board; its president and its chairperson; and any meeting in any setting in which patient safety work product is discussed in the normal course of carrying out the business of the patient safety organization. The proceedings and records of a patient safety organization shall not be subject to discovery or introduction into evidence in any civil action against a provider arising out of the matter or matters that are the subject of consideration by a patient safety organization. Information, documents, or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because

they were presented during proceedings of a patient safety organization. The provisions of this section shall not be construed to prevent a person from testifying to or reporting information obtained independently of the activities of a patient safety organization or which is public information.

197.575. Patient safety work product shall be privileged and confidential pursuant to the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended, and regulations promulgated thereunder.

197.578. 1. Any reference to or offer into evidence in the presence of the jury or other fact-finder or admission into evidence of patient safety work product during any proceeding that is contrary to the provisions of sections 197.551 to 197.587 shall constitute grounds for a mistrial or a similar termination of the proceeding and reversible error on appeal from any judgment or order entered in favor of any party who so discloses or offers into evidence patient safety work product.

2. The prohibition against discovery, disclosure, or admission into evidence of patient safety work product is in addition to any other protections provided by law.

197.581. A patient safety organization may disclose nonidentifiable information and nonidentifiable aggregate trend data identifying the number and types of patient safety events that occur. A patient safety organization shall publish educational and evidence-based information from the summary reports that can be used by all providers to improve the care provided.

197.584. 1. The confidentiality of patient safety work product shall in no way be impaired or otherwise adversely affected solely by reason of the submission of the same to a patient safety organization. The confidentiality of patient safety work product submitted in compliance with sections 197.551 to 197.587 to a patient safety organization shall not be adversely affected if the entity later ceases to meet the statutory definition of a patient safety organization.

2. The exchange or disclosure of patient safety work product by a patient safety organization shall not constitute a waiver of confidentiality or privilege by the health care provider who submitted the data.

197.587. Any provider furnishing services to a patient safety organization shall not be liable for civil damages as a result of such ads, omissions, decisions, or other such conduct in connection with the lawful duties on behalf of a patient safety organization, except for acts, omissions, decisions, or conduct done with actual malice, fraudulent intent, or bad faith.

208.145. **1.** For the purposes of the application of section 208.151, individuals shall be deemed to be recipients of aid to families with dependent children and individuals shall be deemed eligible for such assistance if:

(1) The individual meets eligibility requirements which are no more restrictive than the July 16, 1996, eligibility requirements for aid to families with dependent children, as established by the division of family services; or

(2) Each dependent child, and each relative with whom such a child is living including the spouse of such relative as described in 42 U.S.C. 606(b), as in effect on July 16, 1996, who ceases to meet the eligibility criteria set forth in subdivision (1) of this section as a result of the collection or increased collection of child or spousal support under part IV-D of the Social Security Act, 42 U.S.C. 651 et seq., and who has received such aid in at least three of the six months immediately preceding the month in which ineligibility begins, shall be deemed eligible for an additional four calendar months beginning with the month in which such ineligibility begins.

2. (1) Beginning August 28, 2008, for purposes for eligibility under this section, subject to appropriation, earned income in the amount of the difference between July 16, 1996 income standard and one hundred percent of the federal poverty level shall be disregarded in place of the four month thirty dollar plus one-third of earned income disregard and the eight month thirty dollar disregard.

(2) Individuals eligible due to the disregard in subdivision (1) of this subsection who are at least nineteen years of age and less than sixty-five years of age shall receive health care coverage through the insure Missouri plan under sections 208.1300 to 208.1345, unless such individual participates in the federal Medicare program, 42 U.S.C. 1395, et seq., or is a pregnant woman.

208.149. The professional services payment committee created by section 208.197 shall review and make recommendations to the MO HealthNet division regarding standards and policies for denying or

withholding payment to a health care provider for treatment costs associated with preventable errors, injuries and infections occurring under that provider's care. The recommendations shall include a list of medical incidents proposed to be included in the payment prohibition, which shall include, at a minimum, those incidents for which the federal Centers for Medicare and Medicaid Services will not make payment under the Medicare program or all or some serious reportable events in health care as defined in section 197.551, RSMo. Such recommendations shall be completed and issued by the committee to the division by December 31, 2008, or six months after the committee is appointed with the advice and consent of the senate, whichever occurs later. After reviewing the recommendations of the committee, the MO HealthNet division may promulgate regulations pursuant to chapter 536, RSMo, to implement such payment restrictions.

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as defined in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section

and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) Drugs and medicines when prescribed by a licensed physician, dentist, or podiatrist; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, or podiatrist may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(8) Emergency ambulance services and, effective January 1, 1990,

medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(9) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and federal regulations promulgated thereunder;

(10) Home health care services;

(11) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(12) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. 1396d, et seq.);

(13) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(14) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not

exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198, RSMo, shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if **[**her**]** **he** or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(15) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097, RSMo. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance

with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules.

With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(16) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. 301, et seq.) subject to appropriation by the general assembly;

(17) Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, RSMo, and regulations promulgated thereunder;

(18) Nursing home costs for participants receiving benefit payments under

subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(19) Prescribed medically necessary durable medical equipment **and therapy services including physical, occupational, and speech therapy**. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(20) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual,

social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(21) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(22) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the division of medical services, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010, RSMo;

(3) Optometric services as defined in section 336.010, RSMo;

(4) Orthopedic devices or other prosthetics, including eye glasses,

dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services shall be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an

additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, RSMo, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section shall collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the Missouri MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision

(6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a (a)(13)(C).

10. The MO HealthNet division, may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, RSMo, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178, RSMo, shall not be considered as income for purposes of determining eligibility under this section.

