SECOND REGULAR SESSION

SENATE BILL NO. 1283

94TH GENERAL ASSEMBLY

INTRODUCED BY SENATORS DEMPSEY, SHIELDS, RIDGEWAY, RUPP AND KENNEDY.

Read 1st time February 28, 2008, and ordered printed.

TERRY L. SPIELER, Secretary.

5271S.01I

AN ACT

To repeal sections 23.140, 135.535, 135.562, 143.121, 191.400, 192.014, 192.083, 208.152, 208.955, 376.986, 660.062, and 660.750, RSMo, and to enact in lieu thereof sixty-nine 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 23.140, 135.535, 135.562, 143.121, 191.400, 192.014, 192.083, 208.152, 208.955, 376.986, 660.062, and 660.750, RSMo, are repealed and sixty-nine new sections enacted in lieu thereof, to be known as sections 8.365, 23.140, 26.850, 26.853, 26.856, 26.859, 26.900, 103.185, 135.092, 135.535, 135.562, 135.675, 143.116, 143.121, 148.372, 167.720, 191.1025, 191.1200, 191.1250, 191.1253, 191.1256, 191.1259, 191.1262, 191.1265, 191.1268, 191.1271, 191.1274, 191.1277, 192.083, 196.1200, 197.850, 197.853, 197.856, 197.859, 197.862, 197.865, 197.868, 197.871, 197.874, 197.877, 197.880, 208.005, 208.149, 208.152, 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, 376.986, 376.1600, 376.1603, 376.1606, 376.1609, 376.1612, 376.1615, 376.1618, 660.750, and 660.775, 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 a state building or substantial renovation of a state building. 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.

23.140. 1. Legislation, with the exception of appropriation bills, introduced into either house of the general assembly shall, before being acted upon, be submitted to the oversight division of the committee on legislative research for the preparation of a fiscal note. The staff of the oversight division**, including at least one full-time analyst devoted solely during the legislative session to preparing the information required under subdivision (7) of subsection 2 of this section,** shall prepare a fiscal note, examining the items contained in subsection 2 and such additional items as may be provided either by joint rule of the house and senate or by resolution adopted by the committee or the oversight subcommittee.

2. The fiscal note shall state:

(1) The cost of the proposed legislation to the state for the next two fiscal years;

(2) Whether or not the proposed legislation will establish a program or agency that will duplicate an existing program or agency;

(3) Whether or not there is a federal mandate for the program or agency;

(4) Whether or not the proposed program or agency will have significant direct fiscal impact upon any political subdivision of the state;

(5) Whether or not any new physical facilities will be required; **[**and**]**

(6) Whether or not the proposed legislation will have an economic impact on small businesses. For the purpose of this subdivision "small business" means a corporation, partnership, sole proprietorship or other business entity, including its affiliates, that:

(a) Is independently owned and operated; and

(b) Employs fifty or fewer full-time employees**; and**

(7) How the legislation will impact the health of the citizens in this state.

3. The fiscal note for a bill shall accompany the bill throughout its course of passage. No member of the general assembly, lobbyist or persons other than oversight division staff members shall participate in the preparation of any fiscal note unless the communication is in writing, with a duplicate to be filed with the fiscal note or unless requested for information by the fiscal analyst preparing the note. Violations of this provision shall be reported to the chairman of the

legislative research committee and subject the fiscal note and proposed bill to subcommittee review. Once a fiscal note has been signed and approved by the director of the oversight division, the note shall not be changed or revised without prior approval of the chairman of the legislative research committee, except to reflect changes made in the bill it accompanies, or to correct patent typographical, clerical or drafting errors that do not involve changes of substance, nor shall substitution be made therefor. Appeals to revise, change or to substitute a fiscal note shall be made in writing by a member of the general assembly to the chairman of the legislative research committee and a hearing before the committee or subcommittee shall be granted as soon as possible. Any member of the general assembly, upon presentation of new or additional material, may, within three legislative days after the hearing on the request to revise, change or substitute a fiscal note, request one rehearing before the full committee to further consider the requested change. The subcommittee, if satisfied that new or additional material has been presented, may recommend such rehearing to the full committee, and the rehearing shall be held as soon as possible thereafter.

4. The director of the division, hereinafter provided for, or the director's designees, shall seek information and advice from the affected department, division or agency of state government and shall call upon the research staffs of the house of representatives and of the senate, and upon the staffs of the house and senate appropriations committees for assistance in carrying out fiscal notes and auditing functions and duties, during the interim, and each staff shall supply such information or advice as it may possess in response to the inquiry. The state auditor shall, upon request, cooperate and provide assistance in the conduct of audits and the preparation of reports made in connection therewith.

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 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 seven 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. 1. The cabinet shall have the following duties and responsibilities:

(1) Develop and implement a shared and cohesive vision using integrated services to improve health outcomes in this state;

(2) Develop, no later than December 31, 2008, a strategic plan to achieve the goals of the shared and cohesive vision. The plan shall be centered upon a long-term commitment to health issues and align all public resources to serve Missourians in a manner that supports the healthy growth and development of all citizens;

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

(4) 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;

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

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

(7) 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;

(8) 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;

(9) 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;

(10) 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. The annual report may include recommendations for needed legislation or rulemaking authority.

2. Members of the cabinet shall serve without compensation, but are entitled to receive per diem and travel expenses while in the performance of their duties.

26.859. The governor shall appoint a "Health Policy Council" to assist the cabinet in its tasks. This council replaces the MO HealthNet oversight committee established in section 208.955, RSMo, 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.

It shall include representatives of health policy organizations, health data collection, and analysis experts, health educators, representative of institutions of higher learning who train our health workforce, health facility operators, insurance providers, employers, health economist, health advocacy organizations, 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. Through a prioritization process, each department shall select the three most important functions or issue areas, identify action steps, and forecast expected results.

