SECOND REGULAR SESSION

[P E R F E C T E D**]**

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 1283

94TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR DEMPSEY.

Offered April 22, 2008.

Senate Substitute adopted, April 23, 2008.

Taken up for Perfection April 23, 2008. Bill declared Perfected and Ordered Printed, as amended.

TERRY L. SPIELER, Secretary.

5271S.09P

AN ACT

To repeal sections 33.103, 135.535, 135.562, 191.400, 192.014, 192.083, 195.070, 195.100, 208.145, 208.152, 208.215, 208.955, 334.104, 335.016, 376.811, 376.986, and 660.062, RSMo, and to enact in lieu thereof seventy-two new sections relating to the Missouri health transformation act of 2008, with penalty provisions.

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

Section A. Sections 33.103, 135.535, 135.562, 191.400, 192.014, 192.083, 195.070, 195.100, 208.145, 208.152, 208.215, 208.955, 334.104, 335.016, 376.811, 376.986, and 660.062, RSMo, are repealed and seventy-two new sections enacted in lieu thereof, to be known as sections 8.365, 26.850, 26.853, 26.856, 26.859, 26.900, 33.103, 103.185, 135.535, 135.562, 143.116, 167.182, 191.845, 191.1005, 191.1008, 191.1010, 191.1025, 191.1200, 191.1250, 191.1256, 191.1259, 191.1265, 191.1271, 192.083, 192.631, 192.990, 195.070, 195.100, 196.1200, 197.551, 197.554, 197.557, 197.563, 197.566, 197.572, 197.575, 197.578, 197.581, 197.584, 197.587, 197.588, 208.145, 208.149, 208.152, 208.207, 208.215, 208.955, 208.1300, 208.1303, 208.1306, 208.1309, 208.1312, 208.1315, 208.1318, 208.1321, 208.1324, 208.1327, 208.1330, 208.1333, 208.1336, 208.1345, 334.104, 335.016, 335.019, 376.025, 376.685, 376.811, 376.845, 376.986, 376.1600, 376.1618, and 1, to read as follows:

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

8.365. The office of administration, in consultation with the department of health and senior services, shall submit a report to the governor and general assembly by December 31, 2008, detailing the opportunities for the state to implement a minimum health promotion standard for construction of state buildings or substantial renovation of state buildings. The report shall provide recommendations for creating a voluntary work group of architects, builders, engineers or persons and interest groups with expertise in the field of public and environmental health for the purpose of advising the office of administration on the development of the health promotion standard that would outline architectural features designed to promote and encourage a healthier workforce and environment for those working and using the resources in state buildings. The report shall also include estimates of any additional costs or savings from incorporating such features.

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

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

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

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

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

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

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

(2) Director of the department of social services;

(3) Director of the department of mental health;

(4) Commissioner of education;

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

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

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

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

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

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

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

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

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

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

(7) Develop a health-based budget structure and nomenclature that includes all relevant departments, funding streams, and programs. The budget shall facilitate improved coordination and efficiency, explore options for and allow maximization of federal

financial participation, and implement the state's vision and strategic plan;

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

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

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

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

departments to prepare for the review required under this section.

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

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

33.103. 1. Whenever the employees of any state department, division or agency establish any voluntary retirement plan, or participate in any group hospital service plan, group life insurance plan, medical service plan or other such plan, or if they are members of an employee collective bargaining organization, or if they participate in a group plan for uniform rental, the commissioner of administration may deduct from such employees' compensation warrants the amount necessary for each employee's participation in the plan or collective bargaining dues, provided that such dues deductions shall be made only from those individuals agreeing to such deductions. Before such deductions are made, the person in charge of the department, division or agency shall file with the commissioner of administration an authorization showing the names of participating employees, the amount to be deducted from each such employee's compensation, and the agent authorized to receive the deducted amounts. The amount deducted shall be paid to the authorized agent in the amount of the total deductions by a warrant issued as provided by law.

2. The commissioner of administration may, in the same manner, deduct from any state employee's compensation warrant:

(1) Any amount authorized by the employee for the purchase of shares in a state employees' credit union in Missouri;

(2) Any amount authorized by the employee for contribution to a fund resulting from a united, joint community-wide solicitation or to a fund resulting from a nationwide solicitation by charities rendering services or otherwise fulfilling charitable purposes if the fund is administered in a manner requiring public accountability and public participation in policy decisions;

(3) Any amount authorized by the employee for the payment of dues in an employee association;

(4) Any amount determined to be owed by the employee to the state in accordance with guidelines established by the commissioner of administration

which shall include notice to the employee and an appeal process;

(5) Any amount voluntarily assigned by the employee for payment of child support obligations determined pursuant to chapter 452 or 454, RSMo; **[**and**]**

(6) Any amount authorized by the employee for contributions to any "qualified state tuition program" pursuant to Section 529 of the Internal Revenue Code of 1986, as amended, sponsored by the state of Missouri**; and**

(7) Any amount for cafeteria plan administrative fees under subdivision (4) of subsection 3 of this section.

3. The commissioner of administration may establish a cafeteria plan in accordance with Section 125 of Title 26 United States Code for state employees. The commissioner of administration must file a written plan document to be filed in accordance with chapter 536, RSMo. Employees must be furnished with a summary plan description one hundred twenty days prior to the effective date of the plan. In connection with such plans, the commissioner may:

(1) Include as an option in the plan any employee benefit, otherwise available to state employees, administered by a statutorily created retirement system;

(2) Provide and administer, or select companies on the basis of competitive bids or proposals to provide or administer, any group insurance, or other plan which may be included as part of a cafeteria plan, provided such plan is not duplicative of any other plan, otherwise available to state employees, administered by a statutorily created retirement system;

(3) Include as an option in the plan any other product eligible under Section 125 of Title 26 of the United States Code **the selection of which may be solicited by a vendor on site in state facilities**, subject to regulations promulgated by the office of administration, and including payment to the state by vendors providing those products for the cost of administering those deductions, as set by the office of administration; and

(4) Reduce each **[**participating**]** employee's compensation warrant by the amount necessary for each employee's participation in the cafeteria plan, **[**provided that such salary reduction shall be made only with respect to those individuals agreeing to such reduction**] except for those individual employees who affirmatively elect not to participate in the cafeteria plan**. No such reduction in salary for the purpose of participation in a cafeteria plan shall have the effect of reducing the compensation amount used in calculating the state employee's retirement benefit under a statutorily created

retirement system or reducing the compensation amount used in calculating the state employee's compensation or wages for purposes of any workers' compensation claim governed by chapter 287, RSMo.

4. Employees may authorize deductions as provided in this section in writing or by electronic enrollment.

103.185. Beginning January 1, 2010, 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. In order to keep state employees healthy and productive, any additional costs for preventive services provided under this section shall not be paid by the state employee.

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

taxpayer shall file an application for certification of the tax credits for the first year in which credits are claimed and for each of the two succeeding taxable years for which credits are claimed.

2. Employees of such facilities physically working and earning wages for that work within a distressed community whose employers have been approved for tax credits pursuant to subsection 1 of this section by the department of economic development for whom payroll taxes are paid shall also be eligible to receive a tax credit against individual income tax, imposed pursuant to chapter 143, RSMo, equal to one and one-half percent of their gross salary paid at such facility earned for each of the three years that the facility receives the tax credit provided by this section, so long as they were qualified employees of such entity. The employer shall calculate the amount of such credit and shall report the amount to the employee and the department of revenue.

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

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

5. An existing corporation, partnership or sole proprietorship that is located within a distressed community and that relocates employees from another

facility outside of the distressed community to its facility within the distressed community, and an existing business located within a distressed community that hires new employees for that facility may both be eligible for the tax credits allowed by subsections 1 and 3 of this section. To be eligible for such tax credits, such a business, during one of its tax years, shall employ within a distressed community at least twice as many employees as were employed at the beginning of that tax year. A business hiring employees shall have no more than one hundred employees before the addition of the new employees. This subsection shall only apply to a business which is a manufacturing, biomedical, medical devices, scientific research, animal research, computer software design or development, computer programming or telecommunications business, or a professional firm.