208.215. 1. MO HealthNet is payer of last resort unless otherwise specified by law. When any person, corporation, institution, public agency or private agency is liable, either pursuant to contract or otherwise, to a participant receiving public assistance on account of personal injury to or disability or disease or benefits arising from a health insurance plan to which the participant may be

entitled, payments made by the department of social services or MO HealthNet division shall be a debt due the state and recoverable from the liable party or participant for all payments made in behalf of the participant and the debt due the state shall not exceed the payments made from MO HealthNet benefits provided under sections 208.151 to 208.158 and section 208.162 and section 208.204 on behalf of the participant, minor or estate for payments on account of the injury, disease, or disability or benefits arising from a health insurance program to which the participant may be entitled. **All entities, as defined in section 208.217, are required to process and pay all properly submitted Medicaid subrogation claims for a period of three years from the date the service was provided or rendered, regardless of any other timely filing requirement that might otherwise be imposed by that entity.**

2. The department of social services, MO HealthNet division, or its contractor may maintain an appropriate action to recover funds paid by the department of social services or MO HealthNet division or its contractor that are due under this section in the name of the state of Missouri against the person, corporation, institution, public agency, or private agency liable to the participant, minor or estate.

3. Any participant, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death who pursues legal rights against a person, corporation, institution, public agency, or private agency liable to that participant or minor for injuries, disease or disability or benefits arising from a health insurance plan to which the participant may be entitled as outlined in subsection 1 of this section shall upon actual knowledge that the department of social services or MO HealthNet division has paid MO HealthNet benefits as defined by this chapter promptly notify the MO HealthNet division as to the pursuit of such legal rights.

4. Every applicant or participant by application assigns his right to the department of social services or MO HealthNet division of any funds recovered or expected to be recovered to the extent provided for in this section. All applicants and participants, including a person authorized by the probate code, shall cooperate with the department of social services, MO HealthNet division in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services available under the state's plan for MO HealthNet benefits as provided in sections 208.151 to 208.159 and sections 208.162 and 208.204. All applicants and participants shall cooperate

with the agency in obtaining third-party resources due to the applicant, participant, or child for whom assistance is claimed. Failure to cooperate without good cause as determined by the department of social services, MO HealthNet division in accordance with federally prescribed standards shall render the applicant or participant ineligible for MO HealthNet benefits under sections 208.151 to 208.159 and sections 208.162 and 208.204. A recipient who has notice or who has actual knowledge of the department's rights to third-party benefits who receives any third-party benefit or proceeds for a covered illness or injury is either required to pay the division within sixty days after receipt of settlement proceeds the full amount of the third-party benefits up to the total MO HealthNet benefits provided or to place the full amount of the third-party benefits in a trust account for the benefit of the division pending judicial or administrative determination of the division's right to third-party benefits.

5. Every person, corporation or partnership who acts for or on behalf of a person who is or was eligible for MO HealthNet benefits under sections 208.151 to 208.159 and sections 208.162 and 208.204 for purposes of pursuing the applicant's or participant's claim which accrued as a result of a nonoccupational or nonwork-related incident or occurrence resulting in the payment of MO HealthNet benefits shall notify the MO HealthNet division upon agreeing to assist such person and further shall notify the MO HealthNet division of any institution of a proceeding, settlement or the results of the pursuit of the claim and give thirty days' notice before any judgment, award, or settlement may be satisfied in any action or any claim by the applicant or participant to recover damages for such injuries, disease, or disability, or benefits arising from a health insurance program to which the participant may be entitled.

6. Every participant, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death, or his attorney or legal representative shall promptly notify the MO HealthNet division of any recovery from a third party and shall immediately reimburse the department of social services, MO HealthNet division, or its contractor from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party. A judgment, award, or settlement in an action by a recipient to recover damages for injuries or other third-party benefits in which the division has an interest may not be satisfied without first giving the division notice and a reasonable opportunity to file and satisfy the claim or proceed with any action as otherwise

permitted by law.

7. The department of social services, MO HealthNet division or its contractor shall have a right to recover the amount of payments made to a provider under this chapter because of an injury, disease, or disability, or benefits arising from a health insurance plan to which the participant may be entitled for which a third party is or may be liable in contract, tort or otherwise under law or equity. Upon request by the MO HealthNet division, all third-party payers shall provide the MO HealthNet division with information contained in a 270/271 Health Care Eligibility Benefits Inquiry and Response standard transaction mandated under the federal Health Insurance Portability and Accountability Act, except that third-party payers shall not include accident-only, specified disease, disability income, hospital indemnity, or other fixed indemnity insurance policies.

8. The department of social services or MO HealthNet division shall have a lien upon any moneys to be paid by any insurance company or similar business enterprise, person, corporation, institution, public agency or private agency in settlement or satisfaction of a judgment on any claim for injuries or disability or disease benefits arising from a health insurance program to which the participant may be entitled which resulted in medical expenses for which the department or MO HealthNet division made payment. This lien shall also be applicable to any moneys which may come into the possession of any attorney who is handling the claim for injuries, or disability or disease or benefits arising from a health insurance plan to which the participant may be entitled which resulted in payments made by the department or MO HealthNet division. In each case, a lien notice shall be served by certified mail or registered mail, upon the party or parties against whom the applicant or participant has a claim, demand or cause of action. The lien shall claim the charge and describe the interest the department or MO HealthNet division has in the claim, demand or cause of action. The lien shall attach to any verdict or judgment entered and to any money or property which may be recovered on account of such claim, demand, cause of action or suit from and after the time of the service of the notice.

