Journal of the Senate

SECOND REGULAR SESSION

FIFTY-FIFTH DAY—WEDNESDAY, APRIL 20, 2016

The Senate met pursuant to adjournment.

President Kinder in the Chair.

Reverend Carl Gauck offered the following prayer:

"What soap is to the body, laughter is to the soul." (Yiddish proverb)

King of the Universe, we often take ourselves far too seriously and forget to laugh and laugh often which we know benefits us, especially when we can laugh at ourselves. So assist us to have the courage to look at ourselves and learn how to laugh for it strengthens our bodies, lightens our souls and makes us much more capable to be with others. In Your Holy Name we pray. Amen.

The Pledge of Allegiance to the Flag was recited.

A quorum being established, the Senate proceeded with its business.

The Journal of the previous day was read and approved.

The following Senators were present during the day's proceedings:

Present—Senators

Brown	Chappelle-Nadal	Cunningham	Curls	Dixon	Emery	Hegeman
Holsman	Keaveny	Kehoe	Kraus	Libla	Munzlinger	Nasheed
Onder	Parson	Pearce	Richard	Riddle	Romine	Sater
Schaaf	Schaefer	Schatz	Schmitt	Schupp	Sifton	Silvey
Wallingford	Walsh	Wasson	Wieland—32			

Absent—Senators—None

Absent with leave—Senators—None

Vacancies—2

The Lieutenant Governor was present.

Senator Kehoe requested unanimous consent of the Senate to allow members of Jasper County law enforcement to enter the Chamber with side arms, which request was granted.

RESOLUTIONS

Senator Wallingford offered Senate Resolution No. 2022, regarding Jack A. Liput, Columbia, which was adopted.

Senator Hegeman offered Senate Resolution No. 2023, regarding Jessie Ridenour, Maryville, which was adopted.

Senator Hegeman offered Senate Resolution No. 2024, regarding the Sixtieth Wedding Anniversary of William and Lois Fleshman, Unionville, which was adopted.

Senator Hegeman offered Senate Resolution No. 2025, regarding the Sixtieth Wedding Anniversary of Richard and Lois Brand, Hopkins, which was adopted.

Senator Hegeman offered Senate Resolution No. 2026, regarding the Fiftieth Wedding Anniversary of Lynn and Judy VonKeanel, Savannah, which was adopted.

Senator Hegeman offered Senate Resolution No. 2027, regarding the Fiftieth Wedding Anniversary of Robert and Velda Puffer, Unionville, which was adopted.

Senator Hegeman offered Senate Resolution No. 2028, regarding the Fiftieth Wedding Anniversary of Dave and Marsha Copeland, Excelsior Springs, which was adopted.

Senator Hegeman offered Senate Resolution No. 2029, regarding the Fiftieth Wedding Anniversary of John and Alice Redden, Maryville, which was adopted.

Senator Hegeman offered Senate Resolution No. 2030, regarding the Fiftieth Wedding Anniversary of Ron and Judy Wilmes, Maryville, which was adopted.

MESSAGES FROM THE HOUSE

The following message was received from the House of Representatives through its Chief Clerk:

Mr. President: I am instructed by the Speaker to inform the Senate that Representative Flanigan has removed himself from the Conference Committees on the House appropriation bills and is replaced by the following Representatives:

SCS for **HCS** for **HB 2002**: Gannon; **SCS** for **HCS** for **HB 2003**: Lauer; **SCS** for **HCS** for **HB 2004**: Basye; **SCS** for **HCS** for **HB 2005**: Justus; **SCS** for **HCS** for **HB 2006**: Rone; **SCS** for **HCS** for **HB 2007**: Basye; **SCS** for **HCS** for **HB 2008**: Wilson; **SCS** for **HCS** for **HB 2009**: Wilson; **SCS** for **HCS** for **HB 2010**, as amended: Wood; **SCS** for **HCS** for **HB 2011**: Allen; **SCS** for **HCS** for **HB 2012**: Justus; and **SCS** for **HCS** for **HB 2014**: Alferman.

On motion of Senator Kehoe, the Senate recessed until 3:00 p.m.

RECESS

The time of recess having expired, the Senate was called to order by Senator Onder.

RESOLUTIONS

Senator Romine offered Senate Resolution No. 2031, regarding Mike Mapes, Farmington, which was adopted.

Senator Walsh offered Senate Resolution No. 2032, regarding Eagle Scout Dominic Simon Bell, St. Louis, which was adopted.

Senator Libla offered Senate Resolution No. 2033, regarding Tiffany I. Martin, which was adopted.

Senator Libla offered Senate Resolution No. 2034, regarding Bill Hampton, Dexter, which was adopted.

Senator Libla offered Senate Resolution No. 2035, regarding Dr. Mairead Ryan-Anderson, Ellsinore, which was adopted.

Senator Libla offered Senate Resolution No. 2036, regarding Danetta Norris, Poplar Bluff, which was adopted.

Senator Richard offered Senate Resolution No. 2037, regarding Tom Rhoads, Joplin, which was adopted.

MESSAGES FROM THE HOUSE

The following messages were received from the House of Representatives through its Chief Clerk:

Mr. President: I am instructed by the Speaker to inform the Senate that Representative Lauer has been removed from the Conference Committee on **SCS** for **HCS** for **HB 2003** and is replaced by Representative Fitzpatrick.

Also,

Mr. President: I am instructed by the House of Representatives to inform the Senate that the House has taken up and passed **HCS** for **HB 2017**, entitled:

An Act to appropriate money for capital improvement and other purposes for the several departments of state government and the divisions and programs thereof to be expended only as provided in Article IV, Section 28 of the Constitution of Missouri, from the funds herein designated for the period beginning July 1, 2016 and ending June 30, 2017.

In which the concurrence of the Senate is respectfully requested.

Read 1st time.

Also,

Mr. President: I am instructed by the House of Representatives to inform the Senate that the House has taken up and passed **HCS** for **HB 2018**, entitled:

An Act to appropriate money for purposes for the several departments and offices of state government; for the purchase of equipment; for planning, expenses, and for capital improvement projects involving the maintenance, repair, replacement, and improvement of state buildings and facilities, including installation, modification, and renovation of facility components, equipment or systems; for grants, refunds, distributions, planning, expenses, and capital improvements including but not limited to major additions and renovations, new structures, and land improvements or acquisitions; and to transfer money among certain funds, from the funds designated for the fiscal period beginning July 1, 2016 and ending June 30, 2017.

In which the concurrence of the Senate is respectfully requested.

Read 1st time.

SENATE BILLS FOR PERFECTION

Senator Wasson moved that **SB 951** be called from the Informal Calendar and taken up for perfection, which motion prevailed.

Senator Wieland offered **SA 1**, which was read:

SENATE AMENDMENT NO. 1

Amend Senate Bill No. 951, Page 7, Section 436.455, Line 18, by striking the word "thirty" and inserting in lieu thereof the following: "**five**".

Senator Wieland moved that the above amendment be adopted.

At the request of Senator Wasson, **SB 951**, with **SA 1** (pending), was placed on the Informal Calendar.

Senator Sater moved that **SJR 23** be called from the Informal Calendar and taken up for perfection, which motion prevailed.

Senator Emery offered **SS** for **SJR 23**, entitled:

SENATE SUBSTITUTE FOR
SENATE JOINT RESOLUTION NO. 23

Joint Resolution submitting to the qualified voters of Missouri, an amendment repealing section 50 of article III of the Constitution of Missouri, and adopting one new section in lieu thereof relating to initiative petitions.

Senator Emery moved that **SS** for **SJR 23** be adopted.

Senator Pearce assumed the Chair.

Senator Holsman offered **SA 1**, which was read:

SENATE AMENDMENT NO. 1

Amend Senate Substitute for Senate Joint Resolution No. 23, Page 2, Section 50, Line 8, by inserting at the end of said line the following: "**All amendments to the Missouri constitution proposed by the general assembly shall be adopted by at least a two-thirds majority vote of each house of the general assembly.**".

Senator Holsman moved that the above amendment be adopted and requested a roll call vote be taken. He was joined in his request by Senators Curls, Keaveny, Schupp and Sifton.

Senator Emery raised the point of order that **SA 1** is out of order as it goes beyond the scope of the title.

The point of order was referred to the President Pro Tem.

At the request of Senator Holsman, **SA 1** was withdrawn, rendering the point of order moot.

At the request of Senator Sater, **SJR 23**, with **SS** (pending), was placed on the Informal Calendar.

Senator Dixon moved that **SB 1096** be called from the Informal Calendar and taken up for perfection, which motion prevailed.

Senator Kraus assumed the Chair.

Senator Schaaf offered **SS** for **SB 1096**, entitled:

SENATE SUBSTITUTE FOR
SENATE BILL NO. 1096

An Act to repeal section 196.1003, RSMo, and to enact in lieu thereof one new section relating to the tobacco master settlement agreement, with a referendum clause.

Senator Schaaf moved that **SS** for **SB 1096** be adopted.

At the request of Senator Dixon, **SB 1096**, with **SS** (pending), was placed on the Informal Calendar.

PRIVILEGED MOTIONS

Senator Onder, on behalf of the conference committee appointed to act with a like committee from the House on **SS** for **SCS** for **HB 1979**, as amended, moved that the following conference committee report be taken up, which motion prevailed.

CONFERENCE COMMITTEE REPORT ON
SENATE SUBSTITUTE FOR
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 1979

The Conference Committee appointed on Senate Substitute for Senate Committee Substitute for House Bill No. 1979, with Senate Amendment No. 2, Senate Amendment No. 3, and Senate Amendment No. 4 begs leave to report that we, after free and fair discussion of the differences, have agreed to recommend and do recommend to the respective bodies as follows:

1. That the Senate recede from its position on Senate Substitute for Senate Committee Substitute for House Bill No. 1979, as amended;

2. That the House recede from its position on House Bill No. 1979;

3. That the attached Conference Committee Substitute for Senate Substitute for Senate Committee Substitute for House Bill No. 1979, be Third Read and Finally Passed.

FOR THE HOUSE:	FOR THE SENATE:
/s/ Caleb Rowden	/s/ Bob Onder
/s/ Justin Alferman	/s/ Dan Hegeman
/s/ Jay Barnes	/s/ Mike Kehoe
/s/ Gail McCann Beatty	/s/ Jason Holsman
/s/ Gina Mitten	/s/ Scott Sifton

Senator Onder moved that the above conference committee report be adopted, which motion prevailed by the following vote:

YEAS—Senators

Brown	Chappelle-Nadal	Cunningham	Curls	Dixon	Hegeman	Holsman
Keaveny	Kehoe	Kraus	Libla	Munzlinger	Nasheed	Onder
Parson	Pearce	Richard	Riddle	Romine	Sater	Schaaf

Schaefer	Schatz	Schmitt	Schupp	Sifton	Silvey	Wallingford
Walsh	Wasson	Wieland—31				

NAYS—Senator Emery—1

Absent—Senators—None

Absent with leave—Senators—None

Vacancies—2

Senator Schmitt assumed the Chair.

On motion of Senator Onder, **CCS** for **SS** for **SCS** for **HB 1979**, entitled:

CONFERENCE COMMITTEE SUBSTITUTE FOR
SENATE SUBSTITUTE FOR
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 1979

An Act to repeal section 105.456 as enacted by house bill no. 1120, eighty-ninth general assembly, second regular session, and to enact in lieu thereof two new sections relating solely to certain public officials becoming lobbyists.

Was read the 3rd time and passed by the following vote:

YEAS—Senators

Brown	Chappelle-Nadal	Cunningham	Curls	Dixon	Hegeman	Holsman
Keaveny	Kehoe	Kraus	Libla	Munzlinger	Nasheed	Onder
Parson	Pearce	Richard	Riddle	Romine	Sater	Schaaf
Schaefer	Schatz	Schmitt	Schupp	Sifton	Silvey	Wallingford
Walsh	Wasson	Wieland—31				

NAYS—Senator Emery—1

Absent—Senators—None

Absent with leave—Senators—None

Vacancies—2

The President declared the bill passed.

On motion of Senator Onder, title to the bill was agreed to.

Senator Onder moved that the vote by which the bill passed be reconsidered.

Senator Kehoe moved that motion lay on the table, which motion prevailed.

Senator Kehoe, on behalf of the conference committee appointed to act with a like committee from the House on **SS** for **SCS** for **HB 2203**, as amended, moved that the following conference committee report be

taken up, which motion prevailed.

CONFERENCE COMMITTEE REPORT NO. 2 ON
SENATE SUBSTITUTE FOR
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 2203

The Conference Committee appointed on Senate Substitute for Senate Committee Substitute for House Bill No. 2203, with Senate Amendment No. 1 to Senate Substitute Amendment No. 1 for Senate Amendment No. 1, Senate Amendment No. 4 to Senate Substitute Amendment No. 1 for Senate Amendment No. 1, Senate Substitute Amendment No. 1 for Senate Amendment No. 1, as amended, Senate Amendment No. 2, Senate Amendment No. 1 to Senate Amendment No. 3, Senate Amendment No. 3, as amended, and Senate Amendment No. 4. begs leave to report that we, after free and fair discussion of the differences, have agreed to recommend and do recommend to the respective bodies as follows:

1. That the Senate recede from its position on Senate Substitute for Senate Committee Substitute for House Bill No. 2203, as amended;

2. That the House recede from its position on House Bill No. 2203;

3. That the attached Conference Committee Substitute No. 2 for Senate Substitute for Senate Committee Substitute for House Bill No. 2203 be Third Read and Finally Passed.