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

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

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

agreement covering employees at the facility, unless the affected collective bargaining unit concurs with the move.

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

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

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

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

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

(1) Constructing entrance or exit ramps;

(2) Widening exterior or interior doorways;

(3) Widening hallways;

(4) Installing handrails or grab bars;

(5) Moving electrical outlets and switches;

(6) Installing stairway lifts;

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

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

(9) Modifying bathrooms**; or**

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

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

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

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

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

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

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

143.116. 1. For all tax years beginning on or after January 1, 2009, an individual taxpayer shall be allowed a deduction from Missouri

adjusted gross income in the amount equal to one hundred percent of the premium paid by the taxpayer during the taxable year for high deductible health plans established and used with a health savings account under the applicable provisions of Section 223 of the Internal Revenue Code to the extent the amount is not deducted on the taxpayer's federal income tax return for that taxable year.

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

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

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

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

167.182. 1. Each parent or guardian of a female student enrolling in grade six shall be provided information regarding immunizations against the human papillomavirus in accordance with this section.

2. (1) Each public school district shall provide the names and addresses of all parents and guardians of female students who are entering grade six to the department of health and senior services and the department shall mail to such parent or guardian age appropriate information relating to the connection between human papillomavirus and cervical cancer, and that an immunization against the human papillomavirus infection is available.

(2) Such information shall include:

(a) The risk factors for developing cervical cancer, the symptoms of the disease, how it may be diagnosed and its possible consequences if untreated;

(b) The connection between human papillomavirus and cervical cancer, how human papillomavirus is transmitted, how transmission may be prevented, including abstinence as the best way to prevent sexually transmitted diseases, and the relative risk of contracting human papillomavirus for primary and secondary school students;

(c) The latest scientific information on the immunization against human papillomavirus infection and the immunization's effectiveness against causes of cervical cancer;

(d) That a pap smear is still critical for the detection of precancerous changes in the cervix to allow for treatment before cervical cancer develops; and

(e) A statement that any questions or concerns regarding immunizing the child against human papillomavirus could be answered by contacting a health care provider.

(3) Each informational mailing sent to the parents or guardian of female students who are entering grade six shall request that the parents or guardian of such students voluntarily furnish to the department not later than twenty school days after the first day of school a written statement, in a form prescribed by the department of health and senior services, stating that the parent has received the information required under this subsection and that:

(a) The student has received or is receiving the immunization; or

(b) The parent has decided not to have the student immunized. Such form to be returned voluntarily by the parent or guardian shall not request from the parent or guardian any identifying information of the female student or parent or guardian.

(4) The informational mailing shall have prominently displayed in bold type that the request from the parent or guardian for the written statement under subdivision (3) of this subsection is voluntary.

(5) Beginning July 1, 2009, the department shall submit to the general assembly a report detailing the number of sixth grade female students who have and have not been immunized against the human papillomavirus infection and the number of non-responses to the

request for the written statement under subdivision (3) of this subsection. The information derived from subdivision (3) of this subsection shall be used for statistical purposes only and shall not be used to personally identify any parent or guardian, or any student.

(6) Nothing in this subsection shall be construed to prevent a student from school attendance if such parent or guardian has opted not to have the student receive the human papillomavirus immunization or has not returned the statement prescribed in subdivision (3) of this subsection.

3. If a parent or guardian chooses to have the female student immunized for the human papillomavirus but is unable to pay, the student shall be immunized at public expense by a physician or nurse at or from the county, district, city public health center or a school nurse or by a nurse or physician in the private office or clinic of the child's personal physician with the costs of immunization paid through the Mo HealthNet program, private insurance or in a manner to be determined by the department of health and senior services subject to state and federal appropriations.

4. Funds for the administration of this section and for the purchase of vaccines for students of families unable to afford them shall be appropriated to the department of health and senior services from general revenue or from federal funds if available.

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.

191.845. 1. The department of social services shall issue a grant in the amount of three hundred and fifty thousand dollars to a local government entity or local health department to be used for the establishment of a study to assess the feasibility of pilot projects in the greater St. Charles area and southeast bootheel areas of the state, at

the same time. 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. The pilot projects shall have the involvement of the local community health coalition to establish new approaches to expand coverage for the uninsured population in the respective communities and to create healthier populations through a single comprehensive health care plan that is focused on both of the above-named areas of the state.

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

(1) Is established at the community level;

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

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

191.1005. 1. For purposes of this section, "insurer" includes the state of Missouri for purposes of the rendering of health care services by providers under a medical assistance program of the state.

2. Programs of insurers that publicly assess and compare the quality and cost efficiency of health care providers shall conform to the following criteria:

(1) The insurers shall retain, at their own expense, the services of a nationally-recognized independent health care quality standard-setting organization to review the plan's programs for consumers that measure, report, and tier providers based on their performance. Such review shall include a comparison to national standards and a report detailing the measures and methodologies used by the health plan. The scope of the review shall encompass all elements described in this section and section 191.1008;

(2) The program measures shall provide performance information that reflects consumers' health needs. Programs shall clearly describe the extent to which they encompass particular areas of care, including primary care and other areas of specialty care;

(3) Performance reporting for consumers shall include both

quality and cost efficiency information. While quality information may be reported in the absence of cost-efficiency, cost-efficiency information shall not be reported without accompanying quality information;

(4) When any individual measures or groups of measures are combined, the individual scores, proportionate weighting, and any other formula used to develop composite scores shall be disclosed. Such disclosure shall be done both when quality measures are combined and when quality and cost efficiency are combined;

(5) Consumers or consumer organizations shall be solicited to provide input on the program, including methods used to determine performance strata;

(6) A clearly defined process for receiving and resolving consumer complaints shall be a component of any program;

(7) Performance information presented to consumers shall include context, discussion of data limitations, and guidance on how to consider other factors in choosing a provider;

(8) Relevant providers and provider organizations shall be solicited to provide input on the program, including the methods used to determine performance strata;

(9) Providers shall be given reasonable prior notice before their individual performance information is publicly released;

(10) A clearly defined process for providers to request review of their own performance results and the opportunity to present information that supports what they believe to be inaccurate results, within a reasonable time frame, shall be a component of any program. Results determined to be inaccurate after the reconsideration process shall be corrected;

(11) Information about the comparative performance of providers shall be accessible and understandable to consumers and providers;

(12) Information about factors that might limit the usefulness of results shall be publicly disclosed;

(13) Measures used to assess provider performance and the methodology used to calculate scores or determine rankings shall be published and made readily available to the public. Some elements shall be assessed against national standards. Examples of measurement

elements that shall be assessed against national standards include: risk and severity adjustment, minimum observations, and statistical standards utilized. Examples of other measurement elements that shall be fully disclosed include: data used, how providers' patients are identified, measure specifications and methodologies, known limitations of the data, and how episodes are defined;

(14) The rationale and methodologies supporting the unit of analysis reported shall be clearly articulated, including a group practice model versus the individual provider;

(15) Sponsors of provider measurement and reporting shall work collaboratively to aggregate data whenever feasible to enhance its consistency, accuracy, and use. Sponsors of provider measurement and reporting shall also work collaboratively to align and harmonize measures used to promote consistency and reduce the burden of collection. The nature and scope of such efforts shall be publicly reported;

(16) The program shall be regularly evaluated to assess its effectiveness and any unintended consequences;

(17) Measures shall be based on national standards. The primary source shall be measures endorsed by the National Quality Forum (NQF). When non-NQF measures are used because NQF measures do not exist or are unduly burdensome, it shall be with the understanding that they will be replaced by comparable NQF-endorsed measures when available;

(18) Where NQF-endorsed measures do not exist, the next level of measures to be considered, to the extent practical, shall be those endorsed by the Ambulatory Care Quality Alliance, national accrediting organizations such as the National Committee for Quality Assurance, or the Joint Commission on the Accreditation of Healthcare Organizations and federal agencies;

(19) Supplemental measures are permitted if they address areas of measurement for which national standards do not yet exist or for which existing national standard measure requirements are unreasonably burdensome on providers or program sponsors. Supplemental measures may be used if they are part of a pilot program to assess the extent to which the measures could fill national gaps in measurement. When supplemental measures are used

they shall reasonably adhere to the NQF measure criteria, including importance, scientific acceptability, feasibility and usability, and may include sources such as provider specialty society guidelines. The director of the department of insurance, financial institutions and professional registration shall be authorized to adopt by administrative rule any updates or modifications to the most recent version of the Patient Charter for Physician Performance, Measurement, Reporting and Tiering Programs.