4. The policy brief described under subsection 2 of this section shall be submitted to the governor, lieutenant governor, and general assembly by July 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.

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

(1) "Health savings account" or "account", shall have the same meaning ascribed to it as 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, that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder;

(3) "Qualified medical expense", shall have the same meaning

ascribed to it as in 26 U.S.C. Section 223(d)(2), as amended;

(4) "Taxpayer", any person or entity considered to be an employer for purposes of section 143.191, RSMo, who directly employs fifty or fewer persons.

2. For taxable years commencing on or after January 1, 2009, a taxpayer which does not provide health care coverage shall be allowed a tax credit against the tax imposed by chapter 143, RSMo, exclusive of the provisions relating to the withholding of tax as provided in sections 143.191 to 143.265, RSMo, for contributions to a health savings account maintained in connection with a high deductible health plan of an employee who incurs qualified medical expenses in an amount not to exceed the actual amount contributed to all participating employees or five hundred dollars per participating employee, whichever is less, if such contributions are made available to all of its employees.

3. The amount of the tax credit claimed shall not exceed the amount of the taxpayer's state tax liability for the taxable year for which the credit is claimed, and such taxpayer shall not be allowed to claim a tax credit in excess of twenty-five thousand dollars per taxable year. However, any tax credit that cannot be claimed in the taxable year the contribution was made may be carried over to the next four succeeding taxable years until the full credit has been claimed.

4. 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.

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 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.

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 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.

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.

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

(1) "Department", the department of revenue;

(2) "Health information technology", any systems or technology which allow comprehensive management of medical information and its secure exchange between health care consumers and providers;

(3) "State tax liability", in the case of a business taxpayer, any liability incurred by such taxpayer pursuant to the provisions of chapters 143, 147, and 153, RSMo, excluding sections 143.191 to 143.265, RSMo, and related provisions, and in the case of an individual taxpayer, any liability incurred by such taxpayer pursuant to the provisions of chapter 143, RSMo, excluding sections 143.191 to 143.265, RSMo, and related provisions;

(4) "Taxpayer", a person, firm, a partner in a firm, corporation, or a shareholder in an S corporation doing business in the state of Missouri as a hospital, as such term is defined under section 197.020, RSMo, and subject to the state income tax imposed by the provisions of chapter 143, RSMo, or a corporation doing business as a hospital subject to the annual corporation franchise tax imposed by the provisions of chapter 147, RSMo.

2. For all tax years beginning on or after January 1, 2008, a

taxpayer shall be allowed to claim a tax credit against the taxpayer's state tax liability in an amount equal to the lesser of the actual expenses incurred in purchasing and installing health information technology or five thousand dollars.

3. The amount of the tax credit claimed shall not exceed the amount of the taxpayer's state tax liability for the taxable year for which the credit is claimed. However, any tax credit that cannot be claimed in the taxable year the purchase and installation was made may be carried over to the next three succeeding taxable years until the full credit has been claimed. The tax credit allowed under this section shall be nontransferable.

4. The cumulative amount of tax credits which may be issued under this section in any one fiscal year shall not exceed one million dollars. If the amount of tax credits claimed under this section exceeds ten million dollars in any one fiscal year, the director of the department of revenue shall establish a procedure by which, from the beginning of the fiscal year until some point in time later in the fiscal year to be determined by the director, the cumulative amount of tax credits are equally apportioned among all taxpayers allowed a tax credit under this section. The director may establish more than one period of time and reapportion more than once during each fiscal year. To the maximum extent possible, the director shall establish the procedure described in this subsection in such a manner as to ensure that taxpayers can claim all the tax credits possible up to the cumulative amount of tax credits available for the fiscal year.

5. Not less than one hundred and twenty days from the effective date of this act, the department shall promulgate rules necessary for the implementation of 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.

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.

143.121. 1. The Missouri adjusted gross income of a resident individual shall be the taxpayer's federal adjusted gross income subject to the modifications in this section.

2. There shall be added to the taxpayer's federal adjusted gross income:

(a) The amount of any federal income tax refund received for a prior year which resulted in a Missouri income tax benefit;

(b) Interest on certain governmental obligations excluded from federal gross income by Section 103 of the Internal Revenue Code. The previous sentence

shall not apply to interest on obligations of the state of Missouri or any of its political subdivisions or authorities and shall not apply to the interest described in subdivision (a) of subsection 3 of this section. The amount added pursuant to this paragraph shall be reduced by the amounts applicable to such interest that would have been deductible in computing the taxable income of the taxpayer except only for the application of Section 265 of the Internal Revenue Code. The reduction shall only be made if it is at least five hundred dollars;

(c) The amount of any deduction that is included in the computation of federal taxable income pursuant to Section 168 of the Internal Revenue Code as amended by the Job Creation and Worker Assistance Act of 2002 to the extent the amount deducted relates to property purchased on or after July 1, 2002, but before July 1, 2003, and to the extent the amount deducted exceeds the amount that would have been deductible pursuant to Section 168 of the Internal Revenue Code of 1986 as in effect on January 1, 2002;

(d) The amount of any deduction that is included in the computation of federal taxable income for net operating loss allowed by Section 172 of the Internal Revenue Code of 1986, as amended, other than the deduction allowed by Section 172(b)(1)(G) and Section 172(i) of the Internal Revenue Code of 1986, as amended, for a net operating loss the taxpayer claims in the tax year in which the net operating loss occurred or carries forward for a period of more than twenty years and carries backward for more than two years. Any amount of net operating loss taken against federal taxable income but disallowed for Missouri income tax purposes pursuant to this paragraph after June 18, 2002, may be carried forward and taken against any income on the Missouri income tax return for a period of not more than twenty years from the year of the initial loss; and

(e) For nonresident individuals in all taxable years ending on or after December 31, 2006, the amount of any property taxes paid to another state or a political subdivision of another state for which a deduction was allowed on such nonresident's federal return in the taxable year.