FOR THE HOUSE:	FOR THE SENATE:
/s/ Jay Barnes	/s/ Mike Kehoe
/s/ Justin Alferman	/s/ Bob Onder
/s/ Caleb Jones	/s/ Jay Wasson
/s/ Gail McCann Beatty	Maria Chappelle-Nadal
/s/ Gina Mitten	/s/ Scott Sifton

Senator Kehoe moved that the above conference committee report no. 2 be adopted, which motion prevailed by the following vote:

YEAS—Senators

Brown	Chappelle-Nadal	Cunningham	Dixon	Emery	Hegeman	Holsman
Keaveny	Kehoe	Kraus	Libla	Munzlinger	Nasheed	Onder
Parson	Richard	Riddle	Romine	Sater	Schaaf	Schaefer
Schatz	Schmitt	Schupp	Sifton	Silvey	Wallingford	Walsh
Wasson	Wieland—30					

NAYS—Senator Pearce—1

Absent—Senators—None

Absent with leave—Senator Curls—1

Vacancies—2

On motion of Senator Kehoe, **CCS No. 2** for **SS** for **SCS** for **HB 2203**, entitled:

CONFERENCE COMMITTEE SUBSTITUTE NO. 2 FOR
SENATE SUBSTITUTE FOR
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 2203

An Act to repeal section 130.034, RSMo, and section 130.021 as enacted by senate bill no. 485, ninety-fifth general assembly, first regular session, and to enact in lieu thereof five new sections relating to campaign finance.

Was read the 3rd time and passed by the following vote:

YEAS—Senators

Brown	Chappelle-Nadal	Cunningham	Dixon	Emery	Hegeman	Holsman
Keaveny	Kehoe	Kraus	Libla	Munzlinger	Nasheed	Onder
Parson	Richard	Riddle	Romine	Sater	Schaaf	Schaefer
Schatz	Schmitt	Schupp	Sifton	Silvey	Wallingford	Walsh
Wasson	Wieland—30					

NAYS—Senator Pearce—1

Absent—Senators—None

Absent with leave—Senator Curls—1

Vacancies—2

The President declared the bill passed.

On motion of Senator Kehoe, title to the bill was agreed to.

Senator Kehoe moved that the vote by which the bill passed be reconsidered.

Senator Richard moved that motion lay on the table, which motion prevailed.

HOUSE BILLS ON THIRD READING

Senator Onder moved that **HB 2166**, with **SCS** and **SS** for **SCS** (pending), be called from the Informal Calendar and again taken up for 3rd reading and final passage, which motion prevailed.

SS for **SCS** for **HB 2166** was again taken up.

At the request of Senator Onder, **SS** for **SCS** for **HB 2166** was withdrawn.

Senator Onder offered **SS No. 2** for **SCS** for **HB 2166**, entitled:

SENATE SUBSTITUTE NO. 2 FOR
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 2166

An Act to repeal section 105.470, RSMo, section 105.473 as enacted by senate bill no. 844, ninety-fifth general assembly, second regular session, and section 105.473 as enacted by house bill no. 1900, ninety-third general assembly, second regular session, and to enact in lieu thereof two new sections relating solely

to lobbyist expenditures, with an existing penalty provision.

Senator Onder moved that **SS No. 2** for **SCS** for **HB 2166** be adopted.

Senator Schatz offered **SA 1**:

SENATE AMENDMENT NO. 1

Amend Senate Substitute No. 2 for Senate Committee Substitute for House Bill No. 2166, Page 19, Section 105.473, Line 19, by striking "fifty" and inserting in lieu thereof the following: "**forty-five**".

Senator Schatz moved that the above amendment be adopted.

Senator Schatz offered **SSA 1** for **SA 1**:

SENATE SUBSTITUTE AMENDMENT NO. 1 FOR
SENATE AMENDMENT NO. 1

Amend Senate Substitute No. 2 for Senate Committee Substitute for House Bill No. 2166, Page 19, Section 105.473, Lines 12-23, by striking said lines and inserting in lieu thereof the following:

"**14. (1) No lobbyist, lobbyist principal, or any other person acting on behalf of a lobbyist or lobbyist principal, shall spend more than forty-two dollars on expenditures on any calendar day on behalf of any public official of the state, or such public official's staff, spouse, or dependent children.**".

Senator Schatz moved that the above substitute amendment be adopted.

Senator Schatz offered **SA 1** to **SSA 1** for **SA 1**:

SENATE AMENDMENT NO. 1 TO
SENATE SUBSTITUTE AMENDMENT NO. 1 FOR
SENATE AMENDMENT NO. 1

Amend Senate Substitute Amendment No. 1 for Senate Amendment No. 1 to Senate Substitute No. 2 for Senate Committee Substitute for House Bill No. 2166, Page 1, Section 105.473, Line 6 of said amendment, by striking "forty-two" and inserting in lieu thereof the following: "**forty**".

Senator Schatz moved that **SA 1** to **SSA 1** for **SA 1** be adopted.

President Pro Tem Richard assumed the Chair.

Senator Schaaf raised the point of order that per Senate Rule 88 the withdrawal of **SS** for **SCS** was only permissable with consent of the Senate, as it had been previously amended.

Senator Pearce assumed the Chair.

The point of order was referred to the President Pro Tem who ruled it not well taken.

Senator Romine assumed the Chair.

Senator Pearce assumed the Chair.

Senator Romine assumed the Chair.

Senator Schatz moved that **SA 1** to **SSA 1** for **SA 1** be adopted, which motion prevailed.

Senator Schaaf offered **SA 2** to **SSA 1** for **SA 1**:

SENATE AMENDMENT NO. 2 TO
SENATE SUBSTITUTE AMENDMENT NO. 1 FOR
SENATE AMENDMENT NO. 1

Amend Senate Substitute Amendment No. 1 for Senate Amendment No. 1 to Senate Substitute No. 2 for Senate Committee Substitute for House Bill No. 2166, Page 1, Section 105.473, Line 6 of said amendment, by inserting at the end of such line the following: "**meal on any**"

and further amend said page, line 8, by inserting at the end of said line the following: "**For purposes of this subsection, the term "meal" shall include any occasion on which any type of food or beverage is consumed. Expenditures shall not be made except for meals**"

Senator Schaaf moved that the above amendment be adopted.

Senator Schatz raised the point of order that **SA 2** to **SSA 1** for **SA 1** amends previously amended material.

The point of order was referred to the President Pro Tem.

Senator Schatz raised a further point of order that **SA 2** to **SSA 1** for **SA 1** is dilatory.

The second point of order was referred to the President Pro Tem.

President Pro Tem Richard ruled the first point of order not well taken.

President Pro Tem Richard ruled the second point of order well taken.

Senator Schaaf appealed the ruling on the second point of order.

At the request of Senator Schaaf the above appeal was withdrawn.

At the request of Senator Onder, **HB 2166**, with **SCS**, **SS No. 2** for **SCS**, **SA 1** and **SSA 1** for **SA 1** (pending), was placed on the Informal Calendar.

MESSAGES FROM THE HOUSE

The following messages were received from the House of Representatives through its Chief Clerk:

Mr. President: I am instructed by the House of Representatives to inform the Senate that the House has taken up and passed **SB 579**.

With House Amendment Nos. 1 and 2.

HOUSE AMENDMENT NO. 1

Amend Senate Bill No. 579, Page 2, Section 192.667, Line 31, by deleting the word "Prevention's" and inserting in lieu thereof the words "[Prevention's] **Prevention**"; and

Further amend said bill and section, Pages 2-3, Line 36-40, by deleting all of said lines and inserting in lieu thereof the following:

"**condition of licensure to use the National Healthcare Safety Network for data collection; the use of the National Healthcare Safety Network for risk adjustment and analysis of hospital submitted**

data; and the use of the Centers for Medicare and Medicaid Services' Hospital Compare website, or its successor, for public reporting of the incidence of health care-associated"; and

Further amend said bill and section, Page 3, Line 63, by deleting the numbers "[12] **13**" and inserting in lieu thereof the number "12"; and

Further amend said bill, page, and section, Line 65, by deleting all of said line and inserting in lieu thereof the following:

"Control and [Prevention Nosocomial Infection Surveillance System] **Prevention's National**"; and

Further amend said bill and section, Pages 3-4, Lines 75-77, by deleting all of said lines and inserting in lieu thereof the following:

"**in the National Healthcare Safety Network, or its successor. Such hospitals shall** permit the [federal program] **National Healthcare Safety Network, or its successor,** to disclose facility-specific **infection** data to the department as **required**"; and

Further amend said bill and section, Page 5, Line 121, by deleting the word "publication" and inserting in lieu thereof the word "**publication**"; and

Further amend said bill, page, and section, Line 142, by deleting all of said lines and inserting in lieu thereof the following:

"**(1) Infections associated with a minimum of four surgical procedures for hospitals and a**"; and

Further amend said bill, page, and section, Line 147, by deleting the word "**which**" and inserting in lieu thereof the word "**that**"; and

Further amend said bill, page, and section, Line 151, by inserting immediately after the first instance of the word "**or**" the word "**being**"; and

Further amend said bill and section, Page 6, Lines 157-158, by deleting the words "**, or its successor,**"; and

Further amend said bill, page, and section, Line 158, by deleting the word "**Prevention**" and inserting in lieu thereof the word "**Prevention's**"; and

Further amend said bill, page, and section, Line 161, by inserting a hard return after all of said line; and

Further amend said bill, page, and section, Line 184, by deleting the phrase "infections**, under subsection 12 of this section,**" and inserting in lieu thereof the phrase "infections **under subsection 12 of this section**"; and

Further amend said bill and section, Page 8, Line 230, by deleting the words "**Center for Disease Control's**" and inserting in lieu thereof the following "**Centers for Disease Control and Prevention's**"; and

Further amend said bill, page, and section, Lines 232-234, by deleting all of said lines and inserting in lieu thereof the following:

"**concerning Stage 3 of the Medicare and Medicaid Electronic Health Records Incentive Programs promulgated by the Centers for Medicare and Medicaid Services that enable the electronic interface**

for such reporting are"; and

Further amend said bill, page, and section, Line 240, by deleting the word "**except**" and inserting in lieu thereof the word "**but**"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 2

Amend Senate Bill No. 579, Page 1, In the Title, Line 3, by deleting the words "infection reporting" and inserting in lieu thereof the words "health care"; and

Further amend said bill and page, Section A, Line 3, by inserting after all of said section and line the following:

"**191.1145. 1. As used in sections 191.1145 and 191.1146, the following terms shall mean:**

(1) "Asynchronous store-and-forward transfer", the collection of a patient's relevant health information and the subsequent transmission of that information from an originating site to a health care provider at a distant site without the patient being present;

(2) "Clinical staff", any health care provider licensed in this state;

(3) "Distant site", a site at which a health care provider is located while providing health care services by means of telemedicine;

(4) "Health care provider", as that term is defined in section 376.1350;

(5) "Originating site", a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine. For the purposes of asynchronous store-and-forward transfer, originating site shall also mean the location at which the health care provider transfers information to the distant site;

(6) "Telehealth" or "telemedicine", the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology.

2. Any licensed health care provider shall be authorized to provide telehealth services if such services are within the scope of practice for which the health care provider is licensed and are provided with the same standard of care as services provided in person.

3. In order to treat patients in this state through the use of telemedicine or telehealth, health care providers shall be fully licensed to practice in this state and shall be subject to regulation by their respective professional boards.

4. Nothing in subsection 3 of this section shall apply to:

(1) Informal consultation performed by a health care provider licensed in another state, outside of the context of a contractual relationship, and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation;

(2) Furnishing of health care services by a health care provider licensed and located in another state in case of an emergency or disaster; provided that, no charge is made for the medical assistance; or

(3) Episodic consultation by a health care provider licensed and located in another state who provides such consultation services on request to a physician in this state.

5. Nothing in this section shall be construed to alter the scope of practice of any health care provider or to authorize the delivery of health care services in a setting or in a manner not otherwise authorized by the laws of this state.

6. No originating site for services or activities provided under this section shall be required to maintain immediate availability of on-site clinical staff during the telehealth services, except as necessary to meet the standard of care for the treatment of the patient's medical condition if such condition is being treated by an eligible health care provider who is not at the originating site, has not previously seen the patient in person in a clinical setting, and is not providing coverage for a health care provider who has an established relationship with the patient.

7. Nothing in this section shall be construed to alter any collaborative practice requirement as provided in chapters 334 and 335.

191.1146. 1. Physicians licensed under chapter 334 who use telemedicine shall ensure that a properly established physician-patient relationship exists with the person who receives the telemedicine services. The physician-patient relationship may be established by:

(1) An in-person encounter through a medical interview and physical examination;

(2) Consultation with another physician, or that physician's delegate, who has an established relationship with the patient and an agreement with the physician to participate in the patient's care; or

(3) A telemedicine encounter, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

2. In order to establish a physician-patient relationship through telemedicine:

(1) The technology utilized shall be sufficient to establish an informed diagnosis as though the medical interview and physical examination has been performed in person; and

(2) Prior to providing treatment, including issuing prescriptions, a physician who uses telemedicine shall interview the patient, collect or review relevant medical history, and perform an examination sufficient for the diagnosis and treatment of the patient. A questionnaire completed by the patient, whether via the internet or telephone, does not constitute an acceptable medical interview and examination for the provision of treatment by telehealth."; and

Further amend said bill, Page 8, Section 192.667, Line 247, by inserting after all of said section and line the following:

"208.670. 1. As used in this section, these terms shall have the following meaning:

(1) "Provider", any provider of medical services and mental health services, including all other medical disciplines;

(2) "Telehealth", **[**the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient**]** **the same meaning as such term is defined in section 191.1145.**

2. Reimbursement for the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program shall be allowed for orthopedics, dermatology, ophthalmology and optometry, in cases of diabetic retinopathy, burn and wound care, dental services which require a diagnosis, and maternal-fetal medicine ultrasounds.