3. The use by insurers of programs to publicly assess and compare the quality and cost efficiency of health care providers under subsection 2 of this section shall not be a basis for a provider to decline to enter into a provider contract with an insurer. A provider shall not withhold or otherwise obstruct an insurer from using data collected from medical claims or other sources generated by the provider and in possession of the insurer for the purpose of providing plan enrollees, providers, or the public information on the quality and cost efficiency differences in treatments and providers as long as the data is not used in a manner that violates any provisions of the federal Health Insurance Portability and Accountability Act or antitrust law.

191.1008. 1. Any person who sells or otherwise distributes to the public health care quality and cost efficiency data for disclosure in comparative format to the public shall identify the measure source or evidence-based science behind the measure and the national consensus, multi-stakeholder, or other peer review process, if any, used to confirm the validity of the data and its analysis as an objective indicator of health care quality.

2. Articles or research studies on the topic of health care quality or cost efficiency that are published in peer-reviewed academic journals that do not receive funding from or is affiliated with a health care insurer or by state or local government shall be exempt from the requirements of subsection 1 of this section.

3. (1) Upon receipt of a complaint of an alleged violation of this section by a person or entity other than a health carrier, the department of health and senior services shall investigate the complaint and, upon finding that a violation has occurred, shall be authorized to impose a penalty in an amount not to exceed one thousand dollars. The department shall promulgate rules governing its

processes for conducting such investigations and levying fines authorized by law.

(2) 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.

191.1010. All alleged violations of sections 191.1005 to 191.1008 by a health insurer shall be investigated and enforced by the department of insurance, financial institutions and professional registration under the department's powers and responsibilities to enforce the insurance laws of this state in accordance with chapter 374, RSMo.

191.1025. 1. The department of health and senior services shall develop the Missouri healthy workplace recognition program for the purpose of granting official state recognition to employers with more than fifty employees for excellence in promoting health, wellness, and prevention. The criteria for awarding such recognition shall be developed by the department but at a minimum shall include an examination of whether the employer offers:

(1) Workplace wellness programs;

(2) Incentives for healthier lifestyles;

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

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

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

3. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section

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

191.1200. 1. The general assembly shall appropriate four hundred thousand dollars from the health care technology fund created in section 208.975, RSMo, to the department of social services for the purpose of awarding a grant to implement an Internet web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room. The grantee shall establish a program that diverts patients presenting at an emergency room for nonemergency care to more appropriate outpatient settings as is consistent with federal law and regulations. The program shall refer the patient to an appropriate health care professional based on the patient's health care needs and situation. The program shall provide the patient with a scheduled appointment that is timely, with an appropriate provider who is conveniently located. If the patient is uninsured and potentially eligible for MO HealthNet, the program shall connect the patient to a primary care provider, community clinic, or agency that can assist the patient with the application process. The program shall also ensure that discharged patients are connected with a community-based primary care provider and assist in scheduling any necessary follow-up visits before the patient is discharged.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) A licensed inpatient center;

(b) An ambulatory surgical center;

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

(d) A skilled nursing facility;

(e) A residential treatment facility;

(f) A home health agency;

(g) A diagnostic laboratory or imaging center;

(h) An assisted living facility;

(i) A school-based health program;

(j) A mobile clinic;

(k) A mental health clinic;

(l) A rehabilitation or other therapeutic health setting;

(m) The patient's residence;

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

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

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

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

191.1256. Sections 191.1250 to 191.1277 do not:

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

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

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

191.1265. Only telehealth practitioners qualified under sections 191.1250 to 191.1277 may practice telehealth care in this state. Telehealth practitioners may reside outside this state but shall be licensed by an appropriate board within the division of professional registration. Beginning July 1, 2009, all health carriers, as defined under section 376.1350, RSMo, shall reimburse services provided through telehealth in the same manner they would reimburse a standard office visit or consultation by the provider or specialist. The

department of social services shall promulgate rules for the MO HealthNet program consistent with the provisions of this section.

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.

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

(1) Address new issues related to minority health;

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

(3) Develop health education programs specifically for minorities;

(4) Promote constituency development;

(5) Coordinate programs provided by other agencies;

(6) Develop culturally sensitive health education materials;

(7) Seek extramural funding for programs;

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

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

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

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

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

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

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

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

(16) Analyze federal and state legislation for its impact on the health status of minorities;

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

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

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

192.631. 1. Subject to appropriations, by July 1, 2009, the department of health and senior services shall establish a school-based influenza vaccination pilot program. Participation in the program shall be voluntary on the part of the school district and shall be administered with the consent of the student's parents or legal guardian. When creating the program, the department shall also take into account:

(1) The costs and benefits of establishing a school-based influenza vaccination pilot program;

(2) The barriers to implementing the proposed pilot program; and

(3) The fiscal impact to the state of such program.

2. The department shall work to increase influenza vaccination awareness and participation among parents of children aged six months to five years in child care facilities. The official website of the department shall have information on the benefits of annual vaccination against influenza for children and its programs offered for the children. The department shall cooperate with the department of

social services and department of elementary and secondary education in order to distribute the information to the parents and child care facilities effectively in August or September in every year.

3. The department shall promulgate rules for the implementation of the pilot program created under 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.

4. 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.

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

clinics. Grant support will be limited to capacity building projects for existing clinics. No more than three percent of the funds shall be used by the association for administration of the funds.

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

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

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

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

195.070. 1. A physician, podiatrist, dentist, or a registered optometrist certified to administer pharmaceutical agents as provided in section 336.220, RSMo, in good faith and in the course of his or her professional practice only, may prescribe, administer, and dispense controlled substances or he or she may cause the same to be administered or dispensed by an individual as authorized by

statute.

2. **An advanced practice registered nurse, as defined in section 335.016, RSMo, who holds a certificate of controlled substance prescriptive authority from the board of nursing under section 335.019, RSMo, and who is delegated the authority to prescribe controlled substances under a collaborative practice arrangement under section 334.104, RSMo, may prescribe any controlled substances listed in Schedules III, IV, and V of section 195.017. However, no such certified advanced practice registered nurse shall prescribe controlled substance for his or her own self or family.**

3. A veterinarian, in good faith and in the course of his professional practice only, and not for use by a human being, may prescribe, administer, and dispense controlled substances and he may cause them to be administered by an assistant or orderly under his direction and supervision.

[3.**]** **4.** A practitioner shall not accept any portion of a controlled substance unused by a patient, for any reason, if such practitioner did not originally dispense the drug.

[4.**]** **5.** An individual practitioner may not prescribe or dispense a controlled substance for such practitioner's personal use except in a medical emergency.

195.100. 1. It shall be unlawful to distribute any controlled substance in a commercial container unless such container bears a label containing an identifying symbol for such substance in accordance with federal laws.

2. It shall be unlawful for any manufacturer of any controlled substance to distribute such substance unless the labeling thereof conforms to the requirements of federal law and contains the identifying symbol required in subsection 1 of this section.

3. The label of a controlled substance in Schedule II, III or IV shall, when dispensed to or for a patient, contain a clear, concise warning that it is a criminal offense to transfer such narcotic or dangerous drug to any person other than the patient.

4. Whenever a manufacturer sells or dispenses a controlled substance and whenever a wholesaler sells or dispenses a controlled substance in a package prepared by him, he shall securely affix to each package in which that drug is contained, a label showing in legible English the name and address of the vendor and the quantity, kind, and form of controlled substance contained therein. No

person except a pharmacist for the purpose of filling a prescription under sections 195.005 to 195.425, shall alter, deface, or remove any label so affixed.