9. On petition filed by the department, or by the participant, or by the defendant, the court, on written notice of all interested parties, may adjudicate the rights of the parties and enforce the charge. The court may approve the settlement of any claim, demand or cause of action either before or after a verdict, and nothing in this section shall be construed as requiring the actual trial or final adjudication of any claim, demand or cause of action upon which the department

has charge. The court may determine what portion of the recovery shall be paid to the department against the recovery. In making this determination the court shall conduct an evidentiary hearing and shall consider competent evidence pertaining to the following matters:

(1) The amount of the charge sought to be enforced against the recovery when expressed as a percentage of the gross amount of the recovery; the amount of the charge sought to be enforced against the recovery when expressed as a percentage of the amount obtained by subtracting from the gross amount of the recovery the total attorney's fees and other costs incurred by the participant incident to the recovery; and whether the department should, as a matter of fairness and equity, bear its proportionate share of the fees and costs incurred to generate the recovery from which the charge is sought to be satisfied;

(2) The amount, if any, of the attorney's fees and other costs incurred by the participant incident to the recovery and paid by the participant up to the time of recovery, and the amount of such fees and costs remaining unpaid at the time of recovery;

(3) The total hospital, doctor and other medical expenses incurred for care and treatment of the injury to the date of recovery therefor, the portion of such expenses theretofore paid by the participant, by insurance provided by the participant, and by the department, and the amount of such previously incurred expenses which remain unpaid at the time of recovery and by whom such incurred, unpaid expenses are to be paid;

(4) Whether the recovery represents less than substantially full recompense for the injury and the hospital, doctor and other medical expenses incurred to the date of recovery for the care and treatment of the injury, so that reduction of the charge sought to be enforced against the recovery would not likely result in a double recovery or unjust enrichment to the participant;

(5) The age of the participant and of persons dependent for support upon the participant, the nature and permanency of the participant's injuries as they affect not only the future employability and education of the participant but also the reasonably necessary and foreseeable future material, maintenance, medical rehabilitative and training needs of the participant, the cost of such reasonably necessary and foreseeable future needs, and the resources available to meet such needs and pay such costs;

(6) The realistic ability of the participant to repay in whole or in part the charge sought to be enforced against the recovery when judged in light of the

factors enumerated above.

10. The burden of producing evidence sufficient to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking such reduction.

11. The court may reduce and apportion the department's or MO HealthNet division's lien proportionate to the recovery of the claimant. The court may consider the nature and extent of the injury, economic and noneconomic loss, settlement offers, comparative negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The department or MO HealthNet division shall pay its pro rata share of the attorney's fees based on the department's or MO HealthNet division's lien as it compares to the total settlement agreed upon. This section shall not affect the priority of an attorney's lien under section 484.140, RSMo. The charges of the department or MO HealthNet division or contractor described in this section, however, shall take priority over all other liens and charges existing under the laws of the state of Missouri with the exception of the attorney's lien under such statute.

12. Whenever the department of social services or MO HealthNet division has a statutory charge under this section against a recovery for damages incurred by a participant because of its advancement of any assistance, such charge shall not be satisfied out of any recovery until the attorney's claim for fees is satisfied, irrespective of whether or not an action based on participant's claim has been filed in court. Nothing herein shall prohibit the director from entering into a compromise agreement with any participant, after consideration of the factors in subsections 9 to 13 of this section.

13. This section shall be inapplicable to any claim, demand or cause of action arising under the workers' compensation act, chapter 287, RSMo. From funds recovered pursuant to this section the federal government shall be paid a portion thereof equal to the proportionate part originally provided by the federal government to pay for MO HealthNet benefits to the participant or minor involved. The department or MO HealthNet division shall enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation on permanently institutionalized individuals. The department or MO HealthNet division shall have the right to enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation on all other institutionalized individuals. For the purposes of this subsection, "permanently institutionalized individuals" includes those people who the department or MO HealthNet division determines cannot

reasonably be expected to be discharged and return home, and "property" includes the homestead and all other personal and real property in which the participant has sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than the fair market value within thirty months prior to the participant's entering the nursing facility. The following provisions shall apply to such liens:

(1) The lien shall be for the debt due the state for MO HealthNet benefits paid or to be paid on behalf of a participant. The amount of the lien shall be for the full amount due the state at the time the lien is enforced;

(2) The MO HealthNet division shall file for record, with the recorder of deeds of the county in which any real property of the participant is situated, a written notice of the lien. The notice of lien shall contain the name of the participant and a description of the real estate. The recorder shall note the time of receiving such notice, and shall record and index the notice of lien in the same manner as deeds of real estate are required to be recorded and indexed. The director or the director's designee may release or discharge all or part of the lien and notice of the release shall also be filed with the recorder. The department of social services, MO HealthNet division, shall provide payment to the recorder of deeds the fees set for similar filings in connection with the filing of a lien and any other necessary documents;

(3) No such lien may be imposed against the property of any individual prior to the individual's death on account of MO HealthNet benefits paid except:

(a) In the case of the real property of an individual:

a. Who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution, to spend for costs of medical care all but a minimal amount of his or her income required for personal needs; and

b. With respect to whom the director of the MO HealthNet division or the director's designee determines, after notice and opportunity for hearing, that he cannot reasonably be expected to be discharged from the medical institution and to return home. The hearing, if requested, shall proceed under the provisions of chapter 536, RSMo, before a hearing officer designated by the director of the MO HealthNet division; or

(b) Pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual;

(4) No lien may be imposed under paragraph (b) of subdivision (3) of this subsection on such individual's home if one or more of the following persons is lawfully residing in such home:

(a) The spouse of such individual;

(b) Such individual's child who is under twenty-one years of age, or is blind or permanently and totally disabled; or

(c) A sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution;

(5) Any lien imposed with respect to an individual pursuant to subparagraph b of paragraph (a) of subdivision (3) of this subsection shall dissolve upon that individual's discharge from the medical institution and return home.

14. The debt due the state provided by this section is subordinate to the lien provided by section 484.130, RSMo, or section 484.140, RSMo, relating to an attorney's lien and to the participant's expenses of the claim against the third party.

15. Application for and acceptance of MO HealthNet benefits under this chapter shall constitute an assignment to the department of social services or MO HealthNet division of any rights to support for the purpose of medical care as determined by a court or administrative order and of any other rights to payment for medical care.

16. All participants receiving benefits as defined in this chapter shall cooperate with the state by reporting to the family support division or the MO HealthNet division, within thirty days, any occurrences where an injury to their persons or to a member of a household who receives MO HealthNet benefits is sustained, on such form or forms as provided by the family support division or MO HealthNet division.

