Journal of the Senate

SECOND REGULAR SESSION

SIXTY-FIFTH DAY—MONDAY, MAY 7, 2018

The Senate met pursuant to adjournment.

President Parson in the Chair.

Reverend Carl Gauck offered the following prayer:

"But surely God is my helper, the Lord is the upholder of my life." (Psalm 54:4)

We pray O Lord as we begin a new week that will certainly be filled with new challenges and pressures on us to make the right decisions, so we pray that You will abide with us and help us know what the right path to walk for each of us. Help us to process the material that comes before us that leads us to wise conclusions of what we must do. And keep us from being reticent about what must be done. 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 for Thursday, May 3, 2018 was read and approved.

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

Present—Senators

Brown	Chappelle-Nadal	Cierpiot	Crawford	Cunningham	Curls	Dixon
Eigel	Emery	Hegeman	Holsman	Hoskins	Hummel	Kehoe
Koenig	Munzlinger	Nasheed	Onder	Richard	Riddle	Rizzo
Romine	Rowden	Sater	Schaaf	Schatz	Schupp	Sifton
Wallingford	Walsh	Wasson	Wieland—32			

Absent—Senators—None

Absent with leave—Senator Libla—1

Vacancies—1

The Lieutenant Governor was present.

RESOLUTIONS

Senator Kehoe offered Senate Resolution No. 2010, regarding Dalton "Cole" Walker, Henley, which was adopted.

Senator Emery offered Senate Resolution No. 2011, regarding Liz Kozlowski, Deepwater, which was adopted.

Senator Emery offered Senate Resolution No. 2012, regarding Nadine Poister, Butler, which was adopted.

Senator Emery offered Senate Resolution No. 2013, regarding Monique Lewis, Raymore, which was adopted.

Senator Emery offered Senate Resolution No. 2014, regarding Patricia Arnold, Nevada, which was adopted.

Senator Onder offered Senate Resolution No. 2015, regarding Meagan Turner, which was adopted.

Senator Rowden offered Senate Resolution No. 2016, regarding Jan Mees, which was adopted.

Senator Holsman offered Senate Resolution No. 2017, regarding the Class 4 State Champion Grandview High School boys basketball program, which was adopted.

Senator Crawford offered Senate Resolution No. 2018, regarding Eagle Scout Justin Ender Bruecher, Sedalia, which was adopted.

President Pro Tem Richard assumed the Chair.

REPORTS OF STANDING COMMITTEES

Senator Dixon, Chairman of the Committee on the Judiciary and Civil and Criminal Jurisprudence, submitted the following reports:

Mr. President: Your Committee on the Judiciary and Civil and Criminal Jurisprudence, to which was referred **HB 1633**, begs leave to report that it has considered the same and recommends that the Senate Committee Substitute, hereto attached, do pass.

Also,

Mr. President: Your Committee on the Judiciary and Civil and Criminal Jurisprudence, to which was referred **HB 1250**, begs leave to report that it has considered the same and recommends that the Senate Committee Substitute, hereto attached, do pass.

Also,

Mr. President: Your Committee on the Judiciary and Civil and Criminal Jurisprudence, to which was referred **HCS** for **HB 2042**, begs leave to report that it has considered the same and recommends that the Senate Committee Substitute, hereto attached, do pass.

Senator Sater, Chairman of the Committee on Seniors, Families and Children, submitted the following reports:

Mr. President: Your Committee on Seniors, Families and Children, to which was referred **HCS** for

HB 1868, begs leave to report that it has considered the same and recommends that the Senate Committee Substitute, hereto attached, do pass.

Also,

Mr. President: Your Committee on Seniors, Families and Children, to which was referred **HCS** for **HB 2249**, begs leave to report that it has considered the same and recommends that the Senate Committee Substitute, hereto attached, do pass.

Senator Wallingford, Chairman of the Committee on Ways and Means, submitted the following report:

Mr. President: Your Committee on Ways and Means, to which was referred **HCS** for **HB 2540**, begs leave to report that it has considered the same and recommends that the Senate Committee Substitute, hereto attached, do pass.

Senator Romine, Chairman of the Committee on Education, submitted the following report:

Mr. President: Your Committee on Education, to which was referred **HCS** for **HB 2129**, begs leave to report that it has considered the same and recommends that the bill do pass.

Senator Hegeman, Chairman of the Committee on Local Government and Elections, submitted the following report:

Mr. President: Your Committee on Local Government and Elections, to which was referred **HB 1446**, begs leave to report that it has considered the same and recommends that the Senate Committee Substitute, hereto attached, do pass.

Senator Wieland, Chairman of the Committee on Insurance and Banking, submitted the following report:

Mr. President: Your Committee on Insurance and Banking, to which was referred **HCS** for **HBs 2337** and **2272**, begs leave to report that it has considered the same and recommends that the Senate Committee Substitute, hereto attached, do pass.

Senator Schatz, Chairman of the Committee on Transportation, Infrastructure and Public Safety, submitted the following report:

Mr. President: Your Committee on Transportation, Infrastructure and Public Safety, to which was referred **HCS** for **HBs 2277** and **1983**, begs leave to report that it has considered the same and recommends that the Senate Committee Substitute, hereto attached, do pass.

Senator Onder, Chairman of the Committee on General Laws, submitted the following report:

Mr. President: Your Committee on General Laws, to which was referred **HCS** for **HB 2031**, begs leave to report that it has considered the same and recommends that the bill do pass.

President Parson assumed the Chair.

PRIVILEGED MOTIONS

Senator Hegeman moved that **SB 659**, with **HCS**, be taken up for 3rd reading and final passage, which motion prevailed.

HCS for **SB 659**, entitled:

HOUSE COMMITTEE SUBSTITUTE FOR
SENATE BILL NO. 659

An Act to repeal section 640.620, RSMo, and to enact in lieu thereof three new sections relating to the department of natural resources.

Was taken up.

Senator Hegeman moved that **HCS** for **SB 659**, as amended, be adopted, which motion prevailed by the following vote:

YEAS—Senators

Brown	Cierpiot	Crawford	Cunningham	Dixon	Eigel	Emery
Hegeman	Hoskins	Kehoe	Koenig	Munzlinger	Onder	Richard
Riddle	Rizzo	Romine	Rowden	Sater	Schaaf	Schatz
Wallingford	Wasson	Wieland—24				

NAYS—Senators

Chappelle-Nadal	Curls	Holsman	Hummel	Nasheed	Schupp	Sifton
Walsh—8						

Absent—Senators—None

Absent with leave—Senator Libla—1

Vacancies—1

On motion of Senator Hegeman, **HCS** for **SB 659**, as amended, was read the 3rd time and passed by the following vote:

YEAS—Senators

Brown	Cierpiot	Crawford	Cunningham	Curls	Dixon	Eigel
Emery	Hegeman	Hoskins	Kehoe	Koenig	Munzlinger	Onder
Richard	Riddle	Rizzo	Romine	Rowden	Sater	Schatz
Wallingford	Wasson	Wieland—24				

NAYS—Senators

Chappelle-Nadal	Holsman	Hummel	Nasheed	Schaaf	Schupp	Sifton
Walsh—8						

Absent—Senators—None

Absent with leave—Senator Libla—1

Vacancies—1

The President declared the bill passed.