3. There shall be subtracted from the taxpayer's federal adjusted gross income the following amounts to the extent included in federal adjusted gross income:

(a) Interest or dividends on obligations of the United States and its territories and possessions or of any authority, commission or instrumentality of the United States to the extent exempt from Missouri income taxes pursuant to the laws of the United States. The amount subtracted pursuant to this

paragraph shall be reduced by any interest on indebtedness incurred to carry the described obligations or securities and by any expenses incurred in the production of interest or dividend income described in this paragraph. The reduction in the previous sentence shall only apply to the extent that such expenses including amortizable bond premiums are deducted in determining the taxpayer's federal adjusted gross income or included in the taxpayer's Missouri itemized deduction. The reduction shall only be made if the expenses total at least five hundred dollars;

(b) The portion of any gain, from the sale or other disposition of property having a higher adjusted basis to the taxpayer for Missouri income tax purposes than for federal income tax purposes on December 31, 1972, that does not exceed such difference in basis. If a gain is considered a long-term capital gain for federal income tax purposes, the modification shall be limited to one-half of such portion of the gain;

(c) The amount necessary to prevent the taxation pursuant to this chapter of any annuity or other amount of income or gain which was properly included in income or gain and was taxed pursuant to the laws of Missouri for a taxable year prior to January 1, 1973, to the taxpayer, or to a decedent by reason of whose death the taxpayer acquired the right to receive the income or gain, or to a trust or estate from which the taxpayer received the income or gain;

(d) Accumulation distributions received by a taxpayer as a beneficiary of a trust to the extent that the same are included in federal adjusted gross income;

(e) The amount of any state income tax refund for a prior year which was included in the federal adjusted gross income;

(f) The portion of capital gain specified in section 135.357, RSMo, that would otherwise be included in federal adjusted gross income;

(g) The amount that would have been deducted in the computation of federal taxable income pursuant to Section 168 of the Internal Revenue Code as in effect on January 1, 2002, to the extent that amount relates to property purchased on or after July 1, 2002, but before July 1, 2003, and to the extent that amount exceeds the amount actually deducted pursuant to Section 168 of the Internal Revenue Code as amended by the Job Creation and Worker Assistance Act of 2002;

(h) For all tax years beginning on or after January 1, 2005, the amount of any income received for military service while the taxpayer serves in a combat zone which is included in federal adjusted gross income and not otherwise

excluded therefrom. As used in this section, "combat zone" means any area which the President of the United States by Executive Order designates as an area in which armed forces of the United States are or have engaged in combat. Service is performed in a combat zone only if performed on or after the date designated by the President by Executive Order as the date of the commencing of combat activities in such zone, and on or before the date designated by the President by Executive Order as the date of the termination of combatant activities in such zone; and

(i) For all tax years ending on or after July 1, 2002, with respect to qualified property that is sold or otherwise disposed of during a taxable year by a taxpayer and for which an addition modification was made under paragraph (c) of subsection 2 of this section, the amount by which addition modification made under paragraph (c) of subsection 2 of this section on qualified property has not been recovered through the additional subtractions provided in paragraph (g) of this subsection.

4. There shall be added to or subtracted from the taxpayer's federal adjusted gross income the taxpayer's share of the Missouri fiduciary adjustment provided in section 143.351.

5. There shall be added to or subtracted from the taxpayer's federal adjusted gross income the modifications provided in section 143.411.

6. In addition to the modifications to a taxpayer's federal adjusted gross income in this section, to calculate Missouri adjusted gross income there shall be subtracted from the taxpayer's federal adjusted gross income any gain recognized pursuant to Section 1033 of the Internal Revenue Code of 1986, as amended, arising from compulsory or involuntary conversion of property as a result of condemnation or the imminence thereof.

7. (1) As used in this subsection, "qualified health insurance premium" means the amount paid during the tax year by such taxpayer for any insurance policy primarily providing health care coverage for the taxpayer, the taxpayer's spouse, or the taxpayer's dependents.

(2) In addition to the subtractions in subsection 3 of this section, one hundred percent of the amount of qualified health insurance premiums shall be subtracted from the taxpayer's federal adjusted gross income to the extent the amount paid for such premiums is included in federal taxable income. The taxpayer shall provide the department of revenue with proof of the amount of qualified health insurance premiums paid.

8. In addition to the subtractions in subsection 3 of this section, one hundred percent of the amount of premiums for high deductible health plans as provided for in section 143.116 shall be subtracted from the taxpayer's federal adjusted gross income to the extent the amount paid for such premiums is included in federal taxable income. The taxpayer shall provide the department of revenue with proof of the amount of high deductible health plan premiums paid.

148.372. 1. Every insurance company shall be exempt from otherwise applicable premium taxes provided for in section 148.370 on premiums paid by Missouri residents for high deductible health plans sold or maintained in connection with a health savings account under the applicable provisions of Section 223 of the Internal Revenue Code.

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 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.

167.720. 1. All school districts shall comply with the requirements of this section by July 1, 2011.

2. As used in this section, unless the context otherwise requires, the following terms mean:

(1) "Least restrictive environment", placing the student with a disabling condition at a point along a continuum of educational

placement alternatives where all students coexist, interact, and learn to the fullest extent of each of their respective abilities;

(2) "Moderate physical activity", low to medium impact physical exertion that causes an individual's heart rate to rise to fifty to seventy-five percent of his or her maximum heart rate. Maximum heart rate is roughly calculated as 220 minus a person's age;

(3) "Physical education", instruction in healthy active living by a teacher certified to teach physical education, structured in such a way that it is a regularly scheduled class for students;

(4) "Recess", a structured play environment, outside of regular classroom instructional activities, where students are allowed to engage in supervised safe, active free play. This does not count as physical education.