[2.**]** **3.** The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the practice of telehealth in the MO HealthNet program. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth, certification of agencies offering telehealth, and payment for services by providers. Telehealth providers shall be required to obtain **[**patient**]** **participant** consent before telehealth services are initiated and to ensure confidentiality of medical information.

[3.**]** **4.** Telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. Reimbursement for such services shall be made in the same way as reimbursement for in-person contacts.

5. The provisions of section 208.671 shall apply to the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program.

208.671. 1. As used in this section and section 208.673, the following terms shall mean:

(1) "Asynchronous store-and-forward", the transfer of a participant's clinically important digital samples, such as still images, videos, audio, text files, and relevant data from an originating site through the use of a camera or similar recording device that stores digital samples that are forwarded via telecommunication to a distant site for consultation by a consulting provider without requiring the simultaneous presence of the participant and the participant's treating provider;

(2) "Asynchronous store-and-forward technology", cameras or other recording devices that store images which may be forwarded via telecommunication devices at a later time;

(3) "Consultation", a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association;

(4) "Consulting provider", a provider who, upon referral by the treating provider, evaluates a participant and appropriate medical data or images delivered through asynchronous store-and-forward technology. If a consulting provider is unable to render an opinion due to insufficient information, the consulting provider may request additional information to facilitate the rendering of an opinion or decline to render an opinion;

(5) "Distant site", the site where a consulting provider is located at the time the consultation service is provided;

(6) "Originating site", the site where a MO HealthNet participant receiving services and such participant's treating provider are both physically located;

(7) "Provider", any provider of medical, mental health, optometric, or dental health services, including all other medical disciplines, licensed and providing MO HealthNet services who has the authority to refer participants for medical, mental health, optometric, dental, or other health care services within the scope of practice and licensure of the provider;

(8) "Telehealth", as that term is defined in section 191.1145;

(9) "Treating provider", a provider who:

(a) Evaluates a participant;

(b) Determines the need for a consultation;

(c) Arranges the services of a consulting provider for the purpose of diagnosis and treatment; and

(d) Provides or supplements the participant's history and provides pertinent physical examination findings and medical information to the consulting provider.

2. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program. Such rules shall include, but not be limited to:

(1) Appropriate standards for the use of asynchronous store-and-forward technology in the practice of telehealth;

(2) Certification of agencies offering asynchronous store-and-forward technology in the practice of telehealth;

(3) Timelines for completion and communication of a consulting provider's consultation or opinion, or if the consulting provider is unable to render an opinion, timelines for communicating a request for additional information or that the consulting provider declines to render an opinion;

(4) Length of time digital files of such asynchronous store-and-forward services are to be maintained;

(5) Security and privacy of such digital files;

(6) Participant consent for asynchronous store-and-forward services; and

(7) Payment for services by providers; except that, consulting providers who decline to render an opinion shall not receive payment under this section unless and until an opinion is rendered.

Telehealth providers using asynchronous store-and-forward technology shall be required to obtain participant consent before asynchronous store-and-forward services are initiated and to ensure confidentiality of medical information.

3. Asynchronous store-and-forward technology in the practice of telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. The total payment for both the treating provider and the consulting provider shall not exceed the payment for

a face-to-face consultation of the same level.

4. The standard of care for the use of asynchronous store-and-forward technology in the practice of telehealth shall be the same as the standard of care for services provided in person.

208.673. 1. There is hereby established the "Telehealth Services Advisory Committee" to advise the department of social services and propose rules regarding the coverage of telehealth services in the MO HealthNet program utilizing asynchronous store-and-forward technology.

2. The committee shall be comprised of the following members:

(1) The director of the MO HealthNet division, or the director's designee;

(2) The medical director of the MO HealthNet division;

(3) A representative from a Missouri institution of higher education with expertise in telehealth;

(4) A representative from the Missouri office of primary care and rural health;

(5) Two board-certified specialists licensed to practice medicine in this state;

(6) A representative from a hospital located in this state that utilizes telehealth;

(7) A primary care physician from a federally qualified health center (FQHC) or rural health clinic;

(8) A primary care physician from a rural setting other than from an FQHC or rural health clinic;

(9) A dentist licensed to practice in this state; and

(10) A psychologist, or a physician who specializes in psychiatry, licensed to practice in this state.

3. Members of the committee listed in subdivisions (3) to (10) of subsection 2 of this section shall be appointed by the governor with the advice and consent of the senate. The first appointments to the committee shall consist of three members to serve three-year terms, three members to serve two-year terms, and three members to serve a one-year term as designated by the governor. Each member of the committee shall serve for a term of three years thereafter.

4. Members of the committee shall not receive any compensation for their services but shall be reimbursed for any actual and necessary expenses incurred in the performance of their duties.

5. Any member appointed by the governor may be removed from office by the governor without cause. If there is a vacancy for any cause, the governor shall make an appointment to become effective immediately for the unexpired term.

6. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2016, shall be invalid and void.

208.675. For purposes of the provision of telehealth services in the MO HealthNet program, the

following individuals, licensed in Missouri, shall be considered eligible health care providers:

(1) Physicians, assistant physicians, and physician assistants;

(2) Advanced practice registered nurses;

(3) Dentists, oral surgeons, and dental hygienists under the supervision of a currently registered and licensed dentist;

(4) Psychologists and provisional licensees;

(5) Pharmacists;

(6) Speech, occupational, or physical therapists;

(7) Clinical social workers;

(8) Podiatrists;

(9) Optometrists;

(10) Licensed professional counselors; and

(11) Eligible health care providers under subdivisions (1) to (10) of this section practicing in a rural health clinic, federally qualified health center, or community mental health center.

208.677. 1. For purposes of the provision of telehealth services in the MO HealthNet program, the term "originating site" shall mean a telehealth site where the MO HealthNet participant receiving the telehealth service is located for the encounter. The standard of care in the practice of telehealth shall be the same as the standard of care for services provided in person. An originating site shall be one of the following locations:

(1) An office of a physician or health care provider;

(2) A hospital;

(3) A critical access hospital;

(4) A rural health clinic;

(5) A federally qualified health center;

(6) A long-term care facility licensed under chapter 198;

(7) A dialysis center;

(8) A Missouri state habilitation center or regional office;

(9) A community mental health center;

(10) A Missouri state mental health facility;

(11) A Missouri state facility;

(12) A Missouri residential treatment facility licensed by and under contract with the children's division. Facilities shall have multiple campuses and have the ability to adhere to technology requirements. Only Missouri licensed psychiatrists, licensed psychologists, or provisionally licensed

psychologists, and advanced practice registered nurses who are MO HealthNet providers shall be consulting providers at these locations;

(13) A comprehensive substance treatment and rehabilitation (CSTAR) program;

(14) A school;

(15) The MO HealthNet recipient's home;

(16) A clinical designated area in a pharmacy; or

(17) A child assessment center as described in section 210.001.

2. If the originating site is a school, the school shall obtain permission from the parent or guardian of any student receiving telehealth services prior to each provision of service.

208.686. 1. Subject to appropriations, the department shall establish a statewide program that permits reimbursement under the MO HealthNet program for home telemonitoring services. For the purposes of this section, "home telemonitoring service" shall mean a health care service that requires scheduled remote monitoring of data related to a participant's health and transmission of the data to a health call center accredited by the Utilization Review Accreditation Commission (URAC).

2. The program shall:

(1) Provide that home telemonitoring services are available only to persons who:

(a) Are diagnosed with one or more of the following conditions:

a. Pregnancy;

b. Diabetes;

c. Heart disease;

d. Cancer;

e. Chronic obstructive pulmonary disease;

f. Hypertension;

g. Congestive heart failure;

h. Mental illness or serious emotional disturbance;

i. Asthma;

j. Myocardial infarction; or

k. Stroke; and

(b) Exhibit two or more of the following risk factors:

a. Two or more hospitalizations in the prior twelve-month period;

b. Frequent or recurrent emergency department admissions;

c. A documented history of poor adherence to ordered medication regimens;

d. A documented history of falls in the prior six-month period;

e. Limited or absent informal support systems;

f. Living alone or being home alone for extended periods of time;

g. A documented history of care access challenges; or

h. A documented history of consistently missed appointments with health care providers;

(2) Ensure that clinical information gathered by a home health agency or hospital while providing home telemonitoring services is shared with the participant's physician; and

(3) Ensure that the program does not duplicate any disease management program services provided by MO HealthNet.

3. If, after implementation, the department determines that the program established under this section is not cost effective, the department may discontinue the program and stop providing reimbursement under the MO HealthNet program for home telemonitoring services.

4. The department shall determine whether the provision of home telemonitoring services to persons who are eligible to receive benefits under both the MO HealthNet and Medicare programs achieves cost savings for the Medicare program.

5. If, before implementing any provision of this section, the department determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the department shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

6. The department shall promulgate rules and regulations to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2016, shall be invalid and void.

334.108. 1. Prior to prescribing any drug, controlled substance, or other treatment through **telemedicine, as defined in section 191.1145, or** the internet, a physician shall establish a valid physician-patient relationship **as described in section 191.1146**. This relationship shall include:

(1) Obtaining a reliable medical history and performing a physical examination of the patient, adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions or contraindications to the treatment recommended or provided;

(2) Having sufficient dialogue with the patient regarding treatment options and the risks and benefits of treatment or treatments;

(3) If appropriate, following up with the patient to assess the therapeutic outcome;

(4) Maintaining a contemporaneous medical record that is readily available to the patient and, subject to the patient's consent, to the patient's other health care professionals; and

(5) **[**Including**] Maintaining** the electronic prescription information as part of the patient's medical record.

2. The requirements of subsection 1 of this section may be satisfied by the prescribing physician's designee when treatment is provided in:

(1) A hospital as defined in section 197.020;

(2) A hospice program as defined in section 197.250;

(3) Home health services provided by a home health agency as defined in section 197.400;

(4) Accordance with a collaborative practice agreement as defined in section 334.104;

(5) Conjunction with a physician assistant licensed pursuant to section 334.738;

(6) **Conjunction with an assistant physician licensed under section 334.036;**

(7) Consultation with another physician who has an ongoing physician-patient relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications; or

[(7)**] (8)** On-call or cross-coverage situations.

3. No health care provider, as defined in section 376.1350, shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an evaluation over the telephone; except that, a physician, such physician's on-call designee, an advanced practice registered nurse in a collaborative practice arrangement with such physician, a physician assistant in a supervision agreement with such physician, or an assistant physician in a supervision agreement with such physician may prescribe any drug, controlled substance, or other treatment that is within his or her scope of practice to a patient based solely on a telephone evaluation if a previously established and ongoing physician-patient relationship exists between such physician and the patient being treated.

4. No health care provider shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an internet request or an internet questionnaire.

335.175. 1. No later than January 1, 2014, there is hereby established within the state board of registration for the healing arts and the state board of nursing the "Utilization of Telehealth by Nurses". An advanced practice registered nurse (APRN) providing nursing services under a collaborative practice arrangement under section 334.104 may provide such services outside the geographic proximity requirements of section 334.104 if the collaborating physician and advanced practice registered nurse utilize telehealth in the care of the patient and if the services are provided in a rural area of need. Telehealth providers shall be required to obtain patient consent before telehealth services are initiated and ensure confidentiality of medical information.

2. As used in this section, "telehealth" **[**means the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient, as defined in section 208.670**] shall have the same meaning as such term is defined in section 191.1145**.

3. (1) The boards shall jointly promulgate rules governing the practice of telehealth under this section. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth.

(2) Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2013, shall be invalid and void.

4. For purposes of this section, "rural area of need" means any rural area of this state which is located in a health professional shortage area as defined in section 354.650.

5. Under section 23.253 of the Missouri sunset act:

(1) The provisions of the new program authorized under this section shall automatically sunset six years after August 28, 2013, 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 the program authorized under this section is sunset.

Section B. Because immediate action is necessary to ensure the provision of health care services for Missouri citizens, the enactment of section 191.1145 of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the enactment of section 191.1145 of this act shall be in full force and effect upon its passage and approval."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

In which the concurrence of the Senate is respectfully requested.

Also,

Mr. President: I am instructed by the House of Representatives to inform the Senate that the House has taken up and passed **SS** for **SCS** for **SB 838**.

Bill ordered enrolled.

Also,

Mr. President: I am instructed by the House of Representatives to inform the Senate that the House has taken up and passed **SB 664**.

Bill ordered enrolled

Also,

Mr. President: I am instructed by the House of Representatives to inform the Senate that the House has taken up and passed **HCS** for **SS** for **SB 621**, entitled:

An Act to repeal sections 208.152, 208.670, 334.108, and 335.175, RSMo, and to enact in lieu thereof fourteen new sections relating to health care, with an emergency clause for certain sections.

With House Amendment Nos. 1, 2, 3, 4, 5, 6, House Amendment No. 1 to House Amendment No. 7, House Amendment No. 7, as amended, House Amendment No. 8, House Amendment No. 1 to House Amendment No. 9, House Amendment No. 2 to House Amendment No. 9, House Amendment No. 9, as

amended, and House Amendment No. 10.

HOUSE AMENDMENT NO. 1

Amend House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 5, Section 191.1146, Line 20, by inserting after all of said section and line the following:

"**192.380. 1. For purposes of this section, the following terms shall mean:**

(1) "Birthing facility", any hospital as defined under section 197.020 with more than one licensed obstetric bed or a neonatal intensive care unit, a hospital operated by a state university, or a birthing center licensed under sections 197.200 to 197.240;

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

(3) "Regional perinatal center", a comprehensive maternal and newborn service for women who have been assessed as high-risk patients or are bearing high-risk babies, as determined by a standardized risk assessment tool, who will require the highest specialized care. Centers may be comprised of more than one licensed facility.