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

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

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

Bill ordered enrolled.

MESSAGES FROM THE HOUSE

The following corrected message was 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 adopted **SS**, as amended for **HB 1744** and has taken up and passed **SS** for **HB 1744**, as amended.

Emergency clause adopted.

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 **HCS** for **HB 2019**, entitled:

An Act to appropriate money for planning 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 herein designated for the fiscal period beginning July 1, 2018, and ending June 30, 2019.

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 **SCS** for **SB 718**, entitled:

An Act to repeal sections 338.202 and 376.1237, RSMo, and to enact in lieu thereof two new sections relating to maintenance medication.

With House Amendment Nos. 1, 2, House Amendment No. 1 to House Amendment No. 3, House Amendment No. 3, as amended, House Amendment Nos. 4, 5, 6, 7, 8, 10, 11, House Amendment No. 1 to House Amendment No. 12, House Amendment No. 12, as amended, House Amendment Nos. 13, 14, House Amendment No. 1 to House Amendment No. 15, House Amendment No. 15, as amended and House Amendment No. 16.

HOUSE AMENDMENT NO. 1

Amend House Committee Substitute for Senate Committee Substitute for Senate Bill No. 718, Page 1, In the Title, Line 3, by deleting the words "maintenance medication" and inserting in lieu thereof the words "health care"; 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 Committee Substitute for Senate Bill No. 718, Page 1, Section 338.202, Line 16, by inserting after all of said line the following:

"**376.1223. 1. No third-party payer for health care services including, but not limited to, health carriers, as such terms are defined in section 376.1350, shall limit coverage or deny reimbursement for treatment of symptoms and behaviors for individuals with physical or developmental disabilities, as defined in section 630.005, if, as determined by a licensed physician or psychologist, the symptoms or behaviors caused by the identified disability:**

(1) Require the individual to receive care or assistance at any level or age from another person; and

(2) Directly interfere with or prevent independent participation in the everyday purposeful and functional activities typically practiced by a person of the same chronological age as the disabled individual.

2. Such coverage shall include, but not be limited to, therapeutic care, habilitative or rehabilitative care, or services by a licensed psychologist or applied behavior analyst, as such terms are defined in section 376.1224.

376.1224. 1. For purposes of this section, the following terms shall mean:

(1) "Applied behavior analysis", the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior;

(2) "Autism service provider":

(a) Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or

(b) Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst;

(3) "Autism spectrum disorders", a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;

(4) **"Developmental disability", severe, chronic disabilities that meet all of the following conditions:**

(a) Attributable to cerebral palsy or epilepsy, or any other condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services;

(b) Manifests before the individual reaches age twenty-two;

(c) Likely to continue indefinitely; and

(d) Results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self direction, capacity for independent living, plus a need for the level of care provided in an independent care facility;

(5) "Diagnosis of a developmental disability", medically necessary assessments, evaluations, or tests in order to diagnose a developmental disability;

(6) "Diagnosis of autism spectrum disorders", medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder;

(7) "Diagnosis of physical disability", medically necessary assessments, evaluations, or tests in order to diagnose a physical disability;

[(5)**] (8)** "Habilitative or rehabilitative care", professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual;

[(6)**] (9)** "Health benefit plan", shall have the same meaning ascribed to it as in section 376.1350;

[(7)**] (10)** "Health carrier", shall have the same meaning ascribed to it as in section 376.1350;

[(8)**] (11)** "Line therapist", an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst;

[(9)**] (12)** "Pharmacy care", medications used to address symptoms of an autism spectrum disorder prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan;

[(10)**] (13)** "Psychiatric care", direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

[(11)**] (14)** "Psychological care", direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

[(12)**] (15)** "Therapeutic care", services provided by licensed speech therapists, occupational therapists, or physical therapists;

[(13)**] (16)** "Treatment **[**for autism spectrum disorders**]**", care prescribed or ordered for an individual diagnosed with an autism spectrum disorder**, developmental disabilities, or physical disabilities** by a licensed physician or licensed psychologist, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

(a) Psychiatric care;

(b) Psychological care;

(c) Habilitative or rehabilitative care, including applied behavior analysis therapy;

(d) Therapeutic care;

(e) Pharmacy care.

2. All group health benefit plans that are delivered, issued for delivery, continued, or renewed on or after January 1, 2011, if written inside the state of Missouri, or written outside the state of Missouri but insuring Missouri residents, shall provide coverage for the diagnosis and treatment of autism spectrum disorders**, developmental disabilities, or physical disabilities** to the extent that such diagnosis and treatment is not already covered by the health benefit plan.

3. With regards to a health benefit plan, a health carrier shall not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual or their dependent because the individual is diagnosed with autism spectrum disorder**, developmental disabilities, or physical disabilities**.

4. (1) Coverage provided under this section is limited to medically necessary treatment **[**that**] as determined by the health benefit plan, and** is ordered by the insured's treating licensed physician or licensed psychologist, pursuant to the powers granted under such licensed physician's or licensed psychologist's license**[**, in accordance with**]. For applied behavioral analysis, such provider may submit** a treatment plan.

(2) The treatment plan, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

(3) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder**, developmental disabilities, or physical disabilities**, a health carrier shall have the right to review the treatment plan not more than once every six months unless the health carrier and the individual's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual **[**being treated for an autism spectrum disorder**]** and shall not apply to all individuals being treated for **[**autism spectrum disorders**] that disorder** by a physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

5. Coverage provided under this section for applied behavior analysis shall be subject to a maximum benefit of forty thousand dollars per calendar year for individuals through eighteen years of age. Such maximum benefit limit may be exceeded, upon prior approval by the health benefit plan, if the provision of applied behavior analysis services beyond the maximum limit is medically necessary for such individual. Payments made by a health carrier on behalf of a covered individual for any care, treatment, intervention, service or item, the provision of which was for the treatment of a health condition unrelated to the covered individual's autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection. Any coverage required under this section, other than the coverage for applied behavior analysis, shall not be subject to the age and dollar limitations described in this subsection.

6. Coverage provided under this section for therapeutic care shall be subject to a maximum benefit of forty thousand dollars per calendar year for individuals through eighteen years of age. Such maximum benefit limit may be exceeded, upon prior approval by the health benefit plan, if the provision of therapeutic care beyond the maximum limit is medically necessary for such individual.

Payments made by a health carrier on behalf of a covered individual for any care, treatment, intervention, service or item, the provision of which was for the treatment of a health condition unrelated to the covered individual's developmental disabilities or physical disabilities, shall not be applied toward any maximum benefit established under this subsection. Any coverage required under this section, other than the coverage for applied behavioral analysis or therapeutic care, shall not be subject to the age and dollar limitations described in this subsection.