3. The required elements of physical education shall be as follows:

(1) Every student in kindergarten through twelfth grade shall participate in daily physical education for the entire school year, including students with disabling conditions and those in alternative education programs. Students in elementary schools shall participate in physical education for at least one hundred fifty minutes during each five-day school week. Students in middle schools and high schools shall participate for at least two hundred twenty-five minutes per five-day school week;

(2) A minimum of one recess period of ten minutes per day shall be provided for children in kindergarten through fifth grade;

(3) Schools shall establish specific learning goals and objectives for physical education. A sequential, developmentally appropriate curriculum shall be designed, implemented, and evaluated to help students develop the knowledge, motor skills, self-management skills, attitudes, and confidence needed to adopt and maintain physical activity throughout their lives. The physical activity program shall:

(a) Emphasize knowledge and skills for a lifetime of regular physical activity;

(b) Be consistent with the show-me standards and grade level expectations for physical education that define what students should know and be able to do;

(c) Devote at least fifty percent of class time to moderate

physical activity in each week;

(d) Provide many different physical activity choices;

(e) Feature predominantly fitness-based activities that include cooperative as well as competitive games;

(f) Meet the needs of all students, especially those who are not athletically gifted;

(g) Teach healthy active living skills;

(h) Actively teach cooperation, fair play, and responsible participation in physical activity;

(i) Have student/teacher ratios comparable to those in other curricular areas to ensure safety and to devote adequate attention to each student; and

(j) Promote participation in physical activity outside of school. Recognizing that all students deserve the opportunity to participate as fully as they are able, suitably adapted physical education shall be included as a part of individual education plans for students with chronic health problems, other disabling conditions, or other special needs that preclude such students' participation in regular physical education instruction or activities. The school shall provide students who have either permanent or temporary disabling conditions with opportunities to participate as fully as they are able, rather than summarily dismissing them from the activity. A student may be excused to the least restrictive environment if a physician states in writing that physical activity will jeopardize the student's health and well-being;

(4) All students shall be regularly assessed at the local level for attainment of physical education learning objectives;

(5) Health-related fitness testing shall be integrated into the curriculum as an instructional tool. Tests shall be appropriate to students' developmental levels and physical abilities. Such testing shall be used to teach students how to assess their fitness levels, set goals for improvement, and monitor progress in reaching their goals. All students shall be assessed on their physical fitness proficiency using the state's physical fitness assessment. Results shall be reported to the department in the June reporting cycle for core data.

4. Exemptions for physical education courses shall not be permitted on the basis of participation on an athletic team, community

recreation program, ROTC, marching band, or other school or community activity.

5. Physical education shall be taught by teachers certified by the state to teach physical education. All physical education teachers shall be adequately prepared and regularly participate in professional development activities to deliver the physical education program effectively.

6. School administrators shall ensure the cost-efficient provision of adequate spaces, facilities, equipment, supplies, and operational budgets that are necessary to achieve the objectives of the physical education program.

7. The physical education program shall be closely coordinated with other components of the overall school health program, local wellness policy, and the health education and physical education grade level expectations.

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 director of the department of health and senior services shall award 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. 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. 1. 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) A skilled nursing facility;

(d) A residential treatment facility;

(e) A home health agency;

(f) A diagnostic laboratory or imaging center;

(g) An assisted living facility;

(h) A school-based health program;

(i) A mobile clinic;

(j) A mental health clinic;

(k) A rehabilitation or other therapeutic health setting;

(l) The patient's residence;

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

(n) 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 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.

191.1253. Competent adults in this state have the right to direct their own health care, as recognized in sections 404.800 to 404.872, RSMo, and such right includes, but is not limited to, the right to designate the practitioner who will serve in the absence of their physicians, surgeons, or podiatrists.

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 physicians 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.

191.1268. Telehealth practitioners shall not be subjected to civil, criminal, or regulatory liability to refusing to treat a patient via telehealth.

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.

191.1274. Telehealth practitioners:

(1) May prescribe, dispense or furnish controlled substances, as permitted by current state law, even if a specific telehealth practitioner has not physically examined a patient, except that telehealth practitioners shall not prescribe any drugs that are listed as prohibited substances under the Drug Enforcement Act, 21 U.S.C. Section 801, et seq.;

(2) Shall monitor all drug prescriptions which they prescribe, dispense or furnish; and

(3) Shall not prescribe, dispense or furnish refillable controlled substance prescriptions.

191.1277. Prior to engaging in telehealth practice, a telehealth practitioner shall create and maintain an EMR on each patient that the telehealth practitioner treats using telehealth. All EMRs used in conjunction with telehealth practices under sections 191.1250 to 191.1277 should be portable and accessible from any location at all hours. Each EMR shall adhere to national standards for data portability. All EMR data shall be made available for audit in order to create a simple, transparent system. Telehealth practitioners shall update a patient's EMR prior to undertaking any

consultation. Telehealth patients shall be furnished with an annual EMR update.

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.

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 all moneys 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.

197.850. 1. As used in sections 197.850 to 197.880, the following terms shall mean:

(1) "Ambulatory surgical center", as the term is defined in section 197.200;

(2) "Board", the board of directors of the right to know committee;

(3) "Committee", the right to know committee established under section 197.856;

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

(5) "Employee protection", protection for a person who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms of employment by the person's employer because of a lawful act taken by the person in furtherance of an action under sections 197.850 to 197.880. Such protections include the person being entitled to reinstatement with the same seniority status the person would have had but for the discrimination, not less than two times the amount of back pay, two percent interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees;

(6) "Fund", the right to know trust fund established under section 197.859;

(7) "Health care worker", an employee, independent contractor, licensee or other individual authorized to provide services in a medical facility;

(8) "Incident", an event, occurrence, or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient. The term does not include a serious event;

(9) "Infrastructure", structures related to the physical plant and service delivery systems necessary for the provision of health care services in a medical facility;

(10) "Licensee", an individual who is all of the following:

(a) Licensed or certified by the state to provide professional services in this state; and

(b) Employed by or authorized to provide professional services in a medical facility;

(11) "Medical facility", an ambulatory surgical center or hospital;

(12) "Right to know officer", an individual designated by a medical facility under section 197.871;

(13) "Serious event", an event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises right to know and results in an unanticipated injury requiring the delivery of additional health care services to the patient. The term does not include an incident.