17. If a person fails to comply with the provision of any judicial or administrative decree or temporary order requiring that person to maintain medical insurance on or be responsible for medical expenses for a dependent child, spouse, or ex-spouse, in addition to other remedies available, that person shall be liable to the state for the entire cost of the medical care provided pursuant to eligibility under any public assistance program on behalf of that dependent child, spouse, or ex-spouse during the period for which the required

medical care was provided. Where a duty of support exists and no judicial or administrative decree or temporary order for support has been entered, the person owing the duty of support shall be liable to the state for the entire cost of the medical care provided on behalf of the dependent child or spouse to whom the duty of support is owed.

18. The department director or the director's designee may compromise, settle or waive any such claim in whole or in part in the interest of the MO HealthNet program. Notwithstanding any provision in this section to the contrary, the department of social services, MO HealthNet division is not required to seek reimbursement from a liable third party on claims for which the amount it reasonably expects to recover will be less than the cost of recovery or for which recovery efforts will not be cost-effective. Cost-effectiveness is determined based on the following:

(1) Actual and legal issues of liability as may exist between the recipient and the liable party;

(2) Total funds available for settlement; and

(3) An estimate of the cost to the division of pursuing its claim.

208.955. 1. There is hereby established in the department of social services the "MO HealthNet Oversight Committee", which shall be appointed by January 1, 2008, and shall consist of eighteen members as follows:

(1) Two members of the house of representatives, one from each party, appointed by the speaker of the house of representatives and the minority floor leader of the house of representatives;

(2) Two members of the Senate, one from each party, appointed by the president pro tem of the senate and the minority floor leader of the senate;

(3) One consumer representative;

(4) Two primary care physicians, licensed under chapter 334, RSMo, recommended by any Missouri organization or association that represents a significant number of physicians licensed in this state, who care for participants, not from the same geographic area;

(5) Two physicians, licensed under chapter 334, RSMo, who care for participants but who are not primary care physicians and are not from the same geographic area, recommended by any Missouri organization or association that represents a significant number of physicians licensed in this state;

(6) One representative of the state hospital association;

(7) One nonphysician health care professional who cares for participants,

recommended by the director of the department of insurance, financial institutions and professional registration;

(8) One dentist, who cares for participants. The dentist shall be recommended by any Missouri organization or association that represents a significant number of dentists licensed in this state;

(9) Two patient advocates;

(10) One public member; and

(11) The directors of the department of social services, the department of mental health, the department of health and senior services, or the respective directors' designees, who shall serve as ex-officio members of the committee.

2. The members of the oversight committee, other than the members from the general assembly and ex-officio members, shall be appointed by the governor with the advice and consent of the senate. A chair of the oversight committee shall be selected by the members of the oversight committee. Of the members first appointed to the oversight committee by the governor, eight members shall serve a term of two years, seven members shall serve a term of one year, and thereafter, members shall serve a term of two years. Members shall continue to serve until their successor is duly appointed and qualified. Any vacancy on the oversight committee shall be filled in the same manner as the original appointment. Members shall serve on the oversight committee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of social services for that purpose. The department of social services shall provide technical, actuarial, and administrative support services as required by the oversight committee. The oversight committee shall:

(1) Meet on at least four occasions annually, including at least four before the end of December of the first year the committee is established. Meetings can be held by telephone or video conference at the discretion of the committee;

(2) Review the participant and provider satisfaction reports and the reports of health outcomes, social and behavioral outcomes, use of evidence-based medicine and best practices as required of the health improvement plans and the department of social services under section 208.950;

(3) Review the results from other states of the relative success or failure of various models of health delivery attempted;

(4) Review the results of studies comparing health plans conducted under section 208.950;

(5) Review the data from health risk assessments collected and reported under section 208.950;

(6) Review the results of the public process input collected under section 208.950;

(7) Advise and approve proposed design and implementation proposals for new health improvement plans submitted by the department, as well as make recommendations and suggest modifications when necessary;

(8) Determine how best to analyze and present the data reviewed under section 208.950 so that the health outcomes, participant and provider satisfaction, results from other states, health plan comparisons, financial impact of the various health improvement plans and models of care, study of provider access, and results of public input can be used by consumers, health care providers, and public officials;

(9) Present significant findings of the analysis required in subdivision (8) of this subsection in a report to the general assembly and governor, at least annually, beginning January 1, 2009;

(10) Review the budget forecast issued by the legislative budget office, and the report required under subsection (22) of subsection 1 of section 208.151, and after study:

(a) Consider ways to maximize the federal drawdown of funds;

(b) Study the demographics of the state and of the MO HealthNet population, and how those demographics are changing;

(c) Consider what steps are needed to prepare for the increasing numbers of participants as a result of the baby boom following World War II;

(11) Conduct a study to determine whether an office of inspector general shall be established. Such office would be responsible for oversight, auditing, investigation, and performance review to provide increased accountability, integrity, and oversight of state medical assistance programs, to assist in improving agency and program operations, and to deter and identify fraud, abuse, and illegal acts. The committee shall review the experience of all states that have created a similar office to determine the impact of creating a similar office in this state; and

(12) Perform other tasks as necessary, including but not limited to making recommendations to the division concerning the promulgation of rules and emergency rules so that quality of care, provider availability, and participant satisfaction can be assured.

3. By July 1, 2011, the oversight committee shall issue findings to the general assembly on the success and failure of health improvement plans and shall recommend whether or not any health improvement plans should be discontinued.