[6.**]** **7.** The maximum benefit limitation for applied behavior analysis described in subsection 5 of this section **or therapeutic care as described in subsection 6 of this section** shall be adjusted by the health carrier at least triennially for inflation to reflect the aggregate increase in the general price level as measured by the Consumer Price Index for All Urban Consumers for the United States, or its successor index, as defined and officially published by the United States Department of Labor, or its successor agency. Beginning January 1, 2012, and annually thereafter, the current value of the maximum benefit limitation for applied behavior analysis coverage adjusted for inflation in accordance with this subsection shall be calculated by the director of the department of insurance, financial institutions and professional registration. The director shall furnish the calculated value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021.

[7.**]** **8.** Subject to the provisions set forth in subdivision (3) of subsection 4 of this section, coverage provided under this section shall not be subject to any limits on the number of visits an individual may make to an autism service provider **or therapeutic care provider**, except that the maximum total benefit for applied behavior analysis set forth in subsection 5 **or therapeutic care as set forth in subsection 6** of this section shall apply to this subsection.

[8.**]** **9.** This section shall not be construed as limiting benefits which are otherwise available to an individual under a health benefit plan. The health care coverage required by this section shall not be subject to any greater deductible, coinsurance, or co-payment than other physical health care services provided by a health benefit plan. Coverage of services may be subject to other general exclusions and limitations of the contract or benefit plan, not in conflict with the provisions of this section, such as coordination of benefits, exclusions for services provided by family or household members, and utilization review of health care services, including review of medical necessity and care management; however, coverage for treatment under this section shall not be denied on the basis that it is educational or habilitative in nature.

[9.**]** **10.** To the extent any payments or reimbursements are being made for applied behavior analysis, such payments or reimbursements shall be made to either:

(1) The autism service provider, as defined in this section; or

(2) The entity or group for whom such supervising person, who is certified as a board-certified behavior analyst by the Behavior Analyst Certification Board, works or is associated.

Such payments or reimbursements under this subsection to an autism service provider or a board-certified behavior analyst shall include payments or reimbursements for services provided by a line therapist under the supervision of such provider or behavior analyst if such services provided by the line therapist are included in the treatment plan and are deemed medically necessary.

[10.**]** **11.** Notwithstanding any other provision of law to the contrary, health carriers shall not be held

liable for the actions of line therapists in the performance of their duties.

[11.**] 12.** The provisions of this section shall apply to any health care plans issued to employees and their dependents under the Missouri consolidated health care plan established pursuant to chapter 103 that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2011. The terms "employees" and "health care plans" shall have the same meaning ascribed to them in section 103.003.

[12.**] 13.** The provisions of this section shall also apply to the following types of plans that are established, extended, modified, or renewed on or after January 1, 2011:

(1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section 1002(32);

(2) All self-insured group arrangements, to the extent not preempted by federal law;

(3) All plans provided through a multiple employer welfare arrangement, or plans provided through another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, or any waiver or exception to that act provided under federal law or regulation; and

(4) All self-insured school district health plans.

[13.**] 14.** The provisions of this section shall not automatically apply to an individually underwritten health benefit plan, but shall be offered as an option to any such plan.

[14.**] 15.** 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.

[15.**] 16.** Any health carrier or other entity subject to the provisions of this section shall not be required to provide reimbursement for the applied behavior analysis **or therapy** delivered to a person insured by such health carrier or other entity to the extent such health carrier or other entity is billed for such services by any Part C early intervention program or any school district for applied behavior analysis rendered to the person covered by such health carrier or other entity. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education plan, or an individualized service plan. This section shall not be construed as affecting any obligation to provide reimbursement pursuant to section 376.1218.

[16.**] 17.** The provisions of sections 376.383, 376.384, and 376.1350 to 376.1399 shall apply to this section.

[17.**] 18.** The director of the department of insurance, financial institutions and professional registration shall grant a small employer with a group health plan, as that term is defined in section 379.930, a waiver from the provisions of this section if the small employer demonstrates to the director by actual claims experience over any consecutive twelve-month period that compliance with this section has increased the cost of the health insurance policy by an amount of two and a half percent or greater over the period of a calendar year in premium costs to the small employer.

[18.**] 19.** The provisions of this section shall not apply to the Mo HealthNet program as described in chapter 208.

[19.**] 20.** (1) By February 1, 2012, and every February first thereafter, the department of insurance,

financial institutions and professional registration shall submit a report to the general assembly regarding the implementation of the coverage required under this section. The report shall include, but shall not be limited to, the following:

(a) The total number of insureds diagnosed with autism spectrum disorder;

(b) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this section;

(c) The cost of such coverage per insured per month; and

(d) The average cost per insured for coverage of applied behavior analysis;

(2) All health carriers and health benefit plans subject to the provisions of this section shall provide the department with the data requested by the department for inclusion in the annual report."; and

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

HOUSE AMENDMENT NO. 1 TO
HOUSE AMENDMENT NO. 3

Amend House Amendment No. 3 to House Committee Substitute for Senate Committee Substitute for Senate Bill No. 718, Page 2, Line 38, by deleting said line and inserting in lieu of the following:

"that he or she is the guardian ad litem of the minor child of the deceased.

191.1150. 1. This section shall be known as the "Caregiver, Advise, Record, and Enable (CARE) Act".

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

(1) "Admission", a patient's admission into a hospital as an in-patient;

(2) "After-care", assistance that is provided by a caregiver to a patient after the patient's discharge from a hospital that is related to the condition of the patient at the time of discharge, including assisting with activities of daily living, as defined in section 198.006; instrumental activities of daily living, as defined in section 198.006; or carrying out medical or nursing tasks as permitted by law;

(3) "Ambulatory surgical center", as defined in section 197.200;

(4) "Caregiver", an individual who is eighteen years of age or older, is duly designated as a caregiver by a patient under this section, and who provides after-care assistance to such patient in the patient's residence;

(5) "Discharge", a patient's release from a hospital or an ambulatory surgical center to the patient's residence following an admission;

(6) "Hospital", as defined in section 197.020;

(7) "Residence", a dwelling that the patient considers to be his or her home. "Residence" shall not include:

(a) A facility, as defined in section 198.006;

(b) A hospital, as defined in section 197.020;

(c) A prison, jail, or other detention or correctional facility operated by the state or a political subdivision;

(d) A residential facility, as defined in section 630.005;

(e) A group home or developmental disability facility, as defined in section 633.005; or

(f) Any other place of habitation provided by a public or private entity which bears legal or contractual responsibility for the care, control, or custody of the patient and which is compensated for doing so.

3. A hospital or ambulatory surgical center shall provide each patient or, if applicable, the patient's legal guardian with an opportunity to designate a caregiver following the patient's admission into a hospital or entry into an ambulatory surgical center and prior to the patient's discharge. Such designation shall include a written consent of the patient or the patient's legal guardian to release otherwise confidential medical information to the designated caregiver if such medical record would be needed to enable the completion of after-care tasks. The written consent shall be in compliance with federal and state laws concerning the release of personal health information. Prior to discharge, a patient may elect to change his or her caregiver in the event that the original designated caregiver becomes unavailable, unwilling, or unable to care for the patient. Designation of a caregiver by a patient or a patient's legal guardian does not obligate any person to arrange or perform any after-care tasks for the patient.