197.853. 1. There is established a body corporate and politic to be known as the "Right to Know Committee" within the healthy policy cabinet created under section 26.859, RSMo. The powers and duties of the committee shall be vested in and exercised by a board of directors.

2. The board of the committee shall consist of eleven members and shall be appointed in accordance with the following:

(1) A physician appointed by the governor;

(2) Four public members appointed by the governor;

(3) A health care worker residing in this state who is a licensed physician and is appointed by the governor, who shall serve an initial term of three years;

(4) A health care worker residing in this state who is a licensed nurse and is appointed by the governor, who shall serve an initial term of three years;

(5) A health care worker residing in this state who is a licensed pharmacist and is appointed by the governor, who shall serve an initial term of two years;

(6) A health care worker residing in this state who is employed by a hospital and is appointed by the governor, who shall serve an initial term of two years; and

(7) Two residents of this state, one of whom is a health care worker and one of whom is not a health care worker, appointed by the governor, who shall each serve a term of four years;

(8) Two members who are health policy or patient safety professionals and are residents of Missouri, appointed by the governor, who shall serve a term of four years.

3. With the exceptions of the members in subdivisions (1) and (2) of subsection 2 of this section, members of the board shall serve for terms of four years after completion of the initial terms designated in subsection 2 and shall not be eligible to serve more than two full

consecutive terms.

4. A majority of the members of the board shall constitute a quorum. Notwithstanding any other provision of law, action may be taken by the board at a meeting upon a vote of the majority of its members present in person or through the use of amplified telephonic equipment if authorized by the bylaws of the board.

5. The board shall meet at the call of the chairperson or as may be provided in the bylaws of the board. The board shall hold meetings at least quarterly. Meetings of the board may be held anywhere within this state.

6. The board shall meet and select the chair and vice chair. The committee shall be formed within sixty days of the effective date of this section.

197.856. 1. The committee shall do all of the following:

(1) Adopt bylaws necessary to implement sections 197.850 to 197.880;

(2) Employ staff as necessary to implement sections 197.850 to 197.880;

(3) Make, execute and deliver contracts and other instruments;

(4) Apply for, solicit, receive, establish priorities for, allocate, disburse, contract for, administer and spend moneys in the fund, and other funds that are made available to the committee from any source consistent with the purposes of sections 197.850 to 197.880;

(5) Contract with a for-profit or not-for-profit entity or entities, other than a health care provider, to do the following:

(a) Collect, analyze and evaluate data regarding reports of serious events and incidents, including the identification of performance indicators and patterns in frequency or severity at certain medical facilities or in certain regions of this state;

(b) Transmit to the committee recommendations for changes in health care practices and procedures which may be instituted for the purpose of reducing the number and severity of serious events and incidents;

(c) Directly advise reporting medical facilities of immediate changes that can be instituted to reduce serious events and incidents; and

(d) Conduct reviews in accordance with subsection 2 of this

section;

(6) Receive and evaluate recommendations made by the entity or entities contracted with in accordance with subdivision (5) of this subsection and report those recommendations to the department, which shall have no more than thirty days to approve or disapprove the recommendations;

(7) After consultation and approval by the department, issue recommendations to medical facilities on a facility-specific or on a state-wide basis regarding changes, trends, and improvements in health care practices and procedures for the purpose of reducing the number and severity of serious events and incidents. Prior to issuing recommendations, consideration shall be given to the following factors that include expectation of improved quality care, implementation feasibility, other relevant implementation practices and the cost impact to patients, payors and medical facilities on a continuing basis and shall be published and posted on the department's and the committee's publicly accessible website; and

(8) Meet with the department for purposes of implementing sections 197.850 to 197.880.

2. A health care worker who has complied with section 197.868, may file an anonymous report regarding a serious event with the committee. Upon receipt of the report, the committee shall give notice to the affected medical facility that a report has been filed. The committee shall conduct its own review of the report unless the medical facility has already commenced an investigation of the serious event. The medical facility shall provide the committee with the results of its investigation no later than thirty days after receiving notice pursuant to this section. If the committee is dissatisfied with the adequacy of the investigation conducted by the medical facility, the committee shall perform its own review of the serious event and may refer a medical facility and any involved licensee to the department for failure to report pursuant to subdivisions (5) and (6) of section 197.880.

3. (1) The committee shall report no later than May 1, 2009, and annually thereafter, to the health policy council, the health cabinet, and the general assembly on the committee's activities in the preceding year. The report shall include:

(a) A schedule of the year's meetings;

(b) A list of contracts entered into pursuant to subdivision (5) of subsection 2 of this section, including the amounts awarded to each contractor;

(c) A summary of the fund receipts and expenditures, including a financial statement and balance sheet;

(d) The number of serious events and incidents reported by medical facilities on a geographical basis;

(e) The information derived from the data collected, including any recognized trends concerning right to know;

(f) The number of anonymous reports filed and reviews conducted by the committee;

(g) The number of referrals to licensure boards for failure to report under sections 197.850 to 197.880; and

(h) Recommendations for statutory and regulatory changes which may help improve right to know in the state.

(2) The report shall be distributed to the director of the department of health and senior services, governor, and the general assembly.

(3) The annual report shall be made available for public inspection and shall be posted on the department's Internet website.