5. Whenever a pharmacist or practitioner sells or dispenses any controlled substance on a prescription issued by a physician, dentist, podiatrist **[**or**],** veterinarian, **or advanced practice registered nurse,** he shall affix to the container in which such drug is sold or dispensed, a label showing his own name and address of the pharmacy or practitioner for whom he is lawfully acting; the name of the patient or, if the patient is an animal, the name of the owner of the animal and the species of the animal; the name of the physician, dentist, podiatrist **[**or**], advanced practice registered nurse, or** veterinarian by whom the prescription was written; **the name of the collaborating physician if the prescription is written by an advanced practice registered nurse,** and such directions as may be stated on the prescription. No person shall alter, deface, or remove any label so affixed.

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

2. Moneys in the tobacco use prevention and cessation trust fund shall be used strategically, in cooperation with other governmental and not-for-profit entities, for a comprehensive tobacco control program for the purpose of tobacco prevention and cessation. At least twenty-five percent of the moneys from the fund shall be used for youth smoking prevention programs modeled upon evidence-based programs proven to reduce youth smoking in one or more jurisdictions within the United States.

3. Moneys shall be allocated consistently with the Center for

Disease Control and Prevention, or it successor agency's, best practices and guidelines for state tobacco control programs and as determined by the department of health and senior services.

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

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

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

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

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

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

(b) Meets the statutory and regulatory criteria for certification as a patient safety organization under the federal Patient Safety and

Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended, and regulations promulgated thereunder;

(c) Has a governing board or advisory committee that includes representatives of hospitals, physicians, an employer or group representing employers, an insurance company or group representing insurance companies, the long-term care industry, and a federally recognized quality improvement organization that contracts with the federal government to review medical necessity and quality assurance in the Medicare program;

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

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

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

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

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

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

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

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

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

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

(5) "Provider", as defined in federal regulations promulgated to

implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended;

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

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

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

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

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

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

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

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

197.554. 1. Effective six months after the effective date of initial federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., a hospital shall report each reportable incident to a patient safety organization. The hospital's initial report of the incident shall be submitted to the patient safety organization no later than the close of business on the next business day following discovery of the

incident. The initial report shall include a description of immediate actions to be taken by the hospital to minimize the risk of harm to patients and prevent a reoccurrence and verification that the hospital's patient safety and performance improvement review processes are responding to the reportable incident. The hospital shall, within forty-five days after the incident occurs, submit a completed root cause analysis and a reportable incident prevention plan to the patient safety organization.

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

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

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

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

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

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

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

(b) Health care facility accreditation agencies.

2. Nothing in sections 197.551 to 197.566 shall modify the duty of

a hospital to report disciplinary actions or medical malpractice actions against a health care professional under law.

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

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

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

prevent a person from testifying to or reporting information obtained independently of the activities of a patient safety organization or which is public information.

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

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

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

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

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

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

197.587. Any provider furnishing services to a patient safety organization shall not be liable for civil damages as a result of such

ads, omissions, decisions, or other such conduct in connection with the lawful duties on behalf of a patient safety organization, except for acts, omissions, decisions, or conduct done with actual malice, fraudulent intent, or bad faith.

197.588. This section shall apply to any hospital that reports a reportable incident under section 197.554. A claim for payment filed by a hospital for health care services related to a reportable incident shall not be subject to sections 375.1000 or 375.383, RSMo.

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

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

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

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

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

208.149. The professional services payment committee created by

section 208.197 shall review and make recommendations to the MO HealthNet division regarding standards and policies for denying or withholding payment to a health care provider for treatment costs associated with preventable errors, injuries and infections occurring under that provider's care. The recommendations shall include a list of medical incidents proposed to be included in the payment prohibition, which shall include those incidents for which the federal Centers for Medicare and Medicaid Services will not make payment under the Medicare program or all or some serious reportable events in health care as defined in section 197.551, RSMo. Such recommendations shall be completed and issued by the committee to the division by December 31, 2008, or six months after the committee is appointed with the advice and consent of the senate, whichever occurs later. After reviewing the recommendations of the committee, the MO HealthNet division may promulgate regulations pursuant to chapter 536, RSMo, to implement such payment restrictions.

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

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

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

division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

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

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

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

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

(8) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

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

(10) Home health care services;

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

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

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

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

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

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

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals

in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

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

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

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

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

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

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

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

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

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

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

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

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

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

(20) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must 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 utilizing the expertise of brain injury rehabilitation service providers and the Missouri head injury advisory council created under section 192.745, RSMo. Such services shall be provided in a community-based facility and be authorized on tier levels based on the services the patient requires and the frequency of the services as guided by a qualified rehabilitation professional associated with a health care home. 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, 2008, shall be invalid and void;

[(20)**]** **(21)** 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)**]** **(22)** 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)**]** **(23)** 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)**]** **(24)** 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.

208.207. The MO HealthNet program shall not require a pharmacist filling any prescription for any drug that has been prescribed as an immunosuppressant that denotes that the drug is from a specific manufacturer, be it generic or name brand, to be interchanged from another manufacturer other than the one specified in the prescription, unless the MO HealthNet participant is notified of the interchange, in writing or verbally, upon the delivery of the prescription. If such drug is interchanged with notice to the MO HealthNet participant, the pharmacist who fills such prescription shall also notify the prescribing health care professional before the delivery of the prescription, unless authorized to make such interchange under subdivisions (1) and (2) of subsection 2 of section 338.056, RSMo. This requirement shall not apply to prescriptions dispensed for inpatients

of a hospital, nursing home, assisted living facility, or inpatients of a mental health or residential facility. For purposes of this section, "immunosuppressive drug" means a drug that is used in immunosuppressive therapy to inhibit or prevent activity of the immune system, and is used to prevent the rejection of transplanted organs and tissues. Immunosuppressive drugs shall not include drugs for the treatment of autoimmune disease or diseases that most likely are of autoimmune origin.

208.215. 1. MO HealthNet is payer of last resort unless otherwise specified by law. When any person, corporation, institution, public agency or private agency is liable, either pursuant to contract or otherwise, to a participant receiving public assistance on account of personal injury to or disability or disease or benefits arising from a health insurance plan to which the participant may be entitled, payments made by the department of social services or MO HealthNet division shall be a debt due the state and recoverable from the liable party or participant for all payments made in behalf of the participant and the debt due the state shall not exceed the payments made from MO HealthNet benefits provided under sections 208.151 to 208.158 and section 208.162 and section 208.204 on behalf of the participant, minor or estate for payments on account of the injury, disease, or disability or benefits arising from a health insurance program to which the participant may be entitled. **Any health benefit plan as defined in section 376.1350, RSMo, third party administrator, administrative service organization, and pharmacy benefits manager, shall process and pay all properly submitted medical assistance subrogation claims or MO HealthNet subrogation claims for a period of three years from the date the services were provided or rendered, regardless of any other timely filing requirement otherwise imposed by such entity and the entity shall not deny such claims on the basis of the type or format of the claim form, or a failure to present proper documentation of coverage at the point of sale.**

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

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

4. Every applicant or participant by application assigns his right to the department of social services or MO HealthNet division of any funds recovered or expected to be recovered to the extent provided for in this section. All applicants and participants, including a person authorized by the probate code, shall cooperate with the department of social services, MO HealthNet division in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services available under the state's plan for MO HealthNet benefits as provided in sections 208.151 to 208.159 and sections 208.162 and 208.204. All applicants and participants shall cooperate with the agency in obtaining third-party resources due to the applicant, participant, or child for whom assistance is claimed. Failure to cooperate without good cause as determined by the department of social services, MO HealthNet division in accordance with federally prescribed standards shall render the applicant or participant ineligible for MO HealthNet benefits under sections 208.151 to 208.159 and sections 208.162 and 208.204. A recipient who has notice or who has actual knowledge of the department's rights to third-party benefits who receives any third-party benefit or proceeds for a covered illness or injury is either required to pay the division within sixty days after receipt of settlement proceeds the full amount of the third-party benefits up to the total MO HealthNet benefits provided or to place the full amount of the third-party benefits in a trust account for the benefit of the division pending judicial or administrative determination of the division's right to third-party benefits.