4. The hospital or ambulatory surgical center shall document the patient's or the patient's legal guardian's designation of caregiver, the relationship of the caregiver to the patient, and the caregiver's available contact information.

5. If the patient or the patient's legal guardian declines to designate a caregiver, the hospital or ambulatory surgical center shall document such information.

6. The hospital or ambulatory surgical center shall notify a patient's caregiver of the patient's discharge or transfer to another facility as soon as practicable, which may be after the patient's physician issues a discharge order. In the event that the hospital or ambulatory surgical center is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or otherwise affect the medical care provided to the patient or an appropriate discharge of the patient. The hospital or ambulatory surgical center shall document the attempt to contact the caregiver.

7. Prior to being discharged, if the hospital or ambulatory surgical center is able to contact the caregiver and the caregiver is willing to assist, the hospital or ambulatory surgical center shall provide the caregiver with the patient's discharge plan, if such plan exists, or instructions for the after-care needs of the patient and give the caregiver the opportunity to ask questions about the after-care needs of the patient.

8. A hospital or ambulatory surgical center is not required nor obligated to determine the ability of a caregiver to understand or perform any of the after-care tasks outlined in this section.

9. Nothing in this section shall authorize or require compensation of a caregiver by a state agency or a health carrier, as defined in section 376.1350.

10. Nothing in this section shall require a hospital or ambulatory surgical center to take actions that are inconsistent with or duplicative of the standards of the federal Medicare program under Title XVIII of the Social Security Act and its conditions of participation in the Code of Federal Regulations or the standards of a national accrediting organization with deeming authority under Section 1865(a)(1) of the Social Security Act.

11. Nothing in this section shall create a private right of action against a hospital, ambulatory surgical center, a hospital or ambulatory surgical center employee, or an individual with whom a hospital or ambulatory surgical center has a contractual relationship.

12. A hospital, ambulatory surgical center, hospital or ambulatory surgical center employee, or an individual with whom a hospital or ambulatory surgical center has a contractual relationship shall not be liable in any way for an act or omission of the caregiver.

13. No act or omission under this section by a hospital, ambulatory surgical center, hospital or ambulatory surgical center employee, or an individual with whom a hospital or ambulatory surgical center has a contractual relationship shall give rise to a citation, sanction, or any other adverse action by any licensing authority to whom such individual or entity is subject.

14. Nothing in this section shall be construed to interfere with the rights of an attorney-in-fact under a durable power of health care under sections 404.800 to 404.872.

15. The department of health and senior services shall provide ambulatory surgical centers and hospitals a standard form that may be used to satisfy the requirements of this section. Nothing in this section shall prohibit a hospital or ambulatory surgical center from continuing the use of a current patient communication or disclosure form to satisfy the requirements of this section, provided that the facility's current form is compliant with Centers for Medicare and Medicaid Services (CMS) standards and regulations."; and"; 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 Committee Substitute for Senate Bill No. 718, Page 1, Section A, Line 3, by inserting after all of said section and line the following:

"191.227. 1. All physicians, chiropractors, hospitals, dentists, and other duly licensed practitioners in this state, herein called "providers", shall, upon written request of a patient, or guardian or legally authorized representative of a patient, furnish a copy of his or her record of that patient's health history and treatment rendered to the person submitting a written request, except that such right shall be limited to access consistent with the patient's condition and sound therapeutic treatment as determined by the provider. Beginning August 28, 1994, such record shall be furnished within a reasonable time of the receipt of the request therefor and upon payment of a fee as provided in this section.

2. Health care providers may condition the furnishing of the patient's health care records to the patient, the patient's authorized representative or any other person or entity authorized by law to obtain or reproduce such records upon payment of a fee for:

(1) (a) Search and retrieval, in an amount not more than twenty-four dollars and eighty-five cents plus copying in the amount of fifty-seven cents per page for the cost of supplies and labor plus, if the health care

provider has contracted for off-site records storage and management, any additional labor costs of outside storage retrieval, not to exceed twenty-three dollars and twenty-six cents, as adjusted annually pursuant to subsection 5 of this section; or

(b) The records shall be furnished electronically upon payment of the search, retrieval, and copying fees set under this section at the time of the request or one hundred eight dollars and eighty-eight cents total, whichever is less, if such person:

a. Requests health records to be delivered electronically in a format of the health care provider's choice;

b. The health care provider stores such records completely in an electronic health record; and

c. The health care provider is capable of providing the requested records and affidavit, if requested, in an electronic format;

(2) Postage, to include packaging and delivery cost;

(3) Notary fee, not to exceed two dollars, if requested.

3. **For purposes of subsections 1 and 2 of this section, "a copy of his or her record of that patient's health history and treatment rendered" or "the patient's health care records" include a statement or record that no such health history or treatment record responsive to the request exists.**

4. Notwithstanding provisions of this section to the contrary, providers may charge for the reasonable cost of all duplications of health care record material or information which cannot routinely be copied or duplicated on a standard commercial photocopy machine.

[4.] **5.** The transfer of the patient's record done in good faith shall not render the provider liable to the patient or any other person for any consequences which resulted or may result from disclosure of the patient's record as required by this section.

[5.] **6.** Effective February first of each year, the fees listed in subsection 2 of this section shall be increased or decreased annually based on the annual percentage change in the unadjusted, U.S. city average, annual average inflation rate of the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). The current reference base of the index, as published by the Bureau of Labor Statistics of the United States Department of Labor, shall be used as the reference base. For purposes of this subsection, the annual average inflation rate shall be based on a twelve-month calendar year beginning in January and ending in December of each preceding calendar year. The department of health and senior services shall report the annual adjustment and the adjusted fees authorized in this section on the department's internet website by February first of each year.

[6.] **7.** A health care provider may disclose a deceased patient's health care records or payment records to the executor or administrator of the deceased person's estate, or pursuant to a valid, unrevoked power of attorney for health care that specifically directs that the deceased person's health care records be released to the agent after death. If an executor, administrator, or agent has not been appointed, the deceased prior to death did not specifically object to disclosure of his or her records in writing, and such disclosure is not inconsistent with any prior expressed preference of the deceased that is known to the health care provider, a deceased patient's health care records may be released upon written request of a person who is deemed as the personal representative of the deceased person under this subsection. Priority shall be given to the deceased patient's spouse and the records shall be released on the affidavit of the surviving spouse that he

or she is the surviving spouse. If there is no surviving spouse, the health care records may be released to one of the following persons:

(1) The acting trustee of a trust created by the deceased patient either alone or with the deceased patient's spouse;

(2) An adult child of the deceased patient on the affidavit of the adult child that he or she is the adult child of the deceased;

(3) A parent of the deceased patient on the affidavit of the parent that he or she is the parent of the deceased;

(4) An adult brother or sister of the deceased patient on the affidavit of the adult brother or sister that he or she is the adult brother or sister of the deceased;

(5) A guardian or conservator of the deceased patient at the time of the patient's death on the affidavit of the guardian or conservator that he or she is the guardian or conservator of the deceased; or