197.859. 1. There is hereby established the "Right to Know Trust Fund" to be administered by the committee. 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. Upon appropriation, money in the fund shall be used solely for the administration of sections 197.850 to 197.880. Any moneys remaining in the fund at the end of the biennium shall revert to the credit of the general revenue fund. 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.

2. Beginning December 31, 2008, each medical facility shall pay the department a surcharge on its licensing fee as necessary to provide sufficient revenues to operate the committee. The total assessment for all medical facilities shall not exceed five million dollars. The department shall transfer the total assessment amount to the fund within thirty days of receipt.

3. For each succeeding calendar year, the department shall

determine and assess each medical facility its proportionate share of the committee's budget. The total assessment amount shall not exceed five million dollars.

4. Moneys in the fund shall be expended by the committee to implement sections 197.850 to 197.880.

5. In the event that the fund is discontinued or the committee is dissolved by operation of law, any balance remaining in the fund, after deducting administrative costs of liquidation, shall be returned to the medical facilities in proportion to their financial contributions to the fund in the preceding licensing period.

6. If, after thirty days notice, a medical facility fails to pay a surcharge levied by the department under sections 197.850 to 197.880, the department may assess an administrative penalty of one thousand dollars per day until the surcharge is paid.

197.862. The department shall do all of the following:

(1) Review and approve right to know plans in accordance with section 197.862;

(2) Receive reports of serious events and infrastructure failures under section 197.880;

(3) Investigate serious events and infrastructure failures;

(4) In conjunction with the committee, analyze and evaluate existing health care procedures and approve recommendations issued by the committee pursuant to subdivisions (6) and (7) of subsection 1 of section 197.856;

(5) Meet with the committee for purposes of implementing sections 197.850 to 197.880.

197.865. 1. A medical facility shall develop, implement and comply with an internal right to know plan that shall be established for the purpose of improving the health and safety of patients. The plan shall be developed in consultation with the licensees providing health care services in the medical facility.

2. A right to know plan shall:

(1) Designate a right to know officer as set forth in section 197.871;

(2) Establish a right to know committee as set forth in section 197.874;

(3) Establish a system for the health care workers of a medical

facility to report serious events and incidents which shall be accessible twenty-four hours a day, seven days a week;

(4) Prohibit any retaliatory action against a health care worker for reporting a serious event or incident in accordance with the employee protection described under section 197.850;

(5) Provide for written notification to patients in accordance with subsection 2 of section 197.868.

3. Within sixty days from the effective date of sections 197.850 to 197.880, a medical facility shall submit its right to know plan to the department for approval consistent with the requirements of this section. Unless the department approves or rejects the plan within sixty days of receipt, the plan shall be deemed approved.

4. Upon approval of the right to know plan, a medical facility shall notify all health care workers of the medical facility of the right to know plan. Compliance with the right to know plan shall be required as a condition of employment or credentialing at the medical facility.

197.868. 1. A health care worker who reasonably believes that a serious event or incident has occurred shall report the serious event or incident according to the right to know plan of the medical facility unless the health care worker knows that a report has already been made. The report shall be made immediately or as soon thereafter as reasonably practicable, but in no event later than twenty-four hours after the occurrence or discovery of a serious event or incident.

2. A medical facility, through an appropriate designee, shall provide written notification to a patient affected by a serious event or, with the consent of the patient, to an available family member or designee within seven days of the occurrence or discovery of a serious event. If the patient is unable to give consent, the notification shall be given to an adult member of the immediate family. If an adult member of the immediate family cannot be identified or located, notification shall be given to the closest adult family member. For unemancipated patients who are under eighteen years of age, the parent or guardian shall be notified in accordance with this subsection. The notification requirements of this subsection shall not constitute an acknowledgment or admission of liability.

3. A health care worker who reports the occurrence of a serious

event or incident in accordance with subsections 1 or 2 of this section shall not be subject to any retaliatory action for reporting the serious event or incident and shall be entitled to the employee protection described under section 197.850.

4. Nothing in this section shall limit a medical facility's ability to take appropriate disciplinary action against a health care worker for failure to meet defined performance expectations or to take corrective action against a licensee for unprofessional conduct, including making false reports or failure to report serious events under sections 197.800 and 197.830.

197.871. A right to know officer of a medical facility shall do all of the following:

(1) Serve on the right to know committee;

(2) Ensure the investigation of all reports of serious events and incidents;

(3) Take such action as is immediately necessary to ensure right to know as a result of any investigation; and

(4) Report to the right to know committee regarding any action taken to promote right to know as a result of investigations commenced under this section.

197.874. 1. A hospital's right to know committee shall be composed of the medical facility's right to know officer and at least three health care workers of the medical facility and two residents of the community served by the medical facility who are not agents, employees or contractors of the medical community served by the medical facility. No more than one member of the right to know committee shall be a member of the medical facility's board of trustees. The committee shall include members of the medical facility's medical and nursing staff. The committee shall meet at least monthly.

2. An ambulatory surgical center's right to know committee shall be comprised of the medical facility's right to know officer and at least one health care worker of the medical facility and one resident of the community served by the ambulatory surgical center who is not an agent, employee or contractor of the ambulatory surgical center. No more than one member of the right to know committee shall be a member of the facility's board of governance. The committee shall include members of the medical facility's medical and nursing

staff. The committee shall meet at least quarterly.

3. A right to know committee of a medical facility shall do all of the following:

(1) Receive reports from the right to know officer pursuant to section 197.871;

(2) Evaluate investigations and actions of the right to know officer on all reports;

(3) Review and evaluate the quality of right to know measures utilized by the medical facility. A review shall include the consideration of reports made under subdivision (5) of subsection 1 and subsection 2 of section 197.856, subdivision (3) of subsection 2 of section 197.865 and subsection 1 of section 197.868;

(4) Make recommendations to eliminate future serious events and incidents;

(5) Report to the administrative officer and governing body of the medical facility on a quarterly basis regarding the number of serious events and incidents and its recommendations to eliminate future serious events and incidents.