5. Every person, corporation or partnership who acts for or on behalf of a person who is or was eligible for MO HealthNet benefits under sections 208.151 to 208.159 and sections 208.162 and 208.204 for purposes of pursuing the applicant's or participant's claim which accrued as a result of a nonoccupational or nonwork-related incident or occurrence resulting in the payment of MO

HealthNet benefits shall notify the MO HealthNet division upon agreeing to assist such person and further shall notify the MO HealthNet division of any institution of a proceeding, settlement or the results of the pursuit of the claim and give thirty days' notice before any judgment, award, or settlement may be satisfied in any action or any claim by the applicant or participant to recover damages for such injuries, disease, or disability, or benefits arising from a health insurance program to which the participant may be entitled.

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

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

8. The department of social services or MO HealthNet division shall have a lien upon any moneys to be paid by any insurance company or similar business enterprise, person, corporation, institution, public agency or private agency in settlement or satisfaction of a judgment on any claim for injuries or disability or disease benefits arising from a health insurance program to which the participant may be entitled which resulted in medical expenses for which the department or

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

9. On petition filed by the department, or by the participant, or by the defendant, the court, on written notice of all interested parties, may adjudicate the rights of the parties and enforce the charge. The court may approve the settlement of any claim, demand or cause of action either before or after a verdict, and nothing in this section shall be construed as requiring the actual trial or final adjudication of any claim, demand or cause of action upon which the department has charge. The court may determine what portion of the recovery shall be paid to the department against the recovery. In making this determination the court shall conduct an evidentiary hearing and shall consider competent evidence pertaining to the following matters:

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

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

(3) The total hospital, doctor and other medical expenses incurred for care and treatment of the injury to the date of recovery therefor, the portion of such

expenses theretofore paid by the participant, by insurance provided by the participant, and by the department, and the amount of such previously incurred expenses which remain unpaid at the time of recovery and by whom such incurred, unpaid expenses are to be paid;

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

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

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

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

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

12. Whenever the department of social services or MO HealthNet division has a statutory charge under this section against a recovery for damages incurred

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

13. This section shall be inapplicable to any claim, demand or cause of action arising under the workers' compensation act, chapter 287, RSMo. From funds recovered pursuant to this section the federal government shall be paid a portion thereof equal to the proportionate part originally provided by the federal government to pay for MO HealthNet benefits to the participant or minor involved. The department or MO HealthNet division shall enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation on permanently institutionalized individuals. The department or MO HealthNet division shall have the right to enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation on all other institutionalized individuals. For the purposes of this subsection, "permanently institutionalized individuals" includes those people who the department or MO HealthNet division determines cannot reasonably be expected to be discharged and return home, and "property" includes the homestead and all other personal and real property in which the participant has sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than the fair market value within thirty months prior to the participant's entering the nursing facility. The following provisions shall apply to such liens:

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

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

of deeds the fees set for similar filings in connection with the filing of a lien and any other necessary documents;

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

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

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

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

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

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

(a) The spouse of such individual;

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

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

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

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

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

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

17. If a person fails to comply with the provision of any judicial or administrative decree or temporary order requiring that person to maintain medical insurance on or be responsible for medical expenses for a dependent child, spouse, or ex-spouse, in addition to other remedies available, that person shall be liable to the state for the entire cost of the medical care provided pursuant to eligibility under any public assistance program on behalf of that dependent child, spouse, or ex-spouse during the period for which the required medical care was provided. Where a duty of support exists and no judicial or administrative decree or temporary order for support has been entered, the person owing the duty of support shall be liable to the state for the entire cost of the medical care provided on behalf of the dependent child or spouse to whom the duty of support is owed.

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

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

(2) Total funds available for settlement; and

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

208.955. 1. There is hereby established in the department of social

services the "MO HealthNet Oversight Committee", which shall be appointed by January 1, 2008, and shall consist of **[**eighteen**]** **twenty-nine** 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**]** **Four** physicians, **two each from rural and urban areas,** licensed under chapter 334, RSMo, **board certified in their specialty,** 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**]** **One optometrist, licensed under chapter 336, RSMo, who cares for participants. The optometrist shall be recommended by any Missouri organization or association that represents a significant number of optometrists licensed in this state;**

(6) One nurse, licensed or registered under chapter 335, RSMo, who cares for participants. The nurse shall be recommended by any Missouri organization or association that represents a significant number of nurses in this state;

(7) One mental health professional who cares for participants. The mental health professional shall be either a licensed psychologist, licensed professional counselor, or a licensed social worker and shall be recommended by any Missouri organization or association that represents a significant number of mental health professionals in this state;

(8) One representative from a rural health clinic;

(9) One representative of a not-for-profit health network serving rural counties and providing both patient-based and provider member services;

(10) One representative of a long-term care facility licensed in this state;

[(6)**]** **(11)** One representative of the state hospital association;

[(7)**]** **(12)** One nonphysician health care professional who cares for participants, recommended by the director of the department of insurance, financial institutions and professional registration;

[(8)**]** **(13)** 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)**]** **(14)** **[**Two**]** **Three** patient advocates **with one advocate representing children, one the disabled, and one the elderly community**;

(15) One member representing a federally qualified health center;

(16) One representative from the durable medical equipment industry, who owns or manages a durable medical equipment company operating in Missouri for at least three years, with multiple lines of products and services for participants. The representative shall be in good standing with the federal Medicare program and the MO HealthNet program;

(17) One physical therapist, licensed under chapter 334, RSMo, who cares for participants. The physical therapist shall be recommended by any Missouri organization or association that represents a significant number of physical therapists licensed in this state;

(18) One member representing a managed care organization under the MO HealthNet program, as defined in section 208.431;

[(10)**]** **(19)** One public member; and

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

2. The members of the oversight committee, other than the members from the general assembly and ex-officio members, shall be appointed by the governor with the advice and consent of the senate. A chair of the oversight committee shall be selected by the members of the oversight committee. Of the members first appointed to the oversight committee by the governor, eight members shall

serve a term of two years, seven members shall serve a term of one year, and thereafter, members shall serve a term of two years. Members shall continue to serve until their successor is duly appointed and qualified. Any vacancy on the oversight committee shall be filled in the same manner as the original appointment. Members shall serve on the oversight committee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of social services for that purpose. The department of social services shall provide technical, actuarial, and administrative support services as required by the oversight committee. The oversight committee shall:

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

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

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

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

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

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

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

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

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

annually, beginning January 1, 2009;

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

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

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

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

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

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

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

4. **[**The oversight committee shall designate a subcommittee devoted to advising the department on the development of**] Beginning August 28, 2008, the chairperson of the MO HealthNet oversight committee shall be a member of the health policy council established under section 26.859, RSMo.**

5. Beginning August 28, 2008, the chairperson of the subcommittee on a comprehensive entry point system for long-term care shall be a member of the health policy council under section 26.859, RSMo. The subcommittee on a comprehensive entry point system for long-term care **[**that**]** shall:

(1) Offer Missourians an array of choices including community-based,

in-home, residential and institutional services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

facility-based health and social services as well as access appropriate services to meet individual needs and preferences from the provider of the consumer's choice;

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

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

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

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

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

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

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

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

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

208.1303. 1. Subject to appropriations, the "Insure Missouri" plan is hereby established.

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

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

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

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

are eligible for participation in the plan.

6. The 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 as defined in rules promulgated by the department of social services.

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

(1) Mental health care services;

(2) Inpatient hospital services;

(3) Prescription drug coverage;

(4) Emergency room services;

(5) Physician and advanced practice nurse services;

(6) Diagnostic services;

(7) Outpatient services;

(8) Home health services;

(9) Urgent care center services;

(10) Preventive care services;

(11) Family planning services:

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

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

(12) Hospice services;

(13) Substance abuse services;

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

(15) Durable medical equipment;

(16) Emergency transportation services;

(17) Personal care services;

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

(19) Therapy services including physical, occupational, and speech therapy.