2. There is hereby created the "Perinatal Advisory Council" which shall be composed of representatives from the following organizations representing diverse geographic regions of the state who shall focus on and have experience in maternal and infant health, one of which shall be elected chair by a majority of the members, to be appointed by the governor with the advice and consent of the senate:

(1) One physician practicing obstetrics representing the Missouri Section of the American Congress of Obstetricians and Gynecologists;

(2) One practicing physician from the Missouri Chapter of the American Academy of Pediatrics Section of Perinatal Pediatrics;

(3) One representative from the March of Dimes;

(4) One representative from the National Association for Nurse Practitioners in Women's Health;

(5) One representative from the Missouri affiliate of the American College of Nurse-Midwives;

(6) One representative from the Missouri Section of the Association of Women's Health, Obstetric and Neonatal Nurses;

(7) One representative from the Missouri Chapter of the National Association of Neonatal Nurses;

(8) One family physician practicing obstetrics from the Missouri Academy of Family Physicians;

(9) One representative from a community coalition engaged in infant mortality prevention;

(10) Four representatives from regional Missouri hospitals with one representative from a hospital with neonatal care equivalent to each level;

(11) One practicing physician from the Society for Maternal-Fetal Medicine;

(12) One representative from a free-standing birthing center licensed under sections 197.200 to 197.240;

(13) Five active community-based physicians specializing in obstetrics or gynecology, family medicine practicing obstetrics, or perinatal pediatrics representing the regional diversity of the state;

(14) One representative from the show-me extension for community health care outcomes (ECHO) program; and

(15) One representative from a federally qualified health center.

The director of the department of health and senior services and the director of the department of social services or their designees shall serve as ex officio members of the council and shall not have a vote. The department shall provide necessary staffing support to the council.

3. After holding multiple public hearings in diverse geographic regions of the state and seeking broad public and stakeholder input, the perinatal advisory council shall make recommendations in the best interest of patients for the division of the state into neonatal and maternal care regions. When making such recommendations, the council shall consider:

(1) Geographic proximity of facilities;

(2) Hospital systems;

(3) Insurance networks;

(4) Consistent geographic boundaries for neonatal and maternal care regions, if appropriate; and

(5) Existing referral networks and referral patterns to appropriate birthing facilities.

4. The perinatal advisory council shall establish criteria for levels of maternal care designations and levels of neonatal care designations for birthing facilities and regional perinatal centers. The levels developed under this section shall be based upon:

(1) The most current published version of the "Levels of Neonatal Care" developed by the American Academy of Pediatrics;

(2) The most current published version of the "Levels of Maternal Care" developed by the American Congress of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine; and

(3) Necessary variance when considering the geographic and varied needs of citizens of this state.

5. Nothing in this section shall be construed in any way to modify or expand the licensure of any health care professional.

6. Nothing in this section shall be construed in any way to require a patient be transferred to a different facility.

7. The department shall promulgate rules to implement the provisions of this section no later than January 1, 2017. Such rules shall be limited to those necessary for the establishment of levels of neonatal care designations and levels of maternal care designations for birthing facilities and regional perinatal centers under subsection 4 of this section and the division of the state into neonatal and maternal care regions under subsection 3 of this section. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2016, shall be invalid and void.

8. Beginning January 1, 2018, any hospital with a birthing facility shall report to the department its appropriate level of maternal care designation and neonatal care designation as determined by the criteria outlined under subsection 4 of this section.

9. Beginning January 1, 2018, any hospital with a birthing facility operated by a state university shall report to the department its appropriate level of maternal care designation and neonatal care designation as determined by the criteria outlined under subsection 4 of this section.

10. Nothing in this section shall be construed to impose liability for referral or failure to refer in accordance with the recommendations of the perinatal advisory council.

11. The department may partner with appropriate nationally recognized professional organizations with demonstrated expertise in maternal and neonatal standards of care to administer the provisions of this section.

12. The criteria for levels of maternal and neonatal care developed under subsection 4 of this section shall not include pregnancy termination or counseling or referral for pregnancy termination."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 2

Amend House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 22, Section 335.175, Line 33, by inserting after all of said section and line the following:

"404.1100. Sections 404.1100 to 404.1110 shall be known and may be cited as the "Designated Health Care Decision-Maker Act".

404.1101. As used in sections 404.1100 to 404.1110, the following terms mean:

(1) "Artificially supplied nutrition and hydration", any medical procedure whereby nutrition or hydration is supplied through a tube inserted into a person's nose, mouth, stomach, or intestines, or nutrients or fluids are administered into a person's bloodstream or provided subcutaneously;

(2) "Best interests":

(a) Promoting the incapacitated person's right to enjoy the highest attainable standard of health for that person;

(b) Advocating that the person who is incapacitated receive the same range, quality, and standard of health care, care, and comfort as is provided to a similarly situated individual who is not incapacitated; and

(c) Advocating against the discriminatory denial of health care, care, or comfort, or food or fluids on the basis that the person who is incapacitated is considered an individual with a disability;

(3) "Designated health care decision-maker", the person designated to make health care decisions for a patient under section 404.1104, not including a person acting as a guardian or an agent under a durable power of attorney for health care or any other person legally authorized to consent for the patient under any other law to make health care decisions for an incapacitated patient;

(4) "Disability" or "disabled" shall have the same meaning as defined in 42 U.S.C. Section 12102, the Americans with Disabilities Act of 1990, as amended; provided that the term "this chapter" in that definition shall be deemed to refer to the Missouri health care decision-maker act;

(5) "Health care", a procedure to diagnose or treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin and includes:

(a) Assisted living services, or intermediate or skilled nursing care provided in a facility licensed under chapter 198;

(b) Services for the rehabilitation or treatment of injured, disabled, or sick persons; or

(c) Making arrangements for placement in or transfer to or from a health care facility or health care provider that provides such forms of care;

(6) "Health care facility", any hospital, hospice, inpatient facility, nursing facility, skilled nursing facility, residential care facility, intermediate care facility, dialysis treatment facility, assisted living facility, home health or hospice agency; any entity that provides home or community-based health care services; or any other facility that provides or contracts to provide health care, and which is licensed, certified, or otherwise authorized or permitted by law to provide health care;

(7) "Health care provider", any individual who provides health care to persons and who is licensed, certified, registered, or otherwise authorized or permitted by law to provide health care;

(8) "Incapacitated", a person who is unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions to such an extent that the person lacks capacity to meet essential requirements for food, clothing, shelter, safety, or other care such that serious physical injury, illness, or disease is likely to occur;

(9) "Patient", any adult person or any person otherwise authorized to make health care decisions for himself or herself under Missouri law;

(10) "Physician", a treating, attending, or consulting physician licensed to practice medicine under Missouri law;

(11) "Reasonable medical judgment", a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the health care possibilities with respect to the medical conditions involved.

404.1102. The determination that a patient is incapacitated shall be made as set forth in section 404.825. A health care provider or health care facility may rely in the exercise of good faith and in accordance with reasonable medical judgment upon the health care decisions made for a patient by a designated health care decision-maker selected in accordance with section 404.1104, provided two licensed physicians determine, after reasonable inquiry and in accordance with reasonable medical judgment, that such patient is incapacitated and has neither a guardian with medical decision-making

authority appointed in accordance with chapter 475, an attorney in fact appointed in a durable power of attorney for health care in accordance with sections 404.800 to 404.865, is not a child under the jurisdiction of the juvenile court under section 211.031, nor any other known person who has the legal authority to make health care decisions.

404.1103. Upon a determination that a patient is incapacitated, the physician or another health care provider acting at the direction of the physician shall make reasonable efforts to inform potential designated health care decision-makers set forth in section 404.1104 of whom the physician or physician's designee is aware, of the need to appoint a designated health care decision-maker. Reasonable efforts include, without limitation, identifying potential designated health care decision makers as set forth in subsection 1 of section 404.1104, a guardian with medical decision-making authority appointed in accordance with chapter 475, an attorney in fact appointed in a durable power of attorney for health care in accordance with sections 404.800 to 404.865, the juvenile court under section 211.031, or any other known person who has the legal authority to make health care decisions, by examining the patient's personal effects and medical records. If a family member, attorney in fact for health care or guardian with health care decision-making authority is identified, a documented attempt to contact that person by telephone, with all known telephone numbers and other contact information used, shall be made within twenty-four hours after a determination of incapacity is made as provided in section 404.1102.

404.1104. 1. If a patient is incapacitated under the circumstances described in section 404.1102 and is unable to provide consent regarding his or her own health care, and does not have a legally appointed guardian, an agent under a health care durable power of attorney, is not under the jurisdiction of the juvenile court, or does not have any other person who has legal authority to consent for the patient, decisions concerning the patient's health care may be made by the following competent persons in the following order of priority, with the exception of persons excluded under subsection 4 of section 404.1104:

(1) The spouse of the patient, unless the spouse and patient are separated under one of the following:

(a) A current dissolution of marriage or separation action;

(b) A signed written property or marital settlement agreement;

(c) A permanent order of separate maintenance or support or a permanent order approving a property or marital settlement agreement between the parties;

(2) An adult child of the patient;

(3) A parent of the patient;

(4) An adult sibling of the patient;

(5) A person who is a member of the same community of persons as the patient who is bound by vows to a religious life and who conducts or assists in the conducting of religious services and actually and regularly engages in religious, benevolent, charitable, or educational ministry, or performance of health care services;

(6) An adult who can demonstrate that he or she has a close personal relationship with the patient

and is familiar with the patient's personal values; or

(7) Any other person designated by the unanimous mutual agreement of the persons listed above who is involved in the patient's care.

2. If a person who is a member of the classes listed in subsection 1 of this section, regardless of priority, or a health care provider or a health care facility involved in the care of the patient, disagrees on whether certain health care should be provided to or withheld or withdrawn from a patient, any such person, provider, or facility, or any other person interested in the welfare of the patient may petition the probate court for an order for the appointment of a temporary or permanent guardian in accordance with subsection 8 of this section to act in the best interest of the patient.

3. A person who is a member of the classes listed in subsection 1 of this section shall not be denied priority under this section based solely upon that person's support for, or direction to provide, withhold or withdraw health care to the patient, subject to the rights of other classes of potential designated decision-makers, a healthcare provider, or healthcare facility to petition the probate court for an order for the appointment of a temporary or permanent guardian under subsection 8 of this section to act in the best interests of the patient.

4. Priority under this section shall not be given to persons in any of the following circumstances:

(1) If a report of abuse or neglect of the patient has been made under section 192.2475, 198.070, 208.912, 210.115, 565.188, 630.163 or any other mandatory reporting statutes, and if the health care provider knows of such a report of abuse or neglect, then unless the report has been determined to be unsubstantiated or unfounded, or a determination of abuse was finally reversed after administrative or judicial review, the person reported as the alleged perpetrator of the abuse or neglect shall not be given priority or authority to make health care decisions under subsection 1 of this section, provided that such a report shall not be based on the person's support for, or direction to provide, health care to the patient;

(2) If the patient's physician or the physician's designee reasonably determines, after making a diligent effort to contact the designated health care decision-maker using known telephone numbers and other contact information and receiving no response, that such person is not reasonably available to make medical decisions as needed or is not willing to make health care decisions for the patient; or

(3) If a probate court in a proceeding under subsection 8 of this section finds that the involvement of the person in decisions concerning the patient's health care is contrary to instructions that the patient had unambiguously, and without subsequent contradiction or change, expressed before he or she became incapacitated. Such a statement to the patient's physician or other health care provider contemporaneously recorded in the patient's medical record and signed by the patient's physician or other health care provider shall be deemed such an instruction, subject to the ability of a party to a proceeding under subsection 8 of this section to dispute its accuracy, weight, or interpretation.

5. (1) The designated health care decision-maker shall make reasonable efforts to obtain information regarding the patient's health care preferences from health care providers, family, friends, or others who may have credible information.

(2) The designated health care decision-maker, and the probate court in any proceeding under

subsection 8 of this section, shall always make health care decisions in the patient's best interests, and if the patient's religious and moral beliefs and health care preferences are known, in accordance with those beliefs and preferences.

6. This section does not authorize the provision or withholding of health care services that the patient has unambiguously, without subsequent contradiction or change of instruction, expressed that he or she would or would not want at a time when such patient had capacity. Such a statement to the patient's physician or other health care provider, contemporaneously recorded in the patient's medical record and signed by the patient's physician or other health care provider, shall be deemed such evidence, subject to the ability of a party to a proceeding under subsection 8 of this section to dispute its accuracy, weight, or interpretation.

7. A designated health care decision-maker shall be deemed a personal representative for the purposes of access to and disclosure of private medical information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Section 1320d and 45 CFR 160-164.

8. Nothing in sections 404.1100 to 404.1110 shall preclude any person interested in the welfare of a patient including, but not limited to, a designated health care decision-maker, a member of the classes listed in subsection 1 of this section regardless of priority, or a health care provider or health care facility involved in the care of the patient, from petitioning the probate court for the appointment of a temporary or permanent guardian for the patient including expedited adjudication under chapter 475.

9. Pending the final outcome of proceedings initiated under subsection 8 of this section, the designated health care decision-maker, health care provider, or health care facility shall not withhold or withdraw, or direct the withholding or withdrawal, of health care, nutrition, or hydration whose withholding or withdrawal, in reasonable medical judgment, would result in or hasten the death of the patient, would jeopardize the health or limb of the patient, or would result in disfigurement or impairment of the patient's faculties. If a health care provider or a health care facility objects to the provision of such health care, nutrition, or hydration on the basis of religious beliefs or sincerely held moral convictions, the provider or facility shall not impede the transfer of the patient to another health care provider or health care facility willing to provide it, and shall provide such health care, nutrition, or hydration to the patient pending the completion of the transfer. For purposes of this section, artificially supplied nutrition and hydration may be withheld or withdrawn during the pendency of the guardianship proceeding only if, based on reasonable medical judgment, the patient's physician and a second licensed physician certify that the patient meets the standard set forth in subdivision (2) of subsection 1 of section 404.1105. If tolerated by the patient and adequate to supply the patient's needs for nutrition or hydration, natural feeding should be the preferred method.