(6) A guardian ad litem of the deceased's minor child based on the affidavit of the guardian that he or she is the guardian ad litem of the minor child of the deceased."; 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 Committee Substitute for Senate Bill No. 718, Page 1, Section A, Line 2, by inserting after all of said section and line the following:

"**9.158. The month of November shall be known and designated as "Diabetes Awareness Month". The citizens of the state of Missouri are encouraged to participate in appropriate activities and events to increase awareness of diabetes. Diabetes is a group of metabolic diseases in which the body has elevated blood sugar levels over a prolonged period of time and affects Missourians of all ages.**"; 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 Committee Substitute for Senate Bill No. 718, Page 1, Section A, Line 2, by inserting after all of said section and line the following:

"**9.192. The years of 2018 to 2028 shall hereby be designated as the "Show-Me Freedom from Opioid Addiction Decade".**

191.227. 1. All physicians, chiropractors, hospitals, dentists, and other duly licensed practitioners in this state, herein called "providers", shall, upon written request of a patient, or guardian or legally authorized representative of a patient, furnish a copy of his or her record of that patient's health history and treatment rendered to the person submitting a written request, except that such right shall be limited to access consistent with the patient's condition and sound therapeutic treatment as determined by the provider. Beginning August 28, 1994, such record shall be furnished within a reasonable time of the receipt of the request therefor and upon payment of a fee as provided in this section.

2. Health care providers may condition the furnishing of the patient's health care records to the patient,

the patient's authorized representative or any other person or entity authorized by law to obtain or reproduce such records upon payment of a fee for:

(1) (a) Search and retrieval, in an amount not more than twenty-four dollars and eighty-five cents plus copying in the amount of fifty-seven cents per page for the cost of supplies and labor plus, if the health care provider has contracted for off-site records storage and management, any additional labor costs of outside storage retrieval, not to exceed twenty-three dollars and twenty-six cents, as adjusted annually pursuant to subsection 5 of this section; or

(b) The records shall be furnished electronically upon payment of the search, retrieval, and copying fees set under this section at the time of the request or one hundred eight dollars and eighty-eight cents total, whichever is less, if such person:

a. Requests health records to be delivered electronically in a format of the health care provider's choice;

b. The health care provider stores such records completely in an electronic health record; and

c. The health care provider is capable of providing the requested records and affidavit, if requested, in an electronic format;

(2) Postage, to include packaging and delivery cost; and

(3) Notary fee, not to exceed two dollars, if requested.

3. **For the purposes of subsections 1 and 2 of this section, "a copy of his or her record of that patient's health history and treatment rendered" or "the patient's health care records" includes a statement or record that no such health history or treatment record responsive to the request exists.**

4. Notwithstanding provisions of this section to the contrary, providers may charge for the reasonable cost of all duplications of health care record material or information which cannot routinely be copied or duplicated on a standard commercial photocopy machine.

[4.**]** **5.** The transfer of the patient's record done in good faith shall not render the provider liable to the patient or any other person for any consequences which resulted or may result from disclosure of the patient's record as required by this section.

[5.**]** **6.** Effective February first of each year, the fees listed in subsection 2 of this section shall be increased or decreased annually based on the annual percentage change in the unadjusted, U.S. city average, annual average inflation rate of the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). The current reference base of the index, as published by the Bureau of Labor Statistics of the United States Department of Labor, shall be used as the reference base. For purposes of this subsection, the annual average inflation rate shall be based on a twelve-month calendar year beginning in January and ending in December of each preceding calendar year. The department of health and senior services shall report the annual adjustment and the adjusted fees authorized in this section on the department's internet website by February first of each year.

[6.**]** **7.** A health care provider may disclose a deceased patient's health care records or payment records to the executor or administrator of the deceased person's estate, or pursuant to a valid, unrevoked power of attorney for health care that specifically directs that the deceased person's health care records be released to the agent after death. If an executor, administrator, or agent has not been appointed, the deceased prior to death did not specifically object to disclosure of his or her records in writing, and such disclosure is not

inconsistent with any prior expressed preference of the deceased that is known to the health care provider, a deceased patient's health care records may be released upon written request of a person who is deemed as the personal representative of the deceased person under this subsection. Priority shall be given to the deceased patient's spouse and the records shall be released on the affidavit of the surviving spouse that he or she is the surviving spouse. If there is no surviving spouse, the health care records may be released to one of the following persons:

(1) The acting trustee of a trust created by the deceased patient either alone or with the deceased patient's spouse;

(2) An adult child of the deceased patient on the affidavit of the adult child that he or she is the adult child of the deceased;

(3) A parent of the deceased patient on the affidavit of the parent that he or she is the parent of the deceased;

(4) An adult brother or sister of the deceased patient on the affidavit of the adult brother or sister that he or she is the adult brother or sister of the deceased;

(5) A guardian or conservator of the deceased patient at the time of the patient's death on the affidavit of the guardian or conservator that he or she is the guardian or conservator of the deceased; or

(6) A guardian ad litem of the deceased's minor child based on the affidavit of the guardian that he or she is the guardian ad litem of the minor child of the deceased.

195.070. 1. A physician, podiatrist, dentist, a registered optometrist certified to administer pharmaceutical agents as provided in section 336.220, or an assistant physician in accordance with section 334.037 or a physician assistant in accordance with section 334.747 in good faith and in the course of his or her professional practice only, may prescribe, administer, and dispense controlled substances or he or she may cause the same to be administered or dispensed by an individual as authorized by statute.

2. An advanced practice registered nurse, as defined in section 335.016, but not a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016, who holds a certificate of controlled substance prescriptive authority from the board of nursing under section 335.019 and who is delegated the authority to prescribe controlled substances under a collaborative practice arrangement under section 334.104 may prescribe any controlled substances listed in Schedules III, IV, and V of section 195.017, and may have restricted authority in Schedule II. Prescriptions for Schedule II medications prescribed by an advanced practice registered nurse who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone. However, no such certified advanced practice registered nurse shall prescribe controlled substance for his or her own self or family. Schedule III narcotic controlled substance and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill.

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

4. A practitioner shall not accept any portion of a controlled substance unused by a patient, for any reason, if such practitioner did not originally dispense the drug**, except as provided in section 195.265**.

5. An individual practitioner shall not prescribe or dispense a controlled substance for such practitioner's personal use except in a medical emergency.

195.265. 1. Unused controlled substances may be accepted from ultimate users, from hospice or home health care providers on behalf of ultimate users to the extent federal law allows, or any person lawfully entitled to dispose of a decedent's property if the decedent was an ultimate user who died while in lawful possession of a controlled substance, through:

(1) Collection receptacles, drug disposal boxes, mail back packages, and other means by a Drug Enforcement Agency-authorized collector in accordance with federal regulations even if the authorized collector did not originally dispense the drug; or

(2) Drug take back programs conducted by federal, state, tribal, or local law enforcement agencies in partnership with any person or entity.