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, subject to appropriations, provide to an individual who participates in the plan a list of health care services that qualify as preventive care services for the age, gender, and preexisting conditions of the individual. The plan shall consult with the federal U.S. Preventive Services Task Force for a list of recommended preventive care services.

2. The plan shall, at no cost to the individual, provide payment for at least five hundred dollars of qualifying preventive care services per year for an individual who is eligible based on subdivision (2) of subsection 1 of section 208.1318. Any additional preventive care services covered under the plan and received by an individual who is eligible based on subdivision (2) of subsection 1 of section 208.1318 are subject to the deductible and payment requirements of the plan.

208.1312. Under no circumstances shall less than ninety-three percent of the funds appropriated by the general assembly for the plan be used to fund payment for health care services.

208.1315. The plan is not an entitlement program for individuals eligible based on the requirements of subdivision (2) of subsection 1 of section 208.1318. The maximum enrollment of individuals who may participate in the plan is dependent on funding appropriated for the plan by the general assembly. Eligibility for the plan may be phased in incrementally on the basis of actions taken by the general assembly in the appropriations process.

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

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

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

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

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

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

(d) The individual does not have access to health insurance coverage through the individual's employer. For the purposes of this section "access to health insurance coverage" means that the individual's employer-provided health insurance requires the payment of a premium not exceeding the amount set by subdivision (1) of subsection 1 of section 208.640 for individuals with incomes below one hundred eighty-five percent of the federal poverty level and the amount set by subdivision (2) of subsection 1 of section 208.640 for individuals with incomes one hundred eighty-five percent of the federal poverty level and above. The department may enroll the individual in the health insurance premium payment program if it is more cost beneficial to the insure Missouri program and as allowed by the centers for Medicare and Medicaid services;

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

(f) The individual has household earned income above the temporary assistance for needy families limit; and

(g) The individual does not have household unearned 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, unless she does not qualify by reason of income for MO HealthNet for pregnant women.

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

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

(1) The individual;

(2) An employer;

(3) The state;

(4) Any philanthropic or charitable contributor.

2. The minimum funding amount for a health care account is the amount required under section 208.1324.

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

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

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

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

(3) Another method determined by the division.

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

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

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

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

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

(a) One thousand dollars in the first year adjusted annually each year thereafter by the federal consumer price index, less any amounts paid by the household 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 of the federal poverty level;

(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 of the federal poverty level;

(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 of the federal poverty level;

(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 poverty level; or

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

3. In no case shall the combined household contribution to the health care account and other deductible or co-pay exceed five percent of the annual household income.

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

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

6. After termination from the plan under subsection 5 of this section, the individual may reapply to participate in the plan.

7. The deductible that is required of individuals eligible for the plan based on subdivision (2) of subsection 1 of section 208.1318 shall not be greater than the amount in their health savings account. The plan shall cover any necessary health services if the individual has made the required contribution to the individual's health savings account.

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

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

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

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

208.1330. 1. An insurer or health maintenance organization that contracts with the MO HealthNet division to provide health insurance

coverage to an individual that participates in the plan:

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

(2) Is responsible for provider reimbursement;

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

(4) Shall not charge a deductible exceeding one thousand dollars in the first year of the plan or the amount each year thereafter, as adjusted by the consumer price index.

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 shall not provide funding for health insurance coverage received under this section.

208.1336. The MO HealthNet division 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, provided that any reduction of disproportionate share hospital funds applied to the cost of the program as required by such waiver shall not be disproportionate to the impact the program has on Missouri's low income uninsured.

334.104. 1. A physician may enter into collaborative practice arrangements with registered professional nurses. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which shall be in writing, may delegate to a registered professional nurse the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the registered professional nurse and is consistent with that nurse's skill, training and competence.

2. Collaborative practice arrangements, which shall be in writing, may delegate to a registered professional nurse the authority to administer, dispense or prescribe drugs and provide treatment if the registered professional nurse is an advanced practice nurse as defined in subdivision (2) of section 335.016, RSMo. **Collaborative practice arrangements may delegate to an advanced practice registered nurse, as defined in section 335.016, RSMo, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017, RSMo.** Such collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols or standing orders for the delivery of health care services.

3. **The written collaborative practice arrangement shall contain at least the following provisions:**

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the advanced practice registered nurse;

(2) A list of all other offices or locations besides those listed in subdivision (1) of this subsection where the collaborating physician authorized the advanced practice registered nurse to prescribe;

(3) A requirement that there shall be posted at every office where the advanced practice registered nurse is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by an advanced practice registered nurse and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the advanced practice registered nurse;

(5) The manner of collaboration between the collaborating physician and the advanced practice registered nurse, including how the collaborating physician and the advanced practice registered nurse will:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(6) A description of the advanced practice registered nurse's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the nurse to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(7) A list of all other written practice agreements of the collaborating physician and the advanced practice registered nurse;

(8) The duration of the written practice agreement between the collaborating physician and the advanced practice registered nurse; and

(9) A description of the time and manner of the collaborating physician's review of the advanced practice registered nurse's

prescribing practices. The description shall include provisions that the advanced practice registered nurse shall submit documentation of the advanced practice registered nurse's prescribing practices to the collaborating physician within fourteen days. The documentation shall include, but not be limited to, a random sample review by the collaborating physician of at least twenty percent of the charts and medications prescribed.

4. The state board of registration for the healing arts pursuant to section 334.125 and the board of nursing pursuant to section 335.036, RSMo, may jointly promulgate rules regulating the use of collaborative practice arrangements. Such rules shall be limited to specifying geographic areas to be covered, the methods of treatment that may be covered by collaborative practice arrangements and the requirements for review of services provided pursuant to collaborative practice arrangements **including delegating authority to prescribe controlled substances**. Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither the state board of registration for the healing arts nor the board of nursing may separately promulgate rules relating to collaborative practice arrangements. Such jointly promulgated rules shall be consistent with guidelines for federally funded clinics. The rulemaking authority granted in this subsection shall not extend to collaborative practice arrangements of hospital employees providing inpatient care within hospitals as defined pursuant to chapter 197, RSMo.

[4.**]** **5.** The state board of registration for the healing arts shall not deny, revoke, suspend or otherwise take disciplinary action against a physician for health care services delegated to a registered professional nurse provided the provisions of this section and the rules promulgated thereunder are satisfied. Upon the written request of a physician subject to a disciplinary action imposed as a result of an agreement between a physician and a registered professional nurse or registered physician assistant, whether written or not, prior to August 28, 1993, all records of such disciplinary licensure action and all records pertaining to the filing, investigation or review of an alleged violation of this chapter incurred as a result of such an agreement shall be removed from the records of the state board of registration for the healing arts and the division of

professional registration and shall not be disclosed to any public or private entity seeking such information from the board or the division. The state board of registration for the healing arts shall take action to correct reports of alleged violations and disciplinary actions as described in this section which have been submitted to the National Practitioner Data Bank. In subsequent applications or representations relating to his medical practice, a physician completing forms or documents shall not be required to report any actions of the state board of registration for the healing arts for which the records are subject to removal under this section.

[5.**]** **6.** Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice agreement**, including collaborative practice agreements delegating the authority to prescribe controlled substances,** or physician assistant agreement and also report to the board the name of each licensed professional with whom the physician has entered into such agreement. The board may make this information available to the public. The board shall track the reported information and may routinely conduct random reviews of such agreements to ensure that agreements are carried out for compliance under this chapter.

[6.**]** **7.** Notwithstanding anything to the contrary in this section, a registered nurse who has graduated from a school of nurse anesthesia accredited by the Council on Accreditation of Educational Programs of Nurse Anesthesia or its predecessor and has been certified or is eligible for certification as a nurse anesthetist by the Council on Certification of Nurse Anesthetists shall be permitted to provide anesthesia services without a collaborative practice arrangement provided that he or she is under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed.

8. A collaborating physician shall not enter into a collaborative practice arrangement with more than three full-time equivalent advanced practice registered nurses. This limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197, RSMo.