404.1105. 1. No designated health care decision-maker may, with the intent of hastening or causing the death of the patient, authorize the withdrawal or withholding of nutrition or hydration supplied through either natural or artificial means. A designated health care decision-maker may authorize the withdrawal or withholding of artificially supplied nutrition and hydration only when the physician and a second licensed physician certify in the patient's medical record based on reasonable medical judgment that:

(1) Artificially supplied nutrition or hydration are not necessary for comfort care or the relief of

pain and would serve only to prolong artificially the dying process and where death will occur within a short period of time whether or not such artificially supplied nutrition or hydration is withheld or withdrawn; or

(2) Artificially supplied nutrition or hydration cannot be physiologically assimilated or tolerated by the patient.

2. When tolerated by the patient and adequate to supply the patient's need for nutrition or hydration, natural feeding should be the preferred method.

3. The provisions of this section shall not apply to subsection 3 of section 459.010.

404.1106. If any of the individuals specified in section 404.1104 or the designated health care decision-maker or physician believes the patient is no longer incapacitated, the patient's physician shall reexamine the patient and determine in accordance with reasonable medical judgment whether the patient is no longer incapacitated, shall certify the decision and the basis therefor in the patient's medical record, and shall notify the patient, the designated health care decision-maker, and the person who initiated the redetermination of capacity. Rights of the designated health care decision-maker shall end upon the physician's certification that the patient is no longer incapacitated.

404.1107. No health care provider or health care facility that makes good faith and reasonable attempts to identify, locate, and communicate with potential designated health care decision-makers in accordance with sections 404.1100 to 404.1110 shall be subject to civil or criminal liability or regulatory sanction for any act or omission related to his or her or its effort to identify, locate, and communicate with or act upon any decision by or for such actual or potential designated health care decision-makers.

404.1108. 1. A health care provider or a health care facility may decline to comply with the health care decision of a patient or a designated health care decision-maker if such decision is contrary to the religious beliefs or sincerely held moral convictions of a health care provider or health care facility.

2. If at any time, a health care facility or health care provider determines that any known or anticipated health care preferences expressed by the patient to the health care provider or health care facility, or as expressed through the patient's designated health care decision-maker, are contrary to the religious beliefs or sincerely held moral convictions of the health care provider or health care facility, such provider or facility shall promptly inform the patient or the patient's designated health care decision-maker.

3. If a health care provider declines to comply with such health care decision, no health care provider or health care facility shall impede the transfer of the patient to another health care provider or health care facility willing to comply with the health care decision.

4. Nothing in this section shall relieve or exonerate a health care provider or a health care facility from the duty to provide for the health care, care, and comfort of a patient pending transfer under this section. If withholding or withdrawing certain health care would, in reasonable medical judgment, result in or hasten the death of the patient, such health care shall be provided pending completion of the transfer. Notwithstanding any other provision of this section, no such health care shall be denied on the basis of a view that treats extending the life of an elderly, disabled, or

terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill, or on the basis of the health care provider's or facility's disagreement with how the patient or individual authorized to act on the patient's behalf values the tradeoff between extending the length of the patient's life and the risk of disability.

404.1109. No health care decision-maker shall withhold or withdraw health care from a pregnant patient, consistent with existing law, as set forth in section 459.025.

404.1110. Nothing in sections 404.1100 to 404.1110 is intended to:

(1) Be construed as condoning, authorizing, or approving euthanasia or mercy killing; or

(2) Be construed as permitting any affirmative or deliberate act to end a person's life, except to permit natural death as provided by sections 404.1100 to 404.1110."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 3

Amend House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 20, Section 208.686, Line 55, by inserting after all of said section and line the following:

"324.001. 1. For the purposes of this section, the following terms mean:

(1) "Department", the department of insurance, financial institutions and professional registration;

(2) "Director", the director of the division of professional registration; and

(3) "Division", the division of professional registration.

2. There is hereby established a "Division of Professional Registration" assigned to the department of insurance, financial institutions and professional registration as a type III transfer, headed by a director appointed by the governor with the advice and consent of the senate. All of the general provisions, definitions and powers enumerated in section 1 of the Omnibus State Reorganization Act of 1974 and Executive Order 06-04 shall apply to this department and its divisions, agencies, and personnel.

3. The director of the division of professional registration shall promulgate rules and regulations which designate for each board or commission assigned to the division the renewal date for licenses or certificates. After the initial establishment of renewal dates, no director of the division shall promulgate a rule or regulation which would change the renewal date for licenses or certificates if such change in renewal date would occur prior to the date on which the renewal date in effect at the time such new renewal date is specified next occurs. Each board or commission shall by rule or regulation establish licensing periods of one, two, or three years. Registration fees set by a board or commission shall be effective for the entire licensing period involved, and shall not be increased during any current licensing period. Persons who are required to pay their first registration fees shall be allowed to pay the pro rata share of such fees for the remainder of the period remaining at the time the fees are paid. Each board or commission shall provide the necessary forms for initial registration, and thereafter the director may prescribe standard forms for renewal of licenses and certificates. Each board or commission shall by rule and regulation require each applicant to provide the information which is required to keep the board's records current. Each board or commission shall have the authority to collect and analyze information required to support workforce planning and policy development. Such information shall not be publicly disclosed so as to identify a specific health care

provider, as defined in section 376.1350. Each board or commission shall issue the original license or certificate.

4. The division shall provide clerical and other staff services relating to the issuance and renewal of licenses for all the professional licensing and regulating boards and commissions assigned to the division. The division shall perform the financial management and clerical functions as they each relate to issuance and renewal of licenses and certificates. "Issuance and renewal of licenses and certificates" means the ministerial function of preparing and delivering licenses or certificates, and obtaining material and information for the board or commission in connection with the renewal thereof. It does not include any discretionary authority with regard to the original review of an applicant's qualifications for licensure or certification, or the subsequent review of licensee's or certificate holder's qualifications, or any disciplinary action contemplated against the licensee or certificate holder. The division may develop and implement microfilming systems and automated or manual management information systems.

5. The director of the division shall maintain a system of accounting and budgeting, in cooperation with the director of the department, the office of administration, and the state auditor's office, to ensure proper charges are made to the various boards for services rendered to them. The general assembly shall appropriate to the division and other state agencies from each board's funds moneys sufficient to reimburse the division and other state agencies for all services rendered and all facilities and supplies furnished to that board.

6. For accounting purposes, the appropriation to the division and to the office of administration for the payment of rent for quarters provided for the division shall be made from the "Professional Registration Fees Fund", which is hereby created, and is to be used solely for the purpose defined in subsection 5 of this section. The fund shall consist of moneys deposited into it from each board's fund. Each board shall contribute a prorated amount necessary to fund the division for services rendered and rent based upon the system of accounting and budgeting established by the director of the division as provided in subsection 5 of this section. Transfers of funds to the professional registration fees fund shall be made by each board on July first of each year; provided, however, that the director of the division may establish an alternative date or dates of transfers at the request of any board. Such transfers shall be made until they equal the prorated amount for services rendered and rent by the division. The provisions of section 33.080 to the contrary notwithstanding, money in this fund shall not be transferred and placed to the credit of general revenue.

7. The director of the division shall be responsible for collecting and accounting for all moneys received by the division or its component agencies. Any money received by a board or commission shall be promptly given, identified by type and source, to the director. The director shall keep a record by board and state accounting system classification of the amount of revenue the director receives. The director shall promptly transmit all receipts to the department of revenue for deposit in the state treasury to the credit of the appropriate fund. The director shall provide each board with all relevant financial information in a timely fashion. Each board shall cooperate with the director by providing necessary information.

8. All educational transcripts, test scores, complaints, investigatory reports, and information pertaining to any person who is an applicant or licensee of any agency assigned to the division of professional registration by statute or by the department are confidential and may not be disclosed to the public or any member of the public, except with the written consent of the person whose records are involved. The agency which possesses the records or information shall disclose the records or information if the person whose records or information is involved has consented to the disclosure. Each agency is entitled to the attorney-

client privilege and work-product privilege to the same extent as any other person. Provided, however, that any board may disclose confidential information without the consent of the person involved in the course of voluntary interstate exchange of information, or in the course of any litigation concerning that person, or pursuant to a lawful request, or to other administrative or law enforcement agencies acting within the scope of their statutory authority. Information regarding identity, including names and addresses, registration, and currency of the license of the persons possessing licenses to engage in a professional occupation and the names and addresses of applicants for such licenses is not confidential information.

9. Any deliberations conducted and votes taken in rendering a final decision after a hearing before an agency assigned to the division shall be closed to the parties and the public. Once a final decision is rendered, that decision shall be made available to the parties and the public.

10. A compelling governmental interest shall be deemed to exist for the purposes of section 536.025 for licensure fees to be reduced by emergency rule, if the projected fund balance of any agency assigned to the division of professional registration is reasonably expected to exceed an amount that would require transfer from that fund to general revenue.

11. (1) The following boards and commissions are assigned by specific type transfers to the division of professional registration: Missouri state board of accountancy, chapter 326; board of cosmetology and barber examiners, chapters 328 and 329; Missouri board for architects, professional engineers, professional land surveyors and landscape architects, chapter 327; Missouri state board of chiropractic examiners, chapter 331; state board of registration for the healing arts, chapter 334; Missouri dental board, chapter 332; state board of embalmers and funeral directors, chapter 333; state board of optometry, chapter 336; Missouri state board of nursing, chapter 335; board of pharmacy, chapter 338; state board of podiatric medicine, chapter 330; Missouri real estate appraisers commission, chapter 339; and Missouri veterinary medical board, chapter 340. The governor shall appoint members of these boards by and with the advice and consent of the senate.

(2) The boards and commissions assigned to the division shall exercise all their respective statutory duties and powers, except those clerical and other staff services involving collecting and accounting for moneys and financial management relating to the issuance and renewal of licenses, which services shall be provided by the division, within the appropriation therefor. Nothing herein shall prohibit employment of professional examining or testing services from professional associations or others as required by the boards or commissions on contract. Nothing herein shall be construed to affect the power of a board or commission to expend its funds as appropriated. However, the division shall review the expense vouchers of each board. The results of such review shall be submitted to the board reviewed and to the house and senate appropriations committees annually.

(3) Notwithstanding any other provisions of law, the director of the division shall exercise only those management functions of the boards and commissions specifically provided in the Reorganization Act of 1974, and those relating to the allocation and assignment of space, personnel other than board personnel, and equipment.

(4) "Board personnel", as used in this section or chapters 317, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, and 345, shall mean personnel whose functions and responsibilities are in areas not related to the clerical duties involving the issuance and renewal of licenses, to the collecting and accounting for moneys, or to financial management relating to issuance and renewal of licenses; specifically

included are executive secretaries (or comparable positions), consultants, inspectors, investigators, counsel, and secretarial support staff for these positions; and such other positions as are established and authorized by statute for a particular board or commission. Boards and commissions may employ legal counsel, if authorized by law, and temporary personnel if the board is unable to meet its responsibilities with the employees authorized above. Any board or commission which hires temporary employees shall annually provide the division director and the appropriation committees of the general assembly with a complete list of all persons employed in the previous year, the length of their employment, the amount of their remuneration, and a description of their responsibilities.

(5) Board personnel for each board or commission shall be employed by and serve at the pleasure of the board or commission, shall be supervised as the board or commission designates, and shall have their duties and compensation prescribed by the board or commission, within appropriations for that purpose, except that compensation for board personnel shall not exceed that established for comparable positions as determined by the board or commission pursuant to the job and pay plan of the department of insurance, financial institutions and professional registration. Nothing herein shall be construed to permit salaries for any board personnel to be lowered except by board action.

12. All the powers, duties, and functions of the division of athletics, chapter 317, and others, are assigned by type I transfer to the division of professional registration.

13. Wherever the laws, rules, or regulations of this state make reference to the "division of professional registration of the department of economic development", such references shall be deemed to refer to the division of professional registration.

14. (1) The state board of nursing, board of pharmacy, Missouri dental board, state committee of psychologists, state board of chiropractic examiners, state board of optometry, Missouri board of occupational therapy, or state board of registration for the healing arts may individually or collectively enter into a contractual agreement with the department of health and senior services, a public institution of higher education, or a nonprofit entity for the purpose of collecting and analyzing workforce data from its licensees, registrants, or permit holders for future workforce planning and to assess the accessibility and availability of qualified health care services and practitioners in Missouri. The boards shall work collaboratively with other state governmental entities to ensure coordination and avoid duplication of efforts.

(2) The boards may expend appropriated funds necessary for operational expenses of the program formed under this subsection. Each board is authorized to accept grants to fund the collection or analysis authorized in this subsection. Any such funds shall be deposited in the respective board's fund.

(3) Data collection shall be controlled and approved by the applicable state board conducting or requesting the collection. Notwithstanding the provisions of section 334.001, the boards may release identifying data to the contractor to facilitate data analysis of the health care workforce including, but not limited to, geographic, demographic, and practice or professional characteristics of licensees. The state board shall not request or be authorized to collect income or other financial earnings data.

(4) Data collected under this subsection shall be deemed the property of the state board requesting the data. Data shall be maintained by the state board in accordance with chapter 610, provided that any information deemed closed or confidential under subsection 8 of this section or any other

provision of state law shall not be disclosed without consent of the applicable licensee or entity or as otherwise authorized by law. Data shall only be released in an aggregate form by geography, profession or professional specialization, or population characteristic in a manner that cannot be used to identify a specific individual or entity. Data suppression standards shall be addressed and established in the contractual agreement.