This subsection shall supersede and preempt any local ordinances or regulations, including any ordinances or regulations enacted by any political subdivision of the state, regarding the disposal of unused controlled substances. For the purposes of this section, the term "ultimate user" shall mean a person who has lawfully obtained and possesses a controlled substance for his or her own use or for the use of a member of his or her household or for an animal owned by him or her or a member of his or her household.

2. By August 28, 2019, the department of health and senior services shall develop an education and awareness program regarding drug disposal, including controlled substances. The education and awareness program may include, but not be limited to:

(1) A web-based resource that:

(a) Describes available drug disposal options including take back, take back events, mail back packages, in-home disposal options that render a product safe from misuse, or any other methods that comply with state and federal laws and regulations, may reduce the availability of unused controlled substances, and may minimize the potential environmental impact of drug disposal;

(b) Provides a list of drug disposal take back sites, which may be sorted and searched by name or location and is updated every six months by the department;

(c) Provides a list of take back events and mail back events in the state, including the date, time, and location information for each event and is updated every six months by the department; and

(d) Provides information for authorized collectors regarding state and federal requirements to comply with the provisions of subsection 1 of this section; and

(2) Promotional activities designed to ensure consumer awareness of proper storage and disposal of prescription drugs, including controlled substances.

217.364. 1. The department of corrections shall establish by regulation the "Offenders Under Treatment Program". The program shall include institutional placement of certain offenders, as outlined in subsection 3 of this section, under the supervision and control of the department of corrections. The department shall establish rules determining how, when and where an offender shall be admitted into or removed from the program.

2. As used in this section, the term "offenders under treatment program" means a one-hundred-eighty-day institutional correctional program for the monitoring, control and treatment of certain substance abuse offenders and certain nonviolent offenders followed by placement on parole with continued supervision. **As used in this section, the term "medication-assisted treatment" means the use of pharmacological medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.**

3. The following offenders may participate in the program as determined by the department:

(1) Any nonviolent offender who has not previously been remanded to the department and who has been found guilty of violating the provisions of chapter 195 or 579 or whose substance abuse was a precipitating or contributing factor in the commission of his offense; or

(2) Any nonviolent offender who has pled guilty or been found guilty of a crime which did not involve the use of a weapon, and who has not previously been remanded to the department.

4. This program shall be used as an intermediate sanction by the department. The program may include education, treatment and rehabilitation programs. If an offender successfully completes the institutional phase of the program, the department shall notify the board of probation and parole within thirty days of completion. Upon notification from the department that the offender has successfully completed the program, the board of probation and parole may at its discretion release the offender on parole as authorized in subsection 1 of section 217.690.

5. The availability of space in the institutional program shall be determined by the department of corrections.

6. If the offender fails to complete the program, the offender shall be taken out of the program and shall serve the remainder of his sentence with the department.

7. Time spent in the program shall count as time served on the sentence.

8. If an offender requires treatment for opioid or other substance misuse or dependence, the department shall not prohibit such offender from participating in and receiving medication-assisted treatment under the care of a physician licensed in this state to practice medicine. An offender shall not be required to refrain from using medication-assisted treatment as a term or condition of his or her sentence.

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

(1) "Assistant physician", any medical school graduate who:

(a) Is a resident and citizen of the United States or is a legal resident alien;

(b) Has successfully completed **[**Step 1 and**]** Step 2 of the United States Medical Licensing Examination or the equivalent of such **[**steps**]** **step** of any other board-approved medical licensing examination within the **[**two-year**]** **three-year** period immediately preceding application for licensure as an assistant physician, **[**but in no event more than**]** **or within** three years after graduation from a medical college or osteopathic medical college**, whichever is later**;

(c) Has not completed an approved postgraduate residency and has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such step of any other board-approved

medical licensing examination within the immediately preceding **[**two-year**]** **three-year** period unless when such **[**two-year**]** **three-year** anniversary occurred he or she was serving as a resident physician in an accredited residency in the United States and continued to do so within thirty days prior to application for licensure as an assistant physician; and

(d) Has proficiency in the English language.

Any medical school graduate who could have applied for licensure and complied with the provisions of this subdivision at any time between August 28, 2014, and August 28, 2017, may apply for licensure and shall be deemed in compliance with the provisions of this subdivision;

(2) "Assistant physician collaborative practice arrangement", an agreement between a physician and an assistant physician that meets the requirements of this section and section 334.037;

(3) "Medical school graduate", any person who has graduated from a medical college or osteopathic medical college described in section 334.031.

2. (1) An assistant physician collaborative practice arrangement shall limit the assistant physician to providing only primary care services and only in medically underserved rural or urban areas of this state or in any pilot project areas established in which assistant physicians may practice.

(2) For a physician-assistant physician team working in a rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended:

(a) An assistant physician shall be considered a physician assistant for purposes of regulations of the Centers for Medicare and Medicaid Services (CMS); and

(b) No supervision requirements in addition to the minimum federal law shall be required.

3. (1) For purposes of this section, the licensure of assistant physicians shall take place within processes established by rules of the state board of registration for the healing arts. The board of healing arts is authorized to establish rules under chapter 536 establishing licensure and renewal procedures, supervision, collaborative practice arrangements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. **No licensure fee for an assistant physician shall exceed the amount of any licensure fee for a physician assistant.** An application for licensure may be denied or the licensure of an assistant physician may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule. **No rule or regulation shall require an assistant physician to complete more hours of continuing medical education than that of a licensed physician.**

(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 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, 2014, shall be invalid and void.

(3) Any rules or regulations regarding assistant physicians in effect as of the effective date of this section that conflict with the provisions of this section and section 334.037 shall be null and void as of the effective date of this section.

4. An assistant physician shall clearly identify himself or herself as an assistant physician and shall be permitted to use the terms "doctor", "Dr.", or "doc". No assistant physician shall practice or attempt to practice without an assistant physician collaborative practice arrangement, except as otherwise provided in this section and in an emergency situation.

5. The collaborating physician is responsible at all times for the oversight of the activities of and accepts responsibility for primary care services rendered by the assistant physician.

6. The provisions of section 334.037 shall apply to all assistant physician collaborative practice arrangements. **[**To be eligible to practice as an assistant physician, a licensed assistant physician shall enter into an assistant physician collaborative practice arrangement within six months of his or her initial licensure and shall not have more than a six-month time period between collaborative practice arrangements during his or her licensure period.**]** Any renewal of licensure under this section shall include verification of actual practice under a collaborative practice arrangement in accordance with this subsection during the immediately preceding licensure period.

7. Each health carrier or health benefit plan that offers or issues health benefit plans that are delivered, issued for delivery, continued, or renewed in this state shall reimburse an assistant physician for the diagnosis, consultation, or treatment of an insured or enrollee on the same basis that the health carrier or health benefit plan covers the service when it is delivered by another comparable mid-level health care provider including, but not limited to, a physician assistant.

334.037. 1. A physician may enter into collaborative practice arrangements with assistant physicians. 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 an assistant physician 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 assistant physician and is consistent with that assistant physician's skill, training, and competence and the skill and training of the collaborating physician.