9. It is the responsibility of the collaborating physician to determine and document the completion of at least a one-month period of time during which the advanced practice registered nurse shall

practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present.

10. No agreement made under this section shall supersede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital as defined in section 197.020, RSMo, if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

11. No contract or other agreement shall require a physician to act as a collaborating physician for an advanced practice registered nurse against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular advanced practice registered nurse. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any advanced practice registered nurse, but this requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by hospital's medical staff.

12. No contract or other agreement shall require any advanced practice registered nurse to serve as a collaborating advanced practice registered nurse for any collaborating physician against the advanced practice registered nurse's will. An advanced practice registered nurse shall have the right to refuse to collaborate, without penalty, with a particular physician.

335.016. As used in this chapter, unless the context clearly requires otherwise, the following words and terms mean:

(1) "Accredited", the official authorization or status granted by an agency for a program through a voluntary process;

(2) "Advanced practice **registered** nurse", a nurse who has **[**had**]** education beyond the basic nursing education and is certified by a nationally recognized professional organization **[**as having a nursing specialty, or who meets criteria for advanced practice nurses established by the board of nursing. The board of nursing may promulgate rules specifying which professional nursing organization certifications are to be recognized as advanced practice nurses, and

may set standards for education, training and experience required for those without such specialty certification to become advanced practice nurses**] as a certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or a certified clinical nurse specialist. The board shall promulgate rules specifying which nationally recognized professional organization certifications are to be recognized for the purposes of this section**. Advanced practice nurses and only such individuals may use the title "Advanced Practice Registered Nurse" and the abbreviation "APRN";

(3) "Approval", official recognition of nursing education programs which meet standards established by the board of nursing;

(4) "Board" or "state board", the state board of nursing;

(5) "Certified nurse practitioner", a registered nurse who is currently certified as a nurse practitioner by a nationally recognized certifying body approved by the board of nursing;

(6) "Certified clinical nurse specialist", a registered nurse who is currently certified as a clinical nurse specialist by a nationally recognized certifying board approved by the board of nursing;

(7) "Certified nurse midwife", a registered nurse who is currently certified as a nurse midwife by the American College of Nurse Midwives, or other nationally recognized certifying body approved by the board of nursing;

(8) "Certified registered nurse anesthetist", a registered nurse who is currently certified as a nurse anesthetist by the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or other nationally recognized certifying body approved by the board of nursing;

[(5)**] (9)** "Executive director", a qualified individual employed by the board as executive secretary or otherwise to administer the provisions of this chapter under the board's direction. Such person employed as executive director shall not be a member of the board;

[(6)**] (10)** "Inactive nurse", as defined by rule pursuant to section 335.061;

[(7)**] (11)** "Lapsed license status", as defined by rule under section 335.061;

[(8)**] (12)** "Licensed practical nurse" or "practical nurse", a person

licensed pursuant to the provisions of this chapter to engage in the practice of practical nursing;

[(9)**] (13)** "Licensure", the issuing of a license to practice professional or practical nursing to candidates who have met the specified requirements and the recording of the names of those persons as holders of a license to practice professional or practical nursing;

[(10)**] (14)** "Practical nursing", the performance for compensation of selected acts for the promotion of health and in the care of persons who are ill, injured, or experiencing alterations in normal health processes. Such performance requires substantial specialized skill, judgment and knowledge. All such nursing care shall be given under the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse. For the purposes of this chapter, the term "direction" shall mean guidance or supervision provided by a person licensed by a state regulatory board to prescribe medications and treatments or a registered professional nurse, including, but not limited to, oral, written, or otherwise communicated orders or directives for patient care. When practical nursing care is delivered pursuant to the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse, such care may be delivered by a licensed practical nurse without direct physical oversight;

[(11)**] (15)** "Professional nursing", the performance for compensation of any act which requires substantial specialized education, judgment and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences, including, but not limited to:

(a) Responsibility for the teaching of health care and the prevention of illness to the patient and his or her family;

(b) Assessment, nursing diagnosis, nursing care, and counsel of persons who are ill, injured or experiencing alterations in normal health processes;

(c) The administration of medications and treatments as prescribed by a person licensed by a state regulatory board to prescribe medications and treatments;

(d) The coordination and assistance in the delivery of a plan of health care with all members of a health team;

(e) The teaching and supervision of other persons in the performance of any of the foregoing;

[(12)**] (16)** A "registered professional nurse" or "registered nurse", a person licensed pursuant to the provisions of this chapter to engage in the practice of professional nursing;

[(13)**] (17)** "Retired license status", any person licensed in this state under this chapter who retires from such practice. Such person shall file with the board an affidavit, on a form to be furnished by the board, which states the date on which the licensee retired from such practice, an intent to retire from the practice for at least two years, and such other facts as tend to verify the retirement as the board may deem necessary; but if the licensee thereafter reengages in the practice, the licensee shall renew his or her license with the board as provided by this chapter and by rule and regulation.

335.019. The board of nursing may grant a certificate of controlled substance prescriptive authority to an advanced practice registered nurse who:

(1) Submits proof of successful completion of an advanced pharmacology course that shall include preceptorial experience in the prescription of drugs, medicines and therapeutic devices; and

(2) Provides documentation of a minimum of three hundred clock hours preceptorial experience in the prescription of drugs, medicines, and therapeutic devices with a qualified preceptor; and

(3) Provides evidence of a minimum of one thousand hours of practice in an advanced practice nursing category prior to application for a certificate of prescriptive authority. The one thousand hours shall not include clinical hours obtained in the advanced practice nursing education program. The one thousand hours of practice in an advanced practice nursing category may include transmitting a prescription order orally or telephonically or to an inpatient medical record from protocols developed in collaboration with and signed by a licensed physician; and

(4) Has a controlled substance prescribing authority delegated in the collaborative practice arrangement under section 334.104, RSMo, with a physician who has an unrestricted federal Drug Enforcement Administration registration number and who is actively engaged in a practice comparable in scope, specialty, or expertise to that of the advanced practice registered nurse.

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 one grant not to exceed twenty-five 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. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

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

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

(2) If such program is reauthorized, the program authorized under this section shall automatically sunset twelve years after the

effective date of the reauthorization of this section; and

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

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

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

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

376.811. 1. Every insurance company and health services corporation doing business in this state shall offer in all health insurance policies benefits or coverage for chemical dependency meeting the following minimum standards:

(1) Coverage for outpatient treatment through a nonresidential treatment program, or through partial- or full-day program services, of not less than twenty-six days per policy benefit period;

(2) Coverage for residential treatment program of not less than twenty-one days per policy benefit period;

(3) Coverage for medical or social setting detoxification of not less than six days per policy benefit period;

(4) The coverages set forth in this subsection may be subject to a separate lifetime frequency cap of not less than ten episodes of treatment, except that such separate lifetime frequency cap shall not apply to medical detoxification in a

life-threatening situation as determined by the treating physician and subsequently documented within forty-eight hours of treatment to the reasonable satisfaction of the insurance company or health services corporation; and

(5) The coverages set forth in this subsection:

(a) Shall be subject to the same coinsurance, co-payment and deductible factors as apply to physical illness;

(b) May be administered pursuant to a managed care program established by the insurance company or health services corporation; and

(c) May deliver covered services through a system of contractual arrangements with one or more providers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

2. In addition to the coverages set forth in subsection 1 of this section, every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies, benefits or coverages for recognized mental illness, excluding chemical dependency, meeting the following minimum standards:

(1) Coverage for outpatient treatment, including treatment through partial- or full-day program services, for mental health services for a recognized mental illness rendered by a licensed professional to the same extent as any other illness;

(2) Coverage for residential treatment programs for the therapeutic care and treatment of a recognized mental illness when prescribed by a licensed professional and rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals to the same extent as any other illness;

(3) Coverage for inpatient hospital treatment for a recognized mental illness to the same extent as for any other illness, not to exceed ninety days per year;

(4) The coverages set forth in this subsection shall be subject to the same coinsurance, co-payment, deductible, annual maximum and lifetime maximum factors as apply to physical illness; and

(5) The coverages set forth in this subsection may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered

services may be delivered through a system of contractual arrangements with one or more providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

3. The offer required by sections 376.810 to 376.814 may be accepted or rejected by the group or individual policyholder or contract holder and, if accepted, shall fully and completely satisfy and substitute for the coverage under section 376.779. Nothing in sections 376.810 to 376.814 shall prohibit an insurance company, health services corporation or health maintenance organization from including all or part of the coverages set forth in sections 376.810 to 376.814 as standard coverage in their policies or contracts issued in this state.