4. **[**The oversight committee shall designate a subcommittee devoted to advising the department on the development of**]** **Beginning August 28, 2009, the MO HealthNet oversight committee shall be a subcommittee established within the health policy council established under section 26.859, RSMo.**

5. Beginning August 28, 2009, a subcommittee on a comprehensive entry point system for long-term care shall be established within the health policy council under section 26.859, RSMo. The subcommittee on a comprehensive entry point system for long-term care **[**that**]** shall:

(1) Offer Missourians an array of choices including community-based, in-home, residential and institutional services;

(2) Provide information and assistance about the array of long-term care services to Missourians;

(3) Create a delivery system that is easy to understand and access through multiple points, which shall include but shall not be limited to providers of services;

(4) Create a delivery system that is efficient, reduces duplication, and streamlines access to multiple funding sources and programs;

(5) Strengthen the long-term care quality assurance and quality improvement system;

(6) Establish a long-term care system that seeks to achieve timely access to and payment for care, foster quality and excellence in service delivery, and promote innovative and cost-effective strategies; and

(7) Study one-stop shopping for seniors as established in section 208.612.

[5.**]** **6.** The subcommittee shall include the following members:

(1) The lieutenant governor or his or her designee, who shall serve as the subcommittee chair;

(2) One member from a Missouri area agency on aging, designated by the governor;

(3) One member representing the in-home care profession, designated by the governor;

(4) One member representing residential care facilities, predominantly serving MO HealthNet participants, designated by the governor;

(5) One member representing assisted living facilities or continuing care retirement communities, predominantly serving MO HealthNet participants, designated by the governor;

(6) One member representing skilled nursing facilities, predominantly serving MO HealthNet participants, designated by the governor;

(7) One member from the office of the state ombudsman for long-term care facility residents, designated by the governor;

(8) One member representing Missouri centers for independent living, designated by the governor;

(9) One consumer representative with expertise in services for seniors or the disabled, designated by the governor;

(10) One member with expertise in Alzheimer's disease or related dementia;

(11) One member from a county developmental disability board, designated by the governor;

(12) One member representing the hospice care profession, designated by the governor;

(13) One member representing the home health care profession, designated by the governor;

(14) One member representing the adult day care profession, designated by the governor;

(15) One member gerontologist, designated by the governor;

(16) Two members representing the aged, blind, and disabled population, not of the same geographic area or demographic group designated by the governor;

(17) The directors of the departments of social services, mental health, and health and senior services, or their designees; and

(18) One member of the house of representatives and one member of the senate serving on the oversight committee, designated by the oversight committee chair.

Members shall serve on the subcommittee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of health and senior services for that purpose. The department of health and senior services shall provide technical and administrative support

services as required by the committee.

[6.**]** **7.** By October 1, 2008, the comprehensive entry point system subcommittee shall submit its report to the governor and general assembly containing recommendations for the implementation of the comprehensive entry point system, offering suggested legislative or administrative proposals deemed necessary by the subcommittee to minimize conflict of interests for successful implementation of the system. Such report shall contain, but not be limited to, recommendations for implementation of the following consistent with the provisions of section 208.950:

(1) A complete statewide universal information and assistance system that is integrated into the web-based electronic patient health record that can be accessible by phone, in-person, via MO HealthNet providers and via the Internet that connects consumers to services or providers and is used to establish consumers' needs for services. Through the system, consumers shall be able to independently choose from a full range of home, community-based, and facility-based health and social services as well as access appropriate services to meet individual needs and preferences from the provider of the consumer's choice;

(2) A mechanism for developing a plan of service or care via the web-based electronic patient health record to authorize appropriate services;

(3) A preadmission screening mechanism for MO HealthNet participants for nursing home care;

(4) A case management or care coordination system to be available as needed; and

(5) An electronic system or database to coordinate and monitor the services provided which are integrated into the web-based electronic patient health record.

[7.**]** **8.** Starting July 1, 2009, and for three years thereafter, the subcommittee shall provide to the governor, lieutenant governor and the general assembly a yearly report that provides an update on progress made by the subcommittee toward implementing the comprehensive entry point system.

[8.**]** **9.** The provisions of section 23.253, RSMo, shall not apply to sections 208.950 to 208.955.

208.1300. As used in sections 208.1300 to 208.1345, the following terms shall mean:

(1) "Plan", the insure Missouri initiative established in section 208.1303;

(2) "Preventive care services", care that is provided to an individual to prevent disease, diagnose disease, or promote good health.

208.1303. 1. The "Insure Missouri" plan is hereby established.

2. The department of social services shall administer the plan.

3. The department of insurance, financial institutions and professional registration and the MO HealthNet division of the department of social services shall provide oversight of the marketing practices of the plan.

4. The department of social services shall promote the plan and provide information to potential eligible individuals.

5. The department of social services shall, to the extent possible, ensure that enrollment in the plan is distributed throughout Missouri in proportion to the number of individuals throughout Missouri who are eligible for participation in the plan.

6. The department of social services shall establish standards for consumer protection, including the following:

(1) Quality of care standards;

(2) A uniform process for participant grievances and appeals;

(3) Standardized reporting concerning provider performance, consumer experience, and cost.

208.1306. 1. The plan shall provide for every participating individual a health care home as defined in rules promulgated by the department of social services.

2. The plan shall include the following medically necessary services in a manner and to the extent determined by the MO HealthNet division:

(1) Mental health care services;

(2) Inpatient hospital services;

(3) Prescription drug coverage;

(4) Emergency room services;

(5) Physician and advanced practice nurse services;

(6) Diagnostic services;

(7) Outpatient services;

(8) Home health services;

(9) Urgent care center services;

(10) Preventive care services;

(11) Family planning services:

(a) Including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law, 42 U.S.C. 1396, et seq.; and

(b) Not including abortion or abortifacients, except as required in federal Medicaid law, 42 U.S.C. 1396, et seq.;

(12) Hospice services;

(13) Substance abuse services;

(14) Federally qualified health center and rural health clinic services;

(15) Durable medical equipment;

(16) Emergency transportation services;

(17) Personal care services;

(18) Case management, care coordination and disease management.

3. The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

208.1309. 1. The plan shall provide to an individual who participates in the plan a list of health care services that qualify as preventive care services for the age, gender, and preexisting conditions of the individual. The plan shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventive care services.