2. 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 assistant physician;

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

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

(4) All specialty or board certifications of the collaborating physician and all certifications of the assistant physician;

(5) The manner of collaboration between the collaborating physician and the assistant physician, including how the collaborating physician and the assistant physician shall:

(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.**] Pub. L.** 95-210 **[,] (42 U.S.C. Section 1395x), as amended,** as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. Such exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics if the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics if the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician shall maintain documentation related to such requirement and 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 assistant physician's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the assistant physician 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 assistant physician;

(8) The duration of the written practice agreement between the collaborating physician and the assistant physician;

(9) A description of the time and manner of the collaborating physician's review of the assistant physician's delivery of health care services. The description shall include provisions that the assistant physician shall submit a minimum of ten percent of the charts documenting the assistant physician'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 assistant physician 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.

3. The state board of registration for the healing arts under section 334.125 shall promulgate rules regulating the use of collaborative practice arrangements for assistant physicians. Such rules shall specify:

(1) Geographic areas to be covered;

(2) The methods of treatment that may be covered by collaborative practice arrangements;

(3) In conjunction with deans of medical schools and primary care residency program directors in the state, the development and implementation of educational methods and programs undertaken during the collaborative practice service which shall facilitate the advancement of the assistant physician's medical knowledge and capabilities, and which may lead to credit toward a future residency program for programs that deem such documented educational achievements acceptable; and

(4) The requirements for review of services provided under 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. The state board of registration for the healing arts shall promulgate rules applicable to assistant physicians that 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 in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

4. The state board of registration for the healing arts shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to an assistant physician provided the provisions of this section and the rules promulgated thereunder are satisfied.

5. 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 arrangement, including collaborative practice arrangements delegating the authority to prescribe controlled substances, and also report to the board the name of each assistant physician with whom the physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that arrangements are carried out for compliance under this chapter.

6. A collaborating physician **or supervising physician** shall not enter into a collaborative practice arrangement **or supervision agreement** with more than [three] **six** full-time equivalent assistant physicians**, full-time equivalent physician assistants, or full-time equivalent advance practice registered nurses, or any combination thereof**. Such 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.

7. The collaborating physician shall determine and document the completion of at least a one-month period of time during which the assistant physician shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. **No rule or regulation shall require the collaborating physician to review more than ten percent of the assistant physician's patient charts or records during such one-month period.** Such 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.

8. 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.

9. No contract or other agreement shall require a physician to act as a collaborating physician for an assistant physician against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular assistant physician. 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 assistant physician, but such requirement shall not authorize

a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff.

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

11. All collaborating physicians and assistant physicians in collaborative practice arrangements shall wear identification badges while acting within the scope of their collaborative practice arrangement. The identification badges shall prominently display the licensure status of such collaborating physicians and assistant physicians.

12. (1) An assistant physician with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to prescribe controlled substances in a collaborative practice arrangement. Prescriptions for Schedule II medications prescribed by an assistant physician who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone. Such authority shall be filed with the state board of registration for the healing arts. The collaborating physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the assistant physician is permitted to prescribe. Any limitations shall be listed in the collaborative practice arrangement. Assistant physicians shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill**, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication assisted treatment for substance use disorders under the direction of the collaborating physician**. Assistant physicians who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

(2) The collaborating physician shall be responsible to determine and document the completion of at least one hundred twenty hours in a four-month period by the assistant physician during which the assistant physician shall practice with the collaborating physician on-site prior to prescribing controlled substances when the collaborating physician is not on-site. Such limitation shall not apply to assistant physicians of population-based public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009**, or assistant physicians providing opioid addiction treatment**.

(3) An assistant physician shall receive a certificate of controlled substance prescriptive authority from the state board of registration for the healing arts upon verification of licensure under section 334.036.

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. **An advanced practice registered nurse may prescribe buprenorphine for up to a thirty-day supply without refill for patient's receiving medication assisted treatment for substance use disorders under the direction of the collaborating physician.**

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 **or supervising physician** shall not enter into a collaborative practice arrangement **or supervision agreement** with more than **[**three**] six** full-time equivalent advanced practice registered nurses**, full-time equivalent licensed physician assistants, or full-time equivalent assistant physicians, or any combination thereof**. 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.

334.735. 1. As used in sections 334.735 to 334.749, the following terms mean:

(1) "Applicant", any individual who seeks to become licensed as a physician assistant;

(2) "Certification" or "registration", a process by a certifying entity that grants recognition to applicants meeting predetermined qualifications specified by such certifying entity;

(3) "Certifying entity", the nongovernmental agency or association which certifies or registers individuals who have completed academic and training requirements;

(4) "Department", the department of insurance, financial institutions and professional registration or a designated agency thereof;

(5) "License", a document issued to an applicant by the board acknowledging that the applicant is entitled to practice as a physician assistant;

(6) "Physician assistant", a person who has graduated from a physician assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency, who has passed the certifying examination administered by the National Commission on Certification of Physician Assistants and has active certification by the National Commission on Certification of Physician Assistants who provides health care services delegated by a licensed physician. A person who has been employed as a physician assistant for three years prior to August 28, 1989, who has passed the National Commission on Certification of Physician Assistants examination, and has active certification of the National Commission on Certification of Physician Assistants;

(7) "Recognition", the formal process of becoming a certifying entity as required by the provisions of sections 334.735 to 334.749;

(8) "Supervision", control exercised over a physician assistant working with a supervising physician and oversight of the activities of and accepting responsibility for the physician assistant's delivery of care. The physician assistant shall only practice at a location where the physician routinely provides patient care, except existing patients of the supervising physician in the patient's home and correctional facilities. The supervising physician must be immediately available in person or via telecommunication during the time the physician assistant is providing patient care. Prior to commencing practice, the supervising physician and physician assistant shall attest on a form provided by the board that the physician shall provide supervision appropriate to the physician assistant's training and that the physician assistant shall not practice beyond the physician assistant's training and experience. Appropriate supervision shall require the supervising physician to be working within the same facility as the physician assistant for at least four hours within one calendar day for every fourteen days on which the physician assistant provides patient care as described in subsection 3 of this section. Only days in which the physician assistant provides patient care

as described in subsection 3 of this section shall be counted toward the fourteen-day period. The requirement of appropriate supervision shall be applied so that no more than thirteen calendar days in which a physician assistant provides patient care shall pass between the physician's four hours working within the same facility. The board shall promulgate rules pursuant to chapter 536 for documentation of joint review of the physician assistant activity by the supervising physician and the physician assistant.

2. (1) A supervision agreement shall limit the physician assistant to practice only at locations described in subdivision (8) of subsection 1 of this section, **[**where the supervising physician is no further than fifty miles by road using the most direct route available and where the location is not so situated as to create an impediment to effective intervention and supervision of patient care or adequate review of services**] within a geographic proximity to be determined by the board of registration for the healing arts**.

(2) For a physician-physician assistant team working in a **certified community behavioral health clinic as defined by P.L. 113-93 and a** rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended, **or a federally qualified health center as defined in 42 U.S.C. Section 1395 of the Public Health Service Act, as amended,** no supervision requirements in addition to the minimum federal law shall be required.