4. Every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies mental health benefits or coverage as part of the policy or as a supplement to the policy. Such mental health benefits or coverage shall include at least two sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, **licensed marital and family therapist,** or licensed clinical social worker acting within the scope of such license and under the following minimum standards:

(1) Coverage and benefits in this subsection shall be for the purpose of diagnosis or assessment, but not dependent upon findings; and

(2) Coverage and benefits in this subsection shall not be subject to any conditions of preapproval, and shall be deemed reimbursable as long as the provisions of this subsection are satisfied; and

(3) Coverage and benefits in this subsection shall be subject to the same coinsurance, co-payment and deductible factors as apply to regular office visits under coverages and benefits for physical illness.

5. If the group or individual policyholder or contract holder rejects the offer required by this section, then the coverage shall be governed by the mental health and chemical dependency insurance act as provided in sections 376.825 to 376.836.

6. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy,

long-term care policy, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance.

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

(1) "Applicant", a person who seeks to contract for insurance benefits;

(2) "Director", the director of the department of insurance, financial institutions and professional registration;

(3) "Medicare", the Health Insurance for the Aged Act, Title XVII of the Social Security Amendments of 1965, as amended;

(4) "Medicare Advantage plan", a private health plan approved by the Medicare Advantage Program under section 1876 of the federal Social Security Act, 42 U.S.C. section 1395 w-26;

(5) "Personal solicitation", either an on-site presentation at a facility or a home meeting with an insurance agent for the purpose of enrolling an applicant in a Medicare Advantage plan.

2. No application shall be submitted to an applicant for enrollment in a Medicare Advantage plan until the lapse of two business days from the initial personal solicitation and the applicant has signed the disclosure described under subsection 3 of this section.

3. The disclosure shall be signed and dated by both the applicant and agent on the day of the initial personal solicitation and shall include:

(1) A statement that Medicare Advantage plans are not Medicare supplement policies or what are commonly referred to as Medigap plans;

(2) A statement that advises the applicant to confirm with his or her health care providers, including a primary care physician and hospital, whether or not the health care provider has contracted with the Medicare Advantage plan to provide medical services; and

(3) A statement advising the applicant to contact either a trusted family member, friend, or the state health insurance assistance program to review the plan with the applicant.

4. In addition to the disclosure, the agent shall also provide a list of providers contracting with the Medicare Advantage plan to provide medical services in the applicant's regional area. Such list may be in the form of a provider directory or other similar document.

5. The director shall prescribe the format and content of the disclosure required under subsection 3 of this section. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. 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. A violation of any provision of this section shall constitute a level two violation under section 374.049, RSMo.

376.986. 1. The pool shall offer major medical expense coverage to every person eligible for coverage under section 376.966. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations, shall be established by the board with the advice and recommendations of the pool members, and such plan of pool coverage shall be submitted to the director for approval. The pool shall also offer coverage for drugs and supplies requiring a medical prescription and coverage for patient education services, to be provided at the direction of a physician, encompassing the provision of information, therapy, programs, or other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause remission of the covered condition, illness or defect.

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

3. The pool shall establish premium rates for pool coverage as provided in subsection 4 of this section. Separate schedules of premium rates based on

age, sex and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the director for approval prior to use.

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

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

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

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

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

date on which such prior coverage was terminated.**] The twelve-month preexisting condition exclusion period shall not apply if the person applying for pool coverage has at least three months of uninterrupted prior insurance coverage provided the application for pool coverage is made not later than sixty-three days following the loss of such health insurance coverage.**

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

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

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

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

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

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

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

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

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

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

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

376.1618. The director shall study and recommend to the general assembly changes to remove any unnecessary application and marketing barriers that limit the entry of new health insurance products into the Missouri market. The director shall examine state statutory and regulatory requirements along with market conditions which create barriers for the entry of new health insurance products and health insurance companies. The director shall also examine proposals adopted in other states that streamline the regulatory environment to make it easier for health insurance companies to market new and existing products. The director shall submit a report of his or her findings and recommendations to each member of the general assembly no later than January 1, 2009.

Section 1. In implementing provisions related to coverage of the uninsured and payments to providers for providing care to the uninsured under sections 208.1300 to 208.1345, RSMo, and under the MO HealthNet program, the MO HealthNet division shall take into consideration the special needs of Missouri's Tier I Safety Net providers so that they are not disproportionately impacted by regulations promulgated by the division as it implements the provisions of such programs.

[191.400. 1. There is hereby created a "State Board of Health" which shall consist of seven members, who shall be

appointed by the governor, by and with the advice and consent of the senate. No member of the state board of health shall hold any other office or employment under the state of Missouri other than in a consulting status relevant to the member's professional status, licensure or designation. Not more than four of the members of the state board of health shall be from the same political party.

2. Each member shall be appointed for a term of four years; except that of the members first appointed, two shall be appointed for a term of one year, two for a term of two years, two for a term of three years, and one for a term of four years. The successors of each shall be appointed for full terms of four years. No person may serve on the state board of health for more than two terms. The terms of all members shall continue until their successors have been duly appointed and qualified. Three of the persons appointed to the state board of health shall be persons who are physicians and surgeons licensed by the state board of registration for the healing arts of Missouri. One of the persons appointed to the state board of health shall be a dentist licensed by the Missouri dental board. One of the persons appointed to the state board of health shall be a chiropractic physician licensed by the Missouri state board of chiropractic examiners. Two of the persons appointed to the state board of health shall be persons other than those licensed by the state board of registration for the healing arts, the Missouri dental board, or the Missouri state board of chiropractic examiners and shall be representative of those persons, professions and businesses which are regulated and supervised by the department of health and senior services and the state board of health. If a vacancy occurs in the appointed membership, the governor may appoint a member for the remaining portion of the unexpired term created by the vacancy. If the vacancy occurs while the senate is not in session, the governor shall make a temporary appointment subject to the approval of the senate when it next convenes. The members shall receive actual and necessary expenses plus twenty-five dollars per day for each day of actual attendance.

3. The board shall elect from among its membership a chairperson and a vice chairperson, who shall act as chairperson in

his or her absence. The board shall meet at the call of the chairperson. The chairperson may call meetings at such times as he or she deems advisable, and shall call a meeting when requested to do so by three or more members of the board.**]**

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

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

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

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

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

2. Each member shall be appointed for a term of four years; except that of the members first appointed, two shall be appointed for a term of one year, two for a term of two years, two for a term of three years and one for a term of four years. The successors of each shall be appointed for full terms of four years. No person may serve on the state board of senior services for more than two terms. The terms of all members shall continue until their successors have been duly appointed and qualified. One of the

persons appointed to the state board of senior services shall be a person currently working in the field of gerontology. One of the persons appointed to the state board of senior services shall be a physician with expertise in geriatrics. One of the persons appointed to the state board of senior services shall be a person with expertise in nutrition. One of the persons appointed to the state board of senior services shall be a person with expertise in rehabilitation services of persons with disabilities. One of the persons appointed to the state board of senior services shall be a person with expertise in mental health issues. In making the two remaining appointments, the governor shall give consideration to individuals having a special interest in gerontology or disability-related issues, including senior citizens. Four of the seven members appointed to the state board of senior services shall be members of the governor's advisory council on aging. If a vacancy occurs in the appointed membership, the governor may appoint a member for the remaining portion of the unexpired term created by the vacancy. The members shall receive actual and necessary expenses plus twenty-five dollars per day for each day of actual attendance.

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

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

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

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

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

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