(5) Contractors shall maintain the security and confidentiality of data received or collected under this subsection and shall not use, disclose, or release any data without approval of the applicable state board. The contractual agreement between the applicable state board and contractor shall establish a data release and research review policy to include legal and institutional review board, or agency equivalent, approval.

(6) Each board may promulgate rules subject to the provisions of this subsection and chapter 536 to effectuate and implement the workforce data collection and analysis authorized by this subsection. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly under chapter 536 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, 2016, shall be invalid and void."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 4

Amend House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 3, Section 191.596, Line 38, by inserting after all of said section and line the following:

"**191.1075. As used in sections 191.1075 to 191.1085, the following terms shall mean:**

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

(2) "Health care professional", a physician or other health care practitioner licensed, accredited, or certified by the state of Missouri to perform specified health services;

(3) "Hospital":

(a) A place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care of not less than twenty-four consecutive hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions; or

(b) A place devoted primarily to provide for not less than twenty-four consecutive hours in any week medical or nursing care for three or more unrelated individuals. "Hospital" does not include convalescent, nursing, shelter, or boarding homes as defined in chapter 198.

191.1080. 1. There is hereby created within the department the "Missouri Palliative Care and Quality of Life Interdisciplinary Council", which shall be a palliative care consumer and professional information and education program to improve quality and delivery of patient-centered and family-

focused care in this state.

2. On or before December 1, 2016, the following members shall be appointed to the council:

(1) Two members of the senate, appointed by the president pro tempore of the senate;

(2) Two members of the house of representatives, appointed by the speaker of the house of representatives;

(3) Two board-certified hospice and palliative medicine physicians licensed in this state, appointed by the governor with the advice and consent of the senate;

(4) Two certified hospice and palliative nurses licensed in this state, appointed by the governor with the advice and consent of the senate;

(5) A certified hospice and palliative social worker, appointed by the governor with the advice and consent of the senate;

(6) A patient and family caregiver advocate representative, appointed by the governor with the advice and consent of the senate; and

(7) A spiritual professional with experience in palliative care and health care, appointed by the governor with the advice and consent of the senate.

3. Council members shall serve for a term of three years. The members of the council shall elect a chair and vice chair whose duties shall be established by the council. The department shall determine a time and place for regular meetings of the council, which shall meet at least biannually.

4. Members of the council shall serve without compensation, but shall, subject to appropriations, be reimbursed for their actual and necessary expenses incurred in the performance of their duties as members of the council.

5. The council shall consult with and advise the department on matters related to the establishment, maintenance, operation, and outcomes evaluation of palliative care initiatives in this state, including the palliative care consumer and professional information and education program established in section 191.1085.

6. The council shall submit an annual report to the general assembly, which includes an assessment of the availability of palliative care in this state for patients at early stages of serious disease and an analysis of barriers to greater access to palliative care.

7. The council authorized under this section shall automatically expire August 28, 2022.

191.1085. 1. There is hereby established the "Palliative Care Consumer and Professional Information and Education Program" within the department.

2. The purpose of the program is to maximize the effectiveness of palliative care in this state by ensuring that comprehensive and accurate information and education about palliative care is available to the public, health care providers, and health care facilities.

3. The department shall publish on its website information and resources, including links to external resources, about palliative care for the public, health care providers, and health care facilities

including, but not limited to:

(1) Continuing education opportunities for health care providers;

(2) Information about palliative care delivery in the home, primary, secondary, and tertiary environments; and

(3) Consumer educational materials and referral information for palliative care, including hospice.

4. Each hospital in this state is encouraged to have a palliative care presence on its intranet or internet website which provides links to one or more of the following organizations: the Institute of Medicine, the Center to Advance Palliative Care, the Supportive Care Coalition, the National Hospice and Palliative Care Organization, the American Academy of Hospice and Palliative Medicine, and the National Institute on Aging.

5. Each hospital in this state is encouraged to have patient education information about palliative care available for distribution to patients.

6. The department shall consult with the palliative care and quality of life interdisciplinary council established in section 191.1080 in implementing the section.

7. The department may promulgate rules to implement the provisions of sections 191.1075 to 191.1085. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in sections 191.1075 to 191.1085 shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. Sections 191.1075 to 191.1085 and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2016, shall be invalid and void.

8. Notwithstanding the provisions of section 23.253 to the contrary, the program authorized under this section shall automatically expire on August 28, 2022."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 5

Amend House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 5, Section 191.1146, Line 20, by inserting after all of said section and line the following:

"**195.430. 1. There is hereby established in the state treasury the "Controlled Substance Abuse Prevention Fund", which shall consist of all fees collected by the department of health and senior services for the issuance of registrations to manufacture, distribute, or dispense controlled substances. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and moneys in the fund shall be used solely for the operation, regulation, enforcement, and educational activities of the bureau of narcotics and dangerous drugs. Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund. The state treasurer shall invest moneys in the fund in the same manner**

as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

2. All fees authorized to be charged by the department shall be transmitted to the department of revenue for deposit in the state treasury for credit to the fund, to be disbursed solely for the payment of operating expenses of the bureau of narcotics and dangerous drugs to conduct inspections, enforce controlled substances laws and regulations, provide education to health care professionals and the public, and to prevent abuse of controlled substances.

3. Any moneys appropriated or made available by gift, grant, bequest, contribution, or otherwise to carry out the purposes of this section shall be paid to and deposited in the controlled substances abuse prevention fund.

195.435. The bureau of narcotics and dangerous drugs shall employ no less than one investigator for every two thousand five hundred controlled substance registrants."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 6

Amend House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 20, Section 208.686, Line 55, by inserting immediately after said line the following:

"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 registered nurse as defined in subdivision (2) of section 335.016. Collaborative practice arrangements may delegate to an advanced practice registered nurse, as defined in section 335.016, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017, and Schedule II - hydrocodone; except that, the collaborative practice arrangement shall not delegate the authority to administer any controlled substances listed in Schedules III, IV, and V of section 195.017, or Schedule II - hydrocodone for the purpose of inducing sedation or general anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic controlled substance and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill. 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, except the collaborative practice arrangement may allow for geographic proximity to be waived **[**for a maximum of twenty-eight days per calendar year for rural health clinics as defined by P.L. 95-210,**]** as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. **[**This exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics where the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics where the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician is required to maintain documentation related to this requirement and to present it to the state board of registration for the healing arts when requested**]**; 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;

(9) A description of the time and manner of the collaborating physician's review of the advanced practice registered nurse's delivery of health care services. The description shall include provisions that the advanced practice registered nurse shall submit a minimum of ten percent of the charts documenting the advanced practice registered nurse's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days; and

(10) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the advanced practice registered nurse prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (9) of this

subsection.

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 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. Any rules relating to dispensing or distribution of controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the department of health and senior services and 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 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

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.

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.

7. Notwithstanding any law to the contrary, a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016 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. Nothing in this subsection shall be construed to prohibit or prevent a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016 from entering into a collaborative practice arrangement under this section, except that the collaborative practice arrangement may not delegate the authority to prescribe any controlled substances listed in Schedules III, IV, and V of section 195.017, or Schedule II - hydrocodone.

8. A collaborating physician shall not enter into a collaborative practice arrangement with more than **[**three**]** **five** 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 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

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. This limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

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 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."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 1 TO
HOUSE AMENDMENT NO. 7

Amend House Amendment No. 7 to House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 2, Line 10, by deleting all of said line and inserting in lieu thereof the following:

""197.258. 1. In addition to any survey pursuant to sections 197.250 to 197.280, the department may make such surveys as it deems necessary during normal business hours. The department shall survey every hospice not less than [once annually] **every three years**. The hospice shall permit the department's representatives to enter upon any of its business premises during normal business hours for the purpose of a survey.

2. As a part of its survey of a hospice, the department may visit the home of any client of such hospice with such client's consent.

3. In lieu of any survey required by sections 197.250 to 197.280, the department may accept in whole or in part the survey of any state or federal agency, or of any professional accrediting agency, if such survey:

(1) Is comparable in scope and method to the department's surveys; and

(2) Is conducted within one year of initial application for or renewal of the hospice's certificate.

4. The department shall not be required to survey any hospice providing service to Missouri residents through an office located in a state bordering Missouri if such bordering state has a reciprocal agreement with Missouri on hospice certification and the area served in Missouri by the agency is contiguous to the area served in the bordering state.

5. Any hospice which has its parent office in a state which does not have a reciprocal agreement with Missouri on hospice certification shall maintain a branch office in Missouri. Such branch office shall maintain all records required by the department for survey and shall be certificated as a hospice.

198.054. Each year between October first and March first, all long-term care facilities"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 7

Amend House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 1, Section 9.154, Line 11, by inserting after all of said section and line the following:

"167.638. The department of health and senior services shall develop an informational brochure relating to meningococcal disease that states that **[**an immunization**] immunizations** against meningococcal disease **[**is**] are** available. The department shall make the brochure available on its website and shall notify every public institution of higher education in this state of the availability of the brochure. Each public institution of higher education shall provide a copy of the brochure to all students and if the student is under eighteen years of age, to the student's parent or guardian. Such information in the brochure shall include:

(1) The risk factors for and symptoms of meningococcal disease, how it may be diagnosed, and its possible consequences if untreated;

(2) How meningococcal disease is transmitted;

(3) The latest scientific information on meningococcal disease immunization and its effectiveness**, including information on all meningococcal vaccines receiving a Category A or B recommendation from the Advisory Committee on Immunization Practices**; **[**and**]**

(4) A statement that any questions or concerns regarding immunization against meningococcal disease may be answered by contacting the individuals's health care provider**; and**

(5) A recommendation that the current student or entering student receive meningococcal vaccines in accordance with current Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention guidelines.

174.335. 1. Beginning with the 2004-05 school year and for each school year thereafter, every public

institution of higher education in this state shall require all students who reside in on-campus housing to have received the meningococcal vaccine **not more than five years prior to enrollment and in accordance with the latest recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention,** unless a signed statement of medical or religious exemption is on file with the institution's administration. A student shall be exempted from the immunization requirement of this section upon signed certification by a physician licensed under chapter 334 indicating that either the immunization would seriously endanger the student's health or life or the student has documentation of the disease or laboratory evidence of immunity to the disease. A student shall be exempted from the immunization requirement of this section if he or she objects in writing to the institution's administration that immunization violates his or her religious beliefs.

2. Each public university or college in this state shall maintain records on the meningococcal vaccination status of every student residing in on-campus housing at the university or college.

3. Nothing in this section shall be construed as requiring any institution of higher education to provide or pay for vaccinations against meningococcal disease.

4. For purposes of this section, the term "on-campus housing" shall include, but not be limited to, any fraternity or sorority residence, regardless of whether such residence is privately owned, on or near the campus of a public institution of higher education."; and

Further amend said bill, Page 5, Section 191.1146, Line 20, by inserting after all of said section and line the following:

"**198.054. Each year between October first and March first, all long-term care facilities licensed under this chapter shall assist their health care workers, volunteers, and other employees who have direct contact with residents in obtaining the vaccination for the influenza virus by either offering the vaccination in the facility or providing information as to how they may independently obtain the vaccination, unless contraindicated, in accordance with the latest recommendations of the Centers for Disease Control and Prevention and subject to availability of the vaccine. Facilities are encouraged to document that each health care worker, volunteer, and employee has been offered assistance in receiving a vaccination against the influenza virus and has either accepted or declined.**"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 8

Amend House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 5, Section 191.1146, Line 20, by inserting after all of said line the following:

"**197.170. 1. This section shall be known and may be cited as the "Health Care Cost Reduction and Transparency Act".**

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

(1) "Ambulatory surgical center", as such term is defined under section 197.200;

(2) "Direct payment", as such term is defined under section 1.330;

(3) "Health care provider", the same meaning as such term is defined under section 376.1350. "Health care provider" shall also include any provider located in a Kansas border county, as defined

under section 135.1670, who participates in the MO HealthNet program;

(4) "Hospital", as such term is defined under section 197.020;

(5) "Imaging center", any facility at which diagnostic imaging services are provided including, but not limited to, magnetic resonance imaging (MRI);

(6) "Medical treatment plan", a patient-specific plan of medical treatment for a particular illness, injury, or condition determined by such patient's physician, which includes the applicable current procedural terminology (CPT) code or codes.

3. Beginning July 1, 2018, ambulatory surgical centers and imaging centers shall make available to the public, in a manner that is easily understood, an estimate of the most current direct payment price information for the twenty-five most common surgical procedures or the twenty most common imaging procedures, as appropriate, performed in ambulatory surgical centers or imaging centers. Disclosure of data under this subsection shall constitute compliance with subsection 5 of this section regarding any surgical or imaging procedure for which disclosure is required under this subsection.

4. Not later than July 1, 2017, hospitals shall make available to the public, in a manner that is easily understood, the amount that would be charged without discounts for each the one hundred most prevalent diagnosis-related groups as defined by the Medicare program, Title XVIII of the Social Security Act. The diagnosis-related groups shall be described in layman's language suitable for use by reasonably informed patients. Disclosure of data under this subsection shall constitute compliance with subsection 5 of this section regarding any diagnosis-related group for which disclosure is required under this subsection.

5. Upon written request by a patient, which shall include a medical treatment plan from the patient's physician, for the direct payment cost of a particular health care service or procedure, imaging procedure, or surgery procedure, a health care provider, hospital, ambulatory surgical center, or imaging center shall provide an estimate of the direct payment price information required by this section to the patient in writing either electronically, by mail, or in person, within three business days after receiving the written request. Providing a patient a specific link to such estimated prices and making such estimated prices publicly available or posting such estimated prices on a website of the health care provider, hospital, ambulatory surgical center, or imaging center shall constitute compliance with the provisions of this subsection.

6. No health care provider shall be required to report the information required by this section if the reporting of such information reasonably could lead to the identification of the person or persons receiving health care services or procedures in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law. This section shall not apply to emergency departments, which shall comply with requirements of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd.