197.877. 1. Any documents, materials or information solely prepared or created for the purpose of compliance with subsection 2 of section 197.874 or of reporting under subdivision (5) of subsection 1 and subsection 2 of section 197.877, subdivision (2) of subsection 1 or subsection 3 of section 197.862, subdivision (3) of subsection 2 of section 197.865, subsection 1 of section 197.868, subdivision (4) of section 197.871, subdivision (5) of subsection 2 of section 197.874 or section 197.880 which arise out of matters reviewed by the right to know committee pursuant to the governing board of a medical facility are confidential and shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding. Any documents, materials, records or information that would otherwise be available from original sources shall not be construed as immune from discovery or use in any civil or administrative action or proceeding merely because they were presented to the right to know committee or governing board of a medical facility.

2. No person who performs responsibilities for or participates in meetings of the right to know committee or governing board of a medical facility shall be allowed to testify as to any matters within the

knowledge gained by the person's responsibilities or participation on the right to know committee or governing board of a medical facility, provided, however, the person shall be allowed to testify as to any matters within the person's knowledge which was gained outside of the person's responsibilities or participation on the right to know committee or governing board of a medical facility.

3. The confidentiality protections set forth in subsections 1 and 2 of this section shall only apply to the documents, materials, or information prepared or created pursuant to the responsibilities of the right to know committee or governing board of a medical facility.

4. Except as set forth in subsection 6 of this section, any documents, materials or information received by the committee or department from the medical facility, health care worker, right to know committee or governing board of a medical facility solely prepared or created for the purpose of compliance with subsection 2 of section 197.874 or for the reporting required in subsection 1 of this section, shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding. Any records received by the committee or department from the medical facility, health care worker, right to know committee or governing board of a medical facility pursuant to the requirements of sections 197.850 to 197.880 shall not be discoverable from the department or the committee in any civil or administrative action or proceeding. Documents, materials, records, or information may be used by the committee or department to comply with the reporting requirements under subsection 7 of this section and subdivision (7) of subsection 1 or subsection 3 of section 197.856 or subsection 2 of section 197.862.

5. (1) Except as set forth in subdivision (2) of this subsection, no current or former employee of the committee or the department shall be allowed to testify as to any matters gained by reason of his or her review of documents, materials, records or information submitted to the committee by the medical facility or health care worker pursuant to the requirements of sections 197.850 to 197.880.

(2) Subdivision (1) of this subsection does not apply to findings or actions by the department or the secretary of state which are public records.

6. In the event an original source document as set forth in

subsection 1 of this section is determined by a court of competent jurisdiction to be unavailable from the health care worker or medical facility in a civil action or proceeding, then in that circumstance alone the department may be required pursuant to a court order to release that original document to the party identified in the court order.

7. Any documents, materials or information made confidential by subsection 1 of this section shall not be subject to chapter 610, RSMo.

8. Notwithstanding any other provision of law, no person providing information or services to the right to know committee, governing board of a medical facility, committee, or department shall be held by reason of having provided such information or services to have violated any criminal law, or to be civilly liable under law, unless such information is false and the person providing such information knew or had reason to believe that such information was false and was motivated by malice toward any person directly affected by such action.

197.880. 1. A medical facility shall report the occurrence of a serious event to the department and the committee within twenty-four hours of the medical facility's confirmation of the occurrence of the serious event. The report to the department and the committee shall be in the form and manner prescribed by the committee in consultation with the department and shall not include the name of any patient or any other identifiable individual information.

2. A medical facility shall report the occurrence of an incident to the committee in a form and manner prescribed by the committee and shall not include the name of any patient or any other identifiable individual information.

3. A medical facility shall report the occurrence of an infrastructure failure to the department within twenty-four hours of the medical facility's confirmation of the occurrence or discovery of the infrastructure failure. The report to the department shall be in a form and manner prescribed by the department.

208.005. Beginning July 1, 2009, health care services provided under the MO HealthNet program shall cover all the preventive benefits recommended by the federal U.S. Preventive Services Task Force, except as provided for in sections 208.1300 to 208.1345.

208.149. As of July 1, 2009, the MO HealthNet division shall no

longer reimburse health care providers for the treatment of preventable errors, injuries and infections that occur under the providers' care. By December 31, 2008, the MO HealthNet division shall compile a list of such preventable errors, injuries and infections, including but not limited to:

(1) Falls;

(2) Mediastinitis;

(3) Urinary tract infections or vascular infections resulting from improper use of catheters;

(4) Pressure ulcers;

(5) Objects left in the body during surgery;

(6) Air embolisms;

(7) Blood incompatibility; and

(8) Wrong-site surgery.

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.

208.1300. 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) "Preventative 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 MO HealthNet division of 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 MO HealthNet division shall promote the plan and provide information to potential eligible individuals.

5. The MO HealthNet division 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 MO HealthNet division 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.

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) Preventative 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 preventative 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 preventative care services.

2. The plan shall, at no cost to the individual, provide payment for at least five hundred dollars of qualifying preventative care services per year for an individual who participates in the plan. Any additional preventative 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 noncustodial parents or for custodial parents with incomes over one hundred percent of the federal poverty level. 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 at least nineteen years of age and less than sixty-five years of age;

(2) The individual is a United States citizen and has been a resident of Missouri for at least twelve months;

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

(4) The individual is not eligible for health insurance coverage through the individual's employer;

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

(6) 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.

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 with incomes over one hundred percent of the federal poverty level 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. An individual's 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 per year, 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 a noncustodial parent or other working adult and has an annual household income of less than one hundred percent of the federal poverty level.

3. 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.

4. 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.