2. The plan shall, at no cost to the individual, provide payment for at least five hundred dollars of qualifying preventive care services per year for an individual who participates in the plan. Any additional preventive care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.

208.1312. At least eighty-five percent of the funds appropriated by the general assembly for the plan shall be used to fund payment for health care services.

208.1315. The plan is not an entitlement program for individuals eligible based on the requirements of subdivision (2) of subsection 1 of section 208.1318. The maximum enrollment of individuals who may

participate in the plan is dependent on funding appropriated for the plan by the general assembly. Eligibility for the plan may be phased in incrementally on the basis of actions taken by the general assembly in the appropriations process.

208.1318. 1. An individual is eligible for participation in the plan if the individual meets the following requirements:

(1) The individual is eligible based on subsection 2 of section 208.145; or

(2) The individual meets all of the following requirements:

(a) The individual is at least nineteen years of age and less than sixty-five years of age;

(b) The individual is a United States citizen or eligible qualified legal alien and is a resident of Missouri;

(c) The individual has an annual household income of not more than two hundred twenty-five percent of the federal income poverty level;

(d) The individual does not have access to health insurance coverage through the individual's employer;

(e) The individual has not had health insurance coverage for at least six months; and

(f) The individual has household earned income above the Temporary Assistance for Needy Families limit.

2. The following individuals are not eligible for the plan:

(1) An individual who participates in the federal Medicare program, 42 U.S.C. 1395, et seq.;

(2) A pregnant woman for purposes of pregnancy-related services, except for those pregnant women who would not qualify for coverage under section 208.151.

3. The eligibility requirements specified in subsection 1 of this section are subject to approval for federal financial participation by the United States Department of Health and Human Services.

208.1321. 1. Individuals eligible under subdivision (2) of subsection 1 of section 208.1318 who participate in the plan shall have a health care account to which payments may be made for the individual's participation in the plan by any of the following:

(1) The individual;

(2) An employer;

(3) The state;

(4) Any philanthropic or charitable contributor.

2. The minimum funding amount for a health care account is the amount required under section 208.1327.

3. An individual's health care account shall be used to pay the individual's deductible for health care services under the plan.

4. An individual may make payments to the individual's health care account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this section and distributed equally throughout the calendar year;

(2) Submission of the individual's contribution under sections 208.1300 to 208.1345 to the MO HealthNet division to deposit in the individual's health care account in a manner prescribed by the division;

(3) Another method determined by the division.

5. An employer may make, from funds not payable by the employer to the employee, not more than fifty percent of an individual's required payment to the individual's health care account.

208.1324. 1. For individuals required to contribute to a health care account under section 208.1321, participation in the plan does not begin until an initial payment is made for the individual's participation in the plan. A required payment to the plan for the individual's participation may not exceed one-twelfth of the annual payment required under subsection 2 of this section.

2. To participate in the plan, an individual shall do the following:

(1) Apply for the plan in a manner prescribed by the department of social services. The department of social services may develop and allow a joint application for a household;

(2) If the individual is approved by the department of social services to participate in the plan, contribute to the individual's health care account the lesser of the following:

(a) One thousand dollars in the first year adjusted annually each year thereafter by the federal consumer price index, less any amounts paid by the individual under the:

(i) MO HealthNet program;

(ii) Children's health insurance program; and

(iii) Medicare program, 42 U.S.C. 1395, et seq.,

as determined by the department of social services; or

(b) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program, the children's health insurance program, and the Medicare program, 42 U.S.C. 1395, et seq., as determined by the department of social services:

(i) Two percent of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent and not more than one hundred twenty-five percent;

(ii) Three percent of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent and not more than one hundred fifty percent;

(iii) Four percent of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent and not more than two hundred percent;

(iv) Five percent of the individual's annual household income per year if the individual has an annual household income of more than two hundred and not more than two hundred fifty percent of the federal income poverty level; or

(v) One percent of the individual's annual household income per year if the individual is not described in subsection 2 of section 208.145 and has an annual household income of less than one hundred percent of the federal poverty level.

3. In no case shall the combined household contribution to the health care account exceed five percent of the annual household income.

4. The state shall contribute the difference to the individual's account if the individual's payment required under subdivision (2) of subsection 2 of this section is less than one thousand dollars in the first year or the amount each year thereafter as adjusted by the federal consumer price index.

5. If an individual's required payment to the plan is not made within sixty days after the required payment date, the individual may be terminated from participation in the plan. The individual shall

receive written notice before the individual is terminated from the plan.

6. After termination from the plan under subsection 4 of this section, the individual may reapply to participate in the plan.

208.1327. 1. An individual approved to participate under subdivision (2) of subsection 1 of section 208.1318 is eligible for a twelve month plan period unless the individual fails to make a contribution to the plan as required in section 208.1324. An individual who participates in the plan without a break in service may not be refused renewal of participation in the plan for the sole reason that the plan has reached the plan's maximum enrollment.

2. If the individual chooses to renew participation in the plan, the individual shall complete a renewal application and any necessary documentation on a form prescribed by the department of social services.

3. Any funds remaining in the health care account of an individual who renews participation in the plan at the end of the individual's twelve month plan period shall be used to reduce the individual's payments for the subsequent plan period.

4. If an individual is no longer eligible for the plan, does not renew participation in the plan at the end of the plan period, or is terminated from the plan for nonpayment of a required payment, the MO HealthNet division shall, not more than ninety days after the last date of participation in the plan, refund to the individual the amount of any individual payments remaining in the individual's health care account as determined by rule.

208.1330. 1. An insurer or health maintenance organization that contracts with the MO HealthNet division to provide health insurance coverage to an individual that participates in the plan:

(1) Is responsible for the claim processing for the coverage;

(2) Is responsible for provider reimbursement; and

(3) May not deny coverage to an eligible individual who has been approved by the department of social services to participate in the plan.

2. An insurer or a health maintenance organization that contracts with the MO HealthNet division to provide health insurance coverage under the plan shall incorporate cultural competency

standards established by the office. The standards shall include standards for non-English speaking, minority, and disabled populations.