7. It shall be a condition of participation in the MO HealthNet program for a health care provider located in a Kansas border county, as defined under section 135.1670, to comply with the provisions of this section."; and

Further amend said bill, Page 22, Section 335.175, Line 33, by inserting after all of said line the following:

"**376.1475. 1. This section shall be known and may be cited as the "Predetermination of Health Care Benefits Act".**

2. For the purposes of this section, the following terms shall mean:

(1) "Administrative simplification provision", transaction and code standards promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, and 45 CFR 160 and 162;

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

(3) "Health benefit plan" and "health care provider", the same meanings as those terms are defined in section 376.1350;

(4) "Health care clearinghouse", the same meaning as the term is defined in 45 CFR 160.103;

(5) "Payment", a deductible or coinsurance payment and shall not include a co-payment;

(6) "Standard electronic transactions", electronic claim and remittance advice transactions created by the Accredited Standards Committee (ASC) X12 in the format of ASC X12 837I, ASC X12 837P, or ASC X12 835, or any of their respective successors.

3. Health benefit plans that receive an electronic health care predetermination request from a health care provider consistent with the requirements set forth in subsection 6 of this section shall provide the requesting health care provider with information on the amount of expected benefits coverage on the procedures specified in the request that is accurate at the time of the health benefit plan's response.

4. Any predetermination response provided by a health benefit plan under this section in good faith shall be deemed to be an estimate only and shall not be binding upon the health benefit plan with regard to the final amount of benefits actually provided by the health benefit plan.

5. The amounts for the referenced services under subsection 3 of this section shall include:

(1) The amount the patient will be expected to pay, clearly identifying any deductible amount, coinsurance, and co-payment;

(2) The amount the health care provider will be paid;

(3) The amount the institution will be paid; and

(4) Whether any payments will be reduced, but not to zero dollars, or increased from the agreed fee schedule amounts, and if so, the health care policy that identifies why the payments will be reduced or increased.

6. The health care predetermination request and predetermination response shall be conducted in accordance with administrative simplification provisions using the currently applicable standard electronic transactions, without regard to whether the transaction is mandated by HIPAA. It shall also comply with any rules promulgated by the director, without regard to whether such rules are mandated by HIPAA. To the extent HIPAA-mandated electronic claim and remittance transactions are modified to include predetermination, the provisions of this section shall not apply to health

benefit plans which provide this information under HIPAA.

7. The health benefit plan's predetermination response to the health care predetermination request shall be returned using the same transmission method as that of the request. This shall include a real time response for a real time request.

8. A health care clearinghouse that contracts with a health care provider shall be required to conduct a transaction as described in subsections 5, 6, and 7 of this section if requested by the health care provider.

9. Nothing in this act precludes the collection of payment prior to receiving health benefit services once a health benefit plan has fulfilled any predetermination request.

10. The provisions of 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, short-term major medical policy of six months or less duration, or any other supplemental policy.

11. The director shall adopt rules and regulations necessary to carry out the provisions of this section.

12. Any rule or portion of a rule, as that term is defined in section 536.010 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, and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536, 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, 2016, shall be invalid and void."; and

Further amend said bill, Page 23, Section B, Line 6, by inserting after all of said line the following:

"Section C. Section 376.1475 of Section A of this act shall become effective July 1, 2018."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 1 TO
HOUSE AMENDMENT NO. 9

Amend House Amendment No. 9 to House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 1, Line 12, by inserting immediately after all of said line the following:

"Further amend said bill, Page 22, Section 335.175, Line 33, by inserting immediately after all of said line the following:

"**376.525 The highest rate that a health care provider shall accept as payment in full for health care services from an uninsured individual or an individual not utilizing insurance to pay for such services shall be no greater than the lowest rate that the provider accepts from a health carrier or Medicare as payment in full for the same or similar health care services.**"; and"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 2 TO
HOUSE AMENDMENT NO. 9

Amend House Amendment No. 9 to House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 1, Line 3, by inserting after all of said section and line the following:

"Further amend said bill, Page 3, Section 191.596, Line 38, by inserting after all of said section and line the following:

"**191.875. 1. This section shall be known as the "Health Care Cost Reduction and Transparency Act".**

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

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

(2) "DRG", diagnosis related group;

(3) "Estimate of cost", an estimate based on the information entered and assumptions about typical utilization and costs for health care services. Such estimates of cost shall encompass only those services within the direct control of the health care provider and shall include the following:

(a) The amount that will be charged to a patient for the health services if all charges are paid in full without a public or private third party paying for any portion of the charges;

(b) The average negotiated settlement on the amount that will be charged to a patient required to be provided in paragraph (a) of this subdivision;

(c) The amount of any MO HealthNet reimbursement for the health care services, including claims and pro rata supplemental payments, if known;

(d) The amount of any Medicare reimbursement for the medical services, if known; and

(e) The amount of any insurance copayments for the health benefit plan of the patient, if known;

(4) "Health care provider", any ambulatory surgical center, assistant physician, chiropractor, clinical psychologist, dentist, hospital, long-term care facility, nurse anesthetist, optometrist, pharmacist, physical therapist, physician, physician assistant, podiatrist, registered nurse, or other licensed health care facility or professional providing health care services in this state. In addition, a health care provider shall also include any provider located in a Kansas border county, as defined in section 135.1670, who participates in the MO HealthNet program. To participate in the MO HealthNet program such provider shall comply with the provisions of this section. If such provider, for any reason, does not comply with such condition of participation, then a health care provider, as defined in this section, shall not include any provider located in a Missouri border county, as defined in section 135.670.;

(5) "Health carrier", an entity as such term is defined under section 376.1350;

(6) "Hospital", as such term is defined under section 197.020;

(7) "Insurance costs", an estimate of cost of covered services provided by a health carrier based on a specific insured's coverage and health care services to be provided. Such insurance cost shall

include:

(a) The average negotiated reimbursement amount to any health care provider;

(b) Any deductibles, copayments, or coinsurance amounts, including those whose disclosure is mandated under section 376.446; and

(c) Any amounts not covered under the health benefit plan;

(8) "Public or private third party", a state government, the federal government, employer, health carrier, third-party administrator, or managed care organization.

3. On or after July 1, 2017, any patient or consumer of health care services who makes a written request for an estimate of the cost of health care services from a health care provider shall be provided such estimate no later than five business days after receiving such request, except when the requested information is posted on the department's website under subsection 8 of this section. Any patient or consumer of health care services who makes a written request for the insurance costs from such patient's or consumer's health carrier shall be provided such insurance costs no later than five business days after receiving such request. The provisions of this subsection shall not apply to emergency health care services.

4. Health care providers, and the department under subsection 8 of this section, shall include with any estimate of costs the following: "Your estimated cost is based on the information entered and assumptions about typical utilization and costs. The actual amount billed to you may be different from the estimate of costs provided to you. Many factors affect the actual bill you will receive, and this estimate of costs does not account for all of them. Additionally, the estimate of costs is not a guarantee of insurance coverage. You will be billed at the health care provider's charge for any service provided to you that is not a covered benefit under your plan. Please check with your insurance company to receive an estimate of the amount you will owe under your plan or if you need help understanding your benefits for the service chosen.".

5. Health carriers shall include with any insurance costs the following: "Your insurance costs are based on the information entered and assumptions about typical utilization and costs. The actual amount of insurance costs and the amount billed to you may be different from the insurance costs provided to you. Many factors affect the actual insurance costs, and the insurance costs provided do not account for all of them. Additionally, the insurance costs provided are limited to the specific information provided and are not a guarantee of insurance coverage for additional services. You will be billed at the health care provider's charge for any service provided to you that is not a covered benefit under your plan. You may contact us if you need further assistance in understanding your benefits for the service chosen.".

6. Each health care provider shall also make available the percentage or amount of any discounts for cash payment of any charges incurred through the health care provider's website or by making it available at the health care provider's location.

7. Nothing in this section shall be construed as violating any health care provider contract provisions with a health carrier that prohibit disclosure of the health care provider's fee schedule with a health carrier to third parties.

8. The department shall make available to the public on its website the most current price information it receives from hospitals under subsections 9 and 10 of this section. The department shall provide this information in a manner that is easily understood by the public and meets the following minimum requirements:

(1) Information for each participating hospital shall be listed separately and hospitals shall be listed in groups by category as determined by the department in rules adopted under this section; and

(2) Information for each hospital outpatient department shall be listed separately.

9. Beginning with the quarter ending June 30, 2017, and quarterly thereafter, each participating hospital shall provide to the department, in the manner and format determined by the department, the following information about the one hundred most frequently reported admissions by DRG for inpatients as established by the department:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges;

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection;

(3) The amount of MO HealthNet reimbursement for each DRG, including claims and pro rata supplemental payments; and

(4) The amount of Medicare reimbursement for each DRG.

A hospital shall not report or be required to report the information required by this subsection for any of the one hundred most frequently reported admissions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

10. Beginning with the quarter ending June 30, 2017, and quarterly thereafter, each participating hospital shall provide to the department, in a manner and format determined by the department, information on the total costs for the twenty most common outpatient surgical procedures and the twenty most common imaging procedures, by volume, performed in hospital outpatient settings. Participating hospitals shall report this information in the same manner as required by subsection 9 of this section, provided that hospitals shall not report or be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of HIPAA or other federal law.

11. A hospital shall provide the information specified under subsections 9 and 10 of this section to the department. A hospital which does so shall not be required to provide that information pursuant to subsection 3 of this section.

12. Any data disclosed to the department by a hospital under subsections 9 and 10 of this section shall be the sole property of the hospital that submitted the data. Any data or product derived from the data disclosed under subsections 9 and 10 of this section, including a consolidation or analysis of the data, shall be the sole property of the state. Any proprietary information received by the

department shall be a proprietary interest and may be closed under the provisions of subdivision (15) of section 610.021. The department shall not allow information it receives or discloses under subsections 9 and 10 of this section to be used by any person or entity for commercial purposes.

13. The department shall promulgate rules to implement the provisions of this section. The rules relating to subsections 8 to 12 of this section shall include all of the following:

(1) The one hundred most frequently reported DRGs for inpatients for which participating hospitals will provide the data required under subsection 9 of this section;

(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the department's website; and

(3) The twenty most common outpatient surgical procedures and the twenty most common imaging procedures, by volume, performed in a hospital outpatient setting required under subsection 10 of this section.

Any rule or portion of a rule, as that term is defined in section 536.010 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, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, 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, 2016, shall be invalid and void."; and"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 9

Amend House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 5, Section 191.1146, Line 20, by inserting after all of said section and line the following:

"**192.500. 1. For purposes of this section, the following terms shall mean:**

(1) "Cone beam computed tomography system", a medical imaging device using x-ray computed tomography to capture data using a cone-shaped x-ray beam;

(2) "Panoramic x-ray system", an imaging device that captures the entire mouth in a single, two-dimensional image including the teeth, upper and lower jaws, and surrounding structures and tissues.

2. Cone beam computed tomography systems and panoramic x-ray systems shall not be required to be inspected more frequently than every six years."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 1 TO
HOUSE AMENDMENT NO. 10

Amend House Amendment No. 10 to House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 1, Line 12, by deleting all of said line and inserting in lieu thereof the following:

"**municipality in which such hospital is located.**

105.263. 1. Any employee of the state of Missouri shall be granted ten consecutive work days of paid parental leave for the birth of a child of the employee or because of the finalization of an adoption by the employee of a child who is under two years of age. Such paid parental leave shall be separate from any other type of paid leave granted to such employee.

2. An employee eligible to take the paid leave described under subsection 1 of this section shall not be required to use all or any portion of any accrued vacation leave, accrued sick leave, or other type of accrued leave before being allowed to use the paid leave described under subsection 1 of this section.

3. An employee who intends to take the paid leave described under subsection 1 of this section shall provide reasonable notice of such intent to his or her supervisor.

4. The commissioner of administration may promulgate rules as necessary to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2016, shall be invalid and void."; and"; and

Further amend said amendment, Page 2, Line 38, by deleting all of said line and inserting in lieu thereof the following:

"**its research or teaching missions.**

205.165. 1. The board of trustees of any hospital authorized under subsection 1 of this section and organized under the provisions of sections 205.160 to 205.340 may invest up to fifteen percent of their funds not required for immediate disbursement in obligations or for the operation of the hospital into any mutual fund, in the form of an investment company, in which shareholders combine money to invest in a variety of stocks, bonds, and money-market investments.

2. The provisions of this section shall only apply if the hospital:

(1) Is located within a county of the first classification with more than one hundred fifty thousand but fewer than two hundred thousand inhabitants; and

(2) Receives less than one percent of its annual revenues from county or state taxes."; and

Further amend said bill, Page 14, Section 208.670, Line 8, by deleting the word "**only**"; and

Further amend said bill, Page 15, Section 208.671, Line 25, by deleting the words "**in this state**" and inserting in lieu thereof the words "**and providing MO HealthNet services**"; and

Further amend said bill, Page 19, Section 208.677, Line 21, by deleting the word "**enrolled**"; and"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

HOUSE AMENDMENT NO. 10

Amend House Committee Substitute for Senate Substitute for Senate Bill No. 621, Page 1, Section

9.154, Line 11, by inserting after all of said section and line the following:

"**96.192. 1. The board of trustees of any hospital authorized under subsection 2 of this section, and established and organized under the provisions of sections 96.150 to 96.229, may invest up to twenty-five percent of the hospital's funds not required for immediate disbursement in obligations or for the operation of the hospital in any United States investment grade fixed income funds or any diversified stock funds, or both.**

2. The provisions of this section shall only apply if the hospital:

(1) Receives less than one percent of its annual revenues from municipal, county, or state taxes; and

(2) Receives less than one percent of its annual revenue from appropriated funds from the municipality in which such hospital is located."; and

Further amend said bill, Page 5, Section 191.1146, Line 20, by inserting after all of said line the following:

"197.315. 1. Any person who proposes to develop or offer a new institutional health service within the state must obtain a certificate of need from the committee prior to the time such services are offered.