5. 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 who is approved to participate in the plan is eligible for a twelve month plan period. 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, and submit to the insure Missouri initiative the documentation and application 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.

376.986. 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 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.

376.1603. 1. The general assembly recognizes the need for individuals, employers, and other purchasers of health insurance coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering health insurance coverage. Therefore, the general assembly seeks to increase the availability of health insurance coverage by allowing health carriers domiciled in other states to issue health benefit plans or health insurance policies in Missouri.

2. As used in sections 376.1603 to 376.1615, the terms "health benefit plan" and "health carrier" shall have the same meanings ascribed to them in section 376.1350.

376.1606. 1. Notwithstanding chapter 354, RSMo, section 375.014, RSMo, or any other provision of law to the contrary, a health carrier domiciled in another state is exempt from acquiring and possessing a Missouri license or certificate of authority, if the health carrier meets the following criteria:

(1) It offers, sells, or renews a health care benefit plan in this state that complies with all of the requirements of the domiciliary state applicable to the plan;

(2) It is authorized to issue the plan in the state where it is domiciled and to transact business there; and

(3) It maintains a process to resolve disputes between it and a resident of this state pertaining to the health benefit plan.

2. Notwithstanding any other provision of law, a health benefit plan or health insurance policy offered, sold, or renewed in this state by a health carrier that satisfies the criteria of subsection 1 of this section is exempt from all other provisions of this chapter.

3. Notwithstanding any other law to the contrary, a health carrier that satisfies the criteria of subsection 1 of this section shall not be required to offer or provide state-mandated health benefits required by Missouri law or regulations in health benefit plans or health insurance policies sold to Missouri residents. For purposes of sections 376.1603 to 376.1615, the term "state-mandated health benefits" shall mean coverage for health care services or benefits, required by this chapter, state law or state regulations, requiring the reimbursement or utilization related to a specific illness, injury, or condition of the covered person, or inclusion of a specific category of licensed health care practitioner to be provided to the covered person in a health benefits plan for a health-related condition of a covered person. The term "state-mandated health benefits" shall not include any health care services or benefits which are mandated by federal law.

4. If a Missouri resident purchases or enrolls in a health insurance policy or health benefit plan that is lawfully sold, offered, or issued in another state, the policy or plan shall not be subject to the requirements of this chapter or its accompanying regulations, and the

health carrier, if not otherwise subject to the insurance laws and regulations of this state, shall not be subject to regulation under this chapter with regard to such policy or plan; except that, the health carrier shall be subject to regulation by the director with regard to enforcement of the contractual benefits under the policy or health benefit plan, including the requirements regarding the prompt payment of claims for benefits, pursuant to section 376.383, and the procedure for the denial of benefits, pursuant to sections 376.1350 to 376.1390.

376.1609. 1. Each written application for participation in a health benefit plan offered by a health carrier domiciled in another state shall contain the following language in boldface type at the beginning of the document:

"This policy is primarily governed by the laws of ..... (insert state where the master policy is filed); therefore, all of the rating laws applicable to policies filed in this state do not apply to this policy, which may result in increases in your premium at renewal that would not be permissible in a Missouri-approved policy. Any purchase of individual health insurance should be considered carefully since future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Missouri-approved policy, please consult your insurance agent or the Missouri Department of Insurance, Financial Institutions and Professional Registration.".

2. Each out-of-state health benefit plan shall contain the following language in boldface type at the beginning of the document:

"The benefits of this policy providing your coverage are governed primarily by the laws of a state other than Missouri. While this health benefit plan may provide you a more affordable health insurance policy, it may also provide fewer health benefits than those normally included as state mandated health benefits in policies in Missouri. Please consult your insurance agent to determine which state mandated health benefits are excluded under this policy.".

3. The director shall prepare a disclosure form prior to January 1, 2009, that is easily understood and that summarizes the benefits a health benefit plan is required to include under this chapter and regulations and the benefits that may be waived under section 376.1606. The applicant or the contractholder shall sign the disclosure

form, specifying the benefits he or she waives and indicating that the plan has explained the contents of the disclosure and that he or she understands them, before the health benefit plan may be issued, amended, or renewed without one or more of the state-mandated health benefits.

376.1612. The director shall be authorized to conduct market conduct and solvency examinations of all out-of-state companies seeking to offer health benefit plans in this state. Such examinations shall be conducted in the same manner and under the same terms and conditions as for companies located in this state.

376.1615. The director shall adopt rules and regulations necessary to implement and administer the provisions of sections 376.1603 to 376.1615. 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.

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.

660.750. 1. This act shall be known as the "Faith-Based Organization Liaison Act".

2. The director of the department of social services shall designate

existing regional department employees to serve as liaisons to faith-based organizations in their regions.

3. The director shall ensure that the primary function of each employee designated as a liaison under this section is to:

(1) Communicate with faith-based organizations regarding the need for private community services to benefit persons in need of assistance who otherwise would require financial or other assistance under public programs administered by the department;

(2) Promote the involvement of faith-based organizations in working to meet community needs for assistance;

(3) Coordinate the department's efforts to promote involvement of faith-based organizations in providing community services with similar efforts of other state agencies; and

(4) Provide clear guidance to faith-based organizations of all the rights and responsibilities afforded to them under federal law, including but not limited to federal equal treatment, charitable choice regulations, and the establishment clause of the United States Constitution.

4. No liaison shall discriminate against any faith-based organization in carrying out the provisions of this section.

5. The department shall solicit proposals from faith-based organizations on initiatives to educate citizens on the value of personal responsibility and wellness.

660.775. The department of social services shall work with the family and community trust board created under executive order 01-07, to support and expand local community coalitions working in the area of health and wellness promotion and with the goal of seeking appropriations for such expansion, not to exceed five hundred thousand dollars. The department shall promulgate rules to establish the criteria to ensure that measurable outcomes are achieved.

[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.**]**

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

[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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