208.1333. 1. An insurer or a health maintenance organization that contracts with the MO HealthNet division to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the MO HealthNet division to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

(1) Has not had health insurance coverage during the previous six months; and

(2) Meets the eligibility requirements specified in section 208.1318 for participation in the plan but is not enrolled because the plan has reached maximum enrollment.

2. The insurance underwriting and rating practices applied to health insurance coverage offered under subsection 1 of this section shall not be different from underwriting and rating practices used for the health insurance coverage provided under the plan.

3. The state does not provide funding for health insurance coverage received under this section.

208.1336. The department of social services shall promulgate rules and regulations for the implementation of sections 208.1300 to 208.1345. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

208.1345. The MO HealthNet division shall apply to the United States Department of Health and Human Services for approval of a Section 1115 demonstration waiver and/or a Medicaid state plan amendment to develop and implement the plan.

376.025. 1. The department of insurance, financial institutions and professional registration shall administer a grant program to assist

the start-up of non-profit broker organizations. Eligible applicants shall apply to the department for a grant, using a competitive application process prescribed by the department. The department shall award grants not to exceed twenty-five thousand dollars per applicant, with the maximum cumulative total of grants issued per fiscal year not to exceed one hundred thousand dollars.

2. The department shall, by rule, establish eligibility, rating, and selection criteria for awarding grants under this section. In awarding the grants, the department shall give preference to those applicants who:

(1) Demonstrate the ability to enhance representation of low-cost health insurance coverage models in the market;

(2) Have a sound business plan with appropriate management capabilities and financial resources to carry out its organization's mission;

(3) Demonstrate the ability to be successful; and

(4) Meet all eligibility requirements as required by the department, including the matching grant requirement under subsection 3 of this section.

3. Any grant awarded under this section shall be matched in equal value by the grant recipient. Grant recipients may match the grant with cash, in-kind services, donations of cash or services, and any other forms of match deemed acceptable by the department.

4. No non-profit broker organization shall be awarded more than one grant under this section per year and no non-profit broker organization shall cumulatively receive more than twenty-five thousand dollars in grants under this section.

5. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

6. Pursuant to section 23.253, RSMo, of the Missouri Sunset Act:

(1) Any new program authorized under this section shall automatically sunset six years after the effective date of this section unless reauthorized by an act of the general assembly; and

(2) If such program is reauthorized, the program authorized under this section shall automatically sunset twelve years after the effective date of the reauthorization of this section; and

(3) This section shall terminate on September first of the calendar year immediately following the calendar year in which a program authorized under this section is sunset.

376.685. 1. Notwithstanding any provision of the law to the contrary, health carriers may include wellness and health promotion programs, condition or disease management programs, health risk appraisal programs, and similar provisions in high deductible health plans or policies that comport with federal requirements, provided that such wellness and health promotion programs are approved by the department of insurance, financial institutions and professional registration.

2. Health carriers that include and operate wellness and health promotion programs, disease and condition management programs, health risk appraisal programs, and similar provisions in high deductible health plans or policies that comport with federal requirements shall not be considered to be engaging in unfair trade practices under section 375.936 with respect to references to the practices of illegal inducements, unfair discrimination, and rebating.

3. As used in this section, a "high deductible health plan" shall mean a policy or contract of health insurance or health benefit plan, as defined in section 376.1350, that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

376.986. 1. The pool shall offer major medical expense coverage to every person eligible for coverage under section 376.966. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations, shall be established by the board with the advice and recommendations of the pool members, and such plan of pool coverage shall be submitted to the director for approval. The pool shall also offer coverage for drugs and supplies requiring a

medical prescription and coverage for patient education services, to be provided at the direction of a physician, encompassing the provision of information, therapy, programs, or other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause remission of the covered condition, illness or defect.

2. In establishing the pool coverage the board shall take into consideration the levels of health insurance provided in this state and medical economic factors as may be deemed appropriate, and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of insurers in this state.

3. The pool shall establish premium rates for pool coverage as provided in subsection 4 of this section. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the director for approval prior to use.

4. The pool, with the assistance of the director, shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than one hundred twenty-five percent of rates established as applicable for individual standard risks. Subject to the limits provided in this subsection, subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed the following:

(1) For federally defined eligible individuals and trade act eligible individuals, rates shall be equal to the percent of rates applicable to individual standard risks actuarially determined to be sufficient to recover the sum of the cost of benefits paid under the pool for federally defined and trade act eligible individuals plus the proportion of the pool's administrative expense applicable to federally defined and trade act eligible individuals enrolled for pool coverage, provided that such rates shall not exceed one hundred fifty percent of rates applicable to individual standard risks; and

(2) For all other individuals covered under the pool, one hundred fifty percent of rates applicable to individual standard risks.

5. Pool coverage established pursuant to this section shall provide an appropriate high and low deductible to be selected by the pool applicant. The deductibles and coinsurance factors may be adjusted annually in accordance with the medical component of the consumer price index.

6. Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such condition during the six-month period immediately preceding the effective date of coverage. **[**Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, if application for pool coverage is made not later than sixty-three days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.**] The twelve-month preexisting condition exclusion period shall not apply if the person applying for pool coverage has at least three months of uninterrupted prior insurance coverage provided the application for pool coverage is made not later than sixty-three days following the loss of such health insurance coverage.**

7. No preexisting condition exclusion shall be applied to the following:

(1) A federally defined eligible individual who has not experienced a significant gap in coverage; or

(2) A trade act eligible individual who maintained creditable health insurance coverage for an aggregate period of three months prior to loss of employment and who has not experienced a significant gap in coverage since that time.

8. Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid. The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this

subsection.

9. Medical expenses shall include expenses for comparable benefits for those who rely solely on spiritual means through prayer for healing.