2. Only those new institutional health services which are found by the committee to be needed shall be granted a certificate of need. Only those new institutional health services which are granted certificates of need shall be offered or developed within the state. No expenditures for new institutional health services in excess of the applicable expenditure minimum shall be made by any person unless a certificate of need has been granted.

3. After October 1, 1980, no state agency charged by statute to license or certify health care facilities shall issue a license to or certify any such facility, or distinct part of such facility, that is developed without obtaining a certificate of need.

4. If any person proposes to develop any new institutional health care service without a certificate of need as required by sections 197.300 to 197.366, the committee shall notify the attorney general, and he shall apply for an injunction or other appropriate legal action in any court of this state against that person.

5. After October 1, 1980, no agency of state government may appropriate or grant funds to or make payment of any funds to any person or health care facility which has not first obtained every certificate of need required pursuant to sections 197.300 to 197.366.

6. A certificate of need shall be issued only for the premises and persons named in the application and is not transferable except by consent of the committee.

7. Project cost increases, due to changes in the project application as approved or due to project change orders, exceeding the initial estimate by more than ten percent shall not be incurred without consent of the committee.

8. Periodic reports to the committee shall be required of any applicant who has been granted a certificate of need until the project has been completed. The committee may order the forfeiture of the certificate of need upon failure of the applicant to file any such report.

9. A certificate of need shall be subject to forfeiture for failure to incur a capital expenditure on any approved project within six months after the date of the order. The applicant may request an extension from

the committee of not more than six additional months based upon substantial expenditure made.

10. Each application for a certificate of need must be accompanied by an application fee. The time of filing commences with the receipt of the application and the application fee. The application fee is one thousand dollars, or one-tenth of one percent of the total cost of the proposed project, whichever is greater. All application fees shall be deposited in the state treasury. Because of the loss of federal funds, the general assembly will appropriate funds to the Missouri health facilities review committee.

11. In determining whether a certificate of need should be granted, no consideration shall be given to the facilities or equipment of any other health care facility located more than a fifteen-mile radius from the applying facility.

12. When a nursing facility shifts from a skilled to an intermediate level of nursing care, it may return to the higher level of care if it meets the licensure requirements, without obtaining a certificate of need.

13. In no event shall a certificate of need be denied because the applicant refuses to provide abortion services or information.

14. A certificate of need shall not be required for the transfer of ownership of an existing and operational health facility in its entirety.

15. A certificate of need may be granted to a facility for an expansion, an addition of services, a new institutional service, or for a new hospital facility which provides for something less than that which was sought in the application.

16. The provisions of this section shall not apply to facilities operated by the state, and appropriation of funds to such facilities by the general assembly shall be deemed in compliance with this section, and such facilities shall be deemed to have received an appropriate certificate of need without payment of any fee or charge. **The provisions of this subsection shall not apply to hospitals operated by the state and licensed under chapter 197, except for department of mental health state-operated psychiatric hospitals.**

17. Notwithstanding other provisions of this section, a certificate of need may be issued after July 1, 1983, for an intermediate care facility operated exclusively for the intellectually disabled.

18. To assure the safe, appropriate, and cost-effective transfer of new medical technology throughout the state, a certificate of need shall not be required for the purchase and operation of**:**

(1) Research equipment that is to be used in a clinical trial that has received written approval from a duly constituted institutional review board of an accredited school of medicine or osteopathy located in Missouri to establish its safety and efficacy and does not increase the bed complement of the institution in which the equipment is to be located. After the clinical trial has been completed, a certificate of need must be obtained for continued use in such facility**; or**

(2) Equipment that is to be used by an academic health center operated by the state in furtherance of its research or teaching missions."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Emergency clause adopted.

In which the concurrence of the Senate is respectfully requested.

INTRODUCTIONS OF GUESTS

Senator Cunningham introduced to the Senate, Sandy George, Houston; and Treena and Doyle Heiney, Summersville.

Senator Richard introduced to the Senate, Sheriff Randee Kaiser, Jasper County.

Senator Onder introduced to the Senate, former State Senator Chuck Gross.

Senator Riddle introduced to the Senate, Nancy Heimann, Susan McNay and a delegation from Hungary.

Senator Pearce introduced to the Senate, Jan and Lindel Jones, Johnson County.

Senator Schmitt introduced to the Senate, Regina Rideout and her daughter, Maya, Fenton; and Maya was made an honorary page.

On motion of Senator Kehoe, the Senate adjourned under the rules.

SENATE CALENDAR

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FIFTY-SIXTH DAY–THURSDAY, APRIL 21, 2016

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FORMAL CALENDAR

HOUSE BILLS ON SECOND READING

HB 2667-Shumake
HCS for HBs 2069 & 2371
HCS for HBs 2045 & 2316
HB 1811-Hicks
HCS for HB 1858
HCS for HB 1632
HB 1443-Leara
HCS for HB 2379
HB 2605-Lauer
HB 2217-Morris
HB 1972-Crawford
HB 1611-Swan
HCS for HB 2017
HCS for HB 2018

THIRD READING OF SENATE BILLS

1. SCS for SBs 588, 603 & 942-Dixon and Curls (In Fiscal Oversight)
2. SCS for SB 998-Romine (In Fiscal Oversight)
3. SCS for SB 968-Brown (In Fiscal Oversight)
4. SCS for SB 904-Pearce (In Fiscal Oversight)
5. SB 873-Pearce (In Fiscal Oversight)
6. SB 577-Keaveny
7. SS for SCS for SB 801-Sater
8. SS for SB 612-Cunningham

9. SB 869-Schmitt
10. SS for SCS for SB 1057-Schaaf
11. SB 1139-Silvey, et al
12. SB 658-Wasson
13. SB 941-Dixon
14. SCS for SBs 857 & 712-Romine
    (In Fiscal Oversight)
15. SS for SB 619-Wallingford
16. SB 576-Keaveny
17. SS#2 for SCS for SB 590-Dixon
    (In Fiscal Oversight)

SENATE BILLS FOR PERFECTION

SB 1111-Brown

HOUSE BILLS ON THIRD READING

1. HB 1870-Hoskins (Pearce)
   (In Fiscal Oversight)
2. HB 1568-Lynch (Brown)
   (In Fiscal Oversight)
3. HB 1855-Allen (Schaaf)
   (In Fiscal Oversight)
4. HB 1698-Rowden, with SCS (Sater)
   (In Fiscal Oversight)
5. HCS for HB 2030, with SCS (Silvey)
   (In Fiscal Oversight)
6. HCS for HBs 1366 & 1878, with SCS
   (Schaefer) (In Fiscal Oversight)
7. HB 1795-Haefner, with SCS (Sater)
   (In Fiscal Oversight)
8. HCS for HB 2187, with SCS
   (Cunningham) (In Fiscal Oversight)
9. HCS for HB 1904, with SCS
   (Wallingford) (In Fiscal Oversight)
10. HB 1745-Brattin, with SCS (Schatz)
    (In Fiscal Oversight)
11. HCS for HB 1717 (Wallingford)
12. HCS for HB 1804, with SCS (Emery)
13. HCS for HB 2689 (Silvey)

INFORMAL CALENDAR

THIRD READING OF SENATE BILLS

SB 783-Onder

SENATE BILLS FOR PERFECTION

SB 575-Schaefer, with SCS, SS for SCS & SA 1 (pending)
SB 580-Schaaf, with SCS & SA 2 (pending)
SB 596-Kraus, with SCS
SB 613-Cunningham, et al, with SCS
SB 622-Romine, with SCS
SB 644-Onder, with SCS
SBs 662 & 587-Dixon, with SCS
SB 663-Dixon, with SCS & SA 1 (pending)
SB 680-Emery

SB 686-Wallingford, with SCS
SB 706-Dixon
SB 719-Emery, with SCS
SB 733-Dixon
SB 734-Dixon
SB 771-Onder
SB 772-Onder, with SCS
SB 774-Schmitt
SB 775-Schaefer
SB 785-Schaefer, with SCS, SS for SCS, SA 1, SSA 1 for SA 1, SA 1 to SSA 1 for SA 1 & point of order (pending)
SB 788-Schatz, with SCS
SBs 789 & 595-Wasson, with SCS
SB 792-Richard
SB 793-Richard
SB 798-Kraus, with SCS
SB 802-Sater
SB 805-Onder, with SCS
SB 806-Onder, with SCS
SB 812-Keaveny
SB 816-Wieland, et al
SB 825-Munzlinger, with SA 1 (pending)
SB 830-Wasson, with SCS
SB 848-Emery, with SCS
SBs 851 & 694-Brown, with SCS
SB 853-Brown
SB 858-Romine, with SCS & SS for SCS (pending)
SB 868-Wasson
SB 871-Wallingford
SB 883-Riddle
SB 884-Munzlinger
SB 894-Munzlinger, with SS (pending)
SB 896-Hegeman
SB 898-Cunningham
SB 908-Sater, with SCS
SB 916-Schaefer
SB 920-Schmitt and Kraus
SB 951-Wasson, with SA 1 (pending)
SB 964-Wallingford, with SCS (pending)
SB 966-Schaaf
SB 972-Silvey
SB 980-Keaveny, with SCS, SS for SCS, SA 1 & SA 3 to SA 1 (pending)
SB 995-Riddle
SB 1003-Onder
SB 1004-Onder
SB 1005-Walsh
SBs 1010, 958 & 878-Curls, with SCS
SB 1012-Dixon
SB 1014-Dixon
SB 1026-Schatz, with SCS
SB 1028-Silvey, et al, with SCS
SB 1033-Pearce
SB 1066-Curls
SB 1074-Schmitt, with SCS
SB 1075-Wallingford
SB 1085-Pearce
SB 1091-Riddle
SB 1094-Kehoe, with SCS
SB 1096-Dixon and Keaveny, with SS (pending)
SB 1117-Wasson, with SCS
SB 1120-Hegeman, et al
SB 1131-Sifton
SB 1144-Brown
SJR 23-Sater, with SS (pending)
SJR 35-Kraus, with SCS

HOUSE BILLS ON THIRD READING

HB 1414-Houghton, with SCS (pending) (Munzlinger)
HB 1452-Hoskins, with SCS (Pearce)
HCS for HB 1477 (Munzlinger)

HCS for HB 1550, with SCS & SS for SCS (pending) (Sater)
HB 1575-Rowden, with SCA 1 (Onder)
HB 1582-Kelley, with SCS (Kraus)
HB 1619-McCaherty (Dixon)
HB 1631-Alferman, with SCS, SS for SCS & SA 1 (pending) (Kraus)
HCS for HB 1649, with SCS (Parson)
HCS for HB 1658 (Onder)
HCS for HB 1729 (Munzlinger)
HB 1733-Davis (Kraus)
SS for HCS for HB 1877 (Wallingford) (In Fiscal Oversight)
HCS for HB 2013 (Schaefer)
HB 2125-Fitzwater, with SCS (Schmitt)
HB 2166-Alferman, with SCS, SS#2 for SCS, SA 1 & SSA 1 for SA 1 (pending) (Onder)
HB 2226-Barnes (Silvey)
HJR 53-Dugger (Kraus)

CONSENT CALENDAR

House Bills

Reported 4/14

HB 1681-Haahr (Dixon)
HB 2428-Swan (Pearce)
HB 2195-Hoskins (Pearce)
HB 1539-Vescovo (Wieland)
HB 1538-Vescovo (Wieland)
HB 1559-McCann Beatty (Curls)
HB 2183-Roeber (Curls)
HCS for HB 2453, with SCS (Schaaf)
HB 2480-Justus (Sater)
HB 1473-Dugger, with SCS (Wasson)
HCS for HB 1480 (Hegeman)
HB 1388-Roeber (Dixon)
HB 1593-Crawford (Hegeman)
HB 2591, HB 1958 & HB 2369-Richardson, with SCS (Libla)
HB 2335-Houghton, with SCS (Riddle)
HB 1851-Alferman, with SCS (Schatz)

SENATE BILLS WITH HOUSE AMENDMENTS

SB 579-Schaaf, et al, with HAs 1 & 2
SS for SB 621-Romine, with HCS, as amended

BILLS IN CONFERENCE AND BILLS CARRYING REQUEST MESSAGES

In Conference

HCS for HB 2002, with SCS (Schaefer)
HCS for HB 2003, with SCS (Schaefer)
HCS for HB 2004, with SCS (Schaefer)
HCS for HB 2005, with SCS (Schaefer)

HCS for HB 2006, with SCS (Schaefer)
HCS for HB 2007, with SCS (Schaefer)
HCS for HB 2008, with SCS (Schaefer)
HCS for HB 2009, with SCS (Schaefer)
HCS for HB 2010, with SCS, as amended (Schaefer)
HCS for HB 2011, with SCS (Schaefer)
HCS for HB 2012, with SCS (Schaefer)
HCS for HB 2014, with SCS (Schaefer)

RESOLUTIONS

Reported from Committee

SCR 42-Curls
SCR 45-Dixon
SCR 50-Nasheed
SCRs 53 & 44-Schaefer, with SCS
SCR 54-Walsh
SCR 55-Holsman
SCR 56-Brown
SCR 59-Emery
SCR 61-Parson
SCR 63-Curls and Munzlinger
SCR 65-Schaefer

To be Referred

HCR 61-Engler

MISCELLANEOUS

CCS for SCS for HCS for HB 2 (Schaefer) (Section 2.030/Appropriation 9235)
CCS for SCS for HCS for HB 10 (Schaefer) (Section 10.710/Appropriation 9859)

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