376.1600. 1. The director of the department of insurance, financial institutions and professional registration is authorized to allow health reimbursement arrangement only plans that encourage employer financial support of health insurance or health related expenses recognized under the rules of the federal Internal Revenue Service to be approved for sale in connection with or packaged with individual health insurance policies otherwise approved by the director. Health reimbursement arrangement only plans that are not sold in connection with or packaged with individual health insurance policies shall not be considered insurance under this chapter.

2. As used in this section, the term "health reimbursement arrangement" shall mean an employee benefit plan provided by an employer which:

(1) Establishes an account or trust which is funded solely by the employer and not through a salary reduction or otherwise under a cafeteria plan established pursuant to Section 125 of the Internal Revenue Code of 1986;

(2) Reimburses the employee for qualified medical care expenses, as defined by 26 U.S.C. Section 213(d), incurred by the employee and the employee's spouse and dependents;

(3) Provides reimbursements up to a maximum stated dollar amount for a defined coverage period; and

(4) Carries forward any unused portion of the maximum dollar amount at the end of the coverage period to increase the maximum reimbursement amount in subsequent coverage periods.

376.1618. The director shall study and recommend to the general assembly changes to remove any unnecessary application and marketing barriers that limit the entry of new health insurance products into the Missouri market. The director shall examine state statutory and regulatory requirements along with market conditions which create barriers for the entry of new health insurance products and health insurance companies. The director shall also examine proposals adopted in other states that streamline the regulatory

environment to make it easier for health insurance companies to market new and existing products. The director shall submit a report of his or her findings and recommendations to each member of the general assembly no later than January 1, 2009.

[191.400. 1. There is hereby created a "State Board of Health" which shall consist of seven members, who shall be appointed by the governor, by and with the advice and consent of the senate. No member of the state board of health shall hold any other office or employment under the state of Missouri other than in a consulting status relevant to the member's professional status, licensure or designation. Not more than four of the members of the state board of health shall be from the same political party.

2. Each member shall be appointed for a term of four years; except that of the members first appointed, two shall be appointed for a term of one year, two for a term of two years, two for a term of three years, and one for a term of four years. The successors of each shall be appointed for full terms of four years. No person may serve on the state board of health for more than two terms. The terms of all members shall continue until their successors have been duly appointed and qualified. Three of the persons appointed to the state board of health shall be persons who are physicians and surgeons licensed by the state board of registration for the healing arts of Missouri. One of the persons appointed to the state board of health shall be a dentist licensed by the Missouri dental board. One of the persons appointed to the state board of health shall be a chiropractic physician licensed by the Missouri state board of chiropractic examiners. Two of the persons appointed to the state board of health shall be persons other than those licensed by the state board of registration for the healing arts, the Missouri dental board, or the Missouri state board of chiropractic examiners and shall be representative of those persons, professions and businesses which are regulated and supervised by the department of health and senior services and the state board of health. If a vacancy occurs in the appointed membership, the governor may appoint a member for the remaining portion of the unexpired term created by the vacancy. If the vacancy occurs while the senate is

not in session, the governor shall make a temporary appointment subject to the approval of the senate when it next convenes. The members shall receive actual and necessary expenses plus twenty-five dollars per day for each day of actual attendance.

3. The board shall elect from among its membership a chairperson and a vice chairperson, who shall act as chairperson in his or her absence. The board shall meet at the call of the chairperson. The chairperson may call meetings at such times as he or she deems advisable, and shall call a meeting when requested to do so by three or more members of the board.**]**

[192.014. The state board of health shall advise the department of health and senior services in the:

(1) Promulgation of rules and regulations by the department of health and senior services. At least sixty days before the rules and regulations prescribed by the department or any subsequent changes in them become effective, a copy shall be filed in the office of the secretary of state. All rules and regulations promulgated by the department shall, as soon as practicable after their adoption, be submitted to the general assembly. The rules and regulations shall continue in force and effect until disapproved by the general assembly;

(2) Formulation of the budget for the department of health and senior services;

(3) Planning for and operation of the department of health and senior services.**]**

[660.062. 1. There is hereby created a "State Board of Senior Services" which shall consist of seven members, who shall be appointed by the governor, by and with the advice and consent of the senate. No member of the state board of senior services shall hold any other office or employment under the state of Missouri other than in a consulting status relevant to the member's professional status, licensure or designation. Not more than four of the members of the state board of senior services shall be from the same political party.

2. Each member shall be appointed for a term of four years; except that of the members first appointed, two shall be appointed

for a term of one year, two for a term of two years, two for a term of three years and one for a term of four years. The successors of each shall be appointed for full terms of four years. No person may serve on the state board of senior services for more than two terms. The terms of all members shall continue until their successors have been duly appointed and qualified. One of the persons appointed to the state board of senior services shall be a person currently working in the field of gerontology. One of the persons appointed to the state board of senior services shall be a physician with expertise in geriatrics. One of the persons appointed to the state board of senior services shall be a person with expertise in nutrition. One of the persons appointed to the state board of senior services shall be a person with expertise in rehabilitation services of persons with disabilities. One of the persons appointed to the state board of senior services shall be a person with expertise in mental health issues. In making the two remaining appointments, the governor shall give consideration to individuals having a special interest in gerontology or disability-related issues, including senior citizens. Four of the seven members appointed to the state board of senior services shall be members of the governor's advisory council on aging. If a vacancy occurs in the appointed membership, the governor may appoint a member for the remaining portion of the unexpired term created by the vacancy. The members shall receive actual and necessary expenses plus twenty-five dollars per day for each day of actual attendance.

3. The board shall elect from among its membership a chairman and a vice chairman, who shall act as chairman in his or her absence. The board shall meet at the call of the chairman. The chairman may call meetings at such times as he or she deems advisable, and shall call a meeting when requested to do so by three or more members of the board.

4. The state board of senior services shall advise the department of health and senior services in the:

(1) Promulgation of rules and regulations by the department of health and senior services;

(2) Formulation of the budget for the department of health and senior services; and

(3) Planning for and operation of the department of health and senior services.**]**

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