3. The scope of practice of a physician assistant shall consist only of the following services and procedures:

(1) Taking patient histories;

(2) Performing physical examinations of a patient;

(3) Performing or assisting in the performance of routine office laboratory and patient screening procedures;

(4) Performing routine therapeutic procedures;

(5) Recording diagnostic impressions and evaluating situations calling for attention of a physician to institute treatment procedures;

(6) Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by a licensed physician;

(7) Assisting the supervising physician in institutional settings, including reviewing of treatment plans, ordering of tests and diagnostic laboratory and radiological services, and ordering of therapies, using procedures reviewed and approved by a licensed physician;

(8) Assisting in surgery;

(9) Performing such other tasks not prohibited by law under the supervision of a licensed physician as the physician's assistant has been trained and is proficient to perform; and

(10) Physician assistants shall not perform or prescribe abortions.

4. Physician assistants shall not prescribe any drug, medicine, device or therapy unless pursuant to a physician supervision agreement in accordance with the law, nor prescribe lenses, prisms or contact lenses for the aid, relief or correction of vision or the measurement of visual power or visual efficiency of the human eye, nor administer or monitor general or regional block anesthesia during diagnostic tests, surgery or obstetric procedures. Prescribing of drugs, medications, devices or therapies by a physician assistant shall

be pursuant to a physician assistant supervision agreement which is specific to the clinical conditions treated by the supervising physician and the physician assistant shall be subject to the following:

(1) A physician assistant shall only prescribe controlled substances in accordance with section 334.747;

(2) The types of drugs, medications, devices or therapies prescribed by a physician assistant shall be consistent with the scopes of practice of the physician assistant and the supervising physician;

(3) All prescriptions shall conform with state and federal laws and regulations and shall include the name, address and telephone number of the physician assistant and the supervising physician;

(4) A physician assistant, or advanced practice registered nurse as defined in section 335.016 may request, receive and sign for noncontrolled professional samples and may distribute professional samples to patients; and

(5) A physician assistant shall not prescribe any drugs, medicines, devices or therapies the supervising physician is not qualified or authorized to prescribe.

5. A physician assistant shall clearly identify himself or herself as a physician assistant and shall not use or permit to be used in the physician assistant's behalf the terms "doctor", "Dr." or "doc" nor hold himself or herself out in any way to be a physician or surgeon. No physician assistant shall practice or attempt to practice without physician supervision or in any location where the supervising physician is not immediately available for consultation, assistance and intervention, except as otherwise provided in this section, and in an emergency situation, nor shall any physician assistant bill a patient independently or directly for any services or procedure by the physician assistant; except that, nothing in this subsection shall be construed to prohibit a physician assistant from enrolling with the department of social services as a MO HealthNet or Medicaid provider while acting under a supervision agreement between the physician and physician assistant.

6. For purposes of this section, the licensing of physician assistants shall take place within processes established by the state board of registration for the healing arts through rule and regulation. The board of healing arts is authorized to establish rules pursuant to chapter 536 establishing licensing and renewal procedures, supervision, supervision agreements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensing may be denied or the license of a physician assistant may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule or regulation. Persons licensed pursuant to the provisions of chapter 335 shall not be required to be licensed as physician assistants. All applicants for physician assistant licensure who complete a physician assistant training program after January 1, 2008, shall have a master's degree from a physician assistant program.

7. "Physician assistant supervision agreement" means a written agreement, jointly agreed-upon protocols or standing order between a supervising physician and a physician assistant, which provides for the delegation of health care services from a supervising physician to a physician assistant and the review of such services. The agreement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, telephone numbers, and state license numbers of the supervising physician and the physician assistant;

(2) A list of all offices or locations where the physician routinely provides patient care, and in which of such offices or locations the supervising physician has authorized the physician assistant to practice;

(3) All specialty or board certifications of the supervising physician;

(4) The manner of supervision between the supervising physician and the physician assistant, including how the supervising physician and the physician assistant shall:

(a) Attest on a form provided by the board that the physician shall provide supervision appropriate to the physician assistant's training and experience and that the physician assistant shall not practice beyond the scope of the physician assistant's training and experience nor the supervising physician's capabilities and training; and

(b) Provide coverage during absence, incapacity, infirmity, or emergency by the supervising physician;

(5) The duration of the supervision agreement between the supervising physician and physician assistant; and

(6) A description of the time and manner of the supervising physician's review of the physician assistant's delivery of health care services. Such description shall include provisions that the supervising physician, or a designated supervising physician listed in the supervision agreement review a minimum of ten percent of the charts of the physician assistant's delivery of health care services every fourteen days.

8. When a physician assistant supervision agreement is utilized to provide health care services for conditions other than acute self-limited or well-defined problems, the supervising physician or other physician designated in the supervision agreement shall see the patient for evaluation and approve or formulate the plan of treatment for new or significantly changed conditions as soon as practical, but in no case more than two weeks after the patient has been seen by the physician assistant.

9. At all times the physician is responsible for the oversight of the activities of, and accepts responsibility for, health care services rendered by the physician assistant.

10. It is the responsibility of the supervising physician to determine and document the completion of at least a one-month period of time during which the licensed physician assistant shall practice with a supervising physician continuously present before practicing in a setting where a supervising physician is not continuously present.

11. No contract or other agreement shall require a physician to act as a supervising physician for a physician assistant against the physician's will. A physician shall have the right to refuse to act as a supervising physician, without penalty, for a particular physician assistant. No contract or other agreement shall limit the supervising physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any physician assistant, 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 the hospital's medical staff.

12. Physician assistants shall file with the board a copy of their supervising physician form.

13. No physician shall be designated to serve as supervising physician **or collaborating physician** for more than **[**three**]** **six** full-time equivalent licensed physician assistants**, full-time equivalent advanced practice registered nurses, or full-time equivalent assistant physicians, or any combination thereof**. This limitation shall not apply to physician assistant agreements of hospital employees providing inpatient care service in hospitals as defined in chapter 197.

334.747. 1. A physician assistant with a certificate of controlled substance prescriptive authority as

provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to prescribe controlled substances in a supervision agreement. Such authority shall be listed on the supervision verification form on file with the state board of healing arts. The supervising physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the physician assistant is permitted to prescribe. Any limitations shall be listed on the supervision form. Prescriptions for Schedule II medications prescribed by a physician assistant with authority to prescribe delegated in a supervision agreement are restricted to only those medications containing hydrocodone. Physician assistants shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill**, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication assisted treatment for substance use disorders under the direction of the supervising physician**. Physician assistants who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

2. The supervising physician shall be responsible to determine and document the completion of at least one hundred twenty hours in a four-month period by the physician assistant during which the physician assistant shall practice with the supervising physician on-site prior to prescribing controlled substances when the supervising physician is not on-site. Such limitation shall not apply to physician assistants of population-based public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009.

3. A physician assistant shall receive a certificate of controlled substance prescriptive authority from the board of healing arts upon verification of the completion of the following educational requirements:

(1) Successful completion of an advanced pharmacology course that includes clinical training in the prescription of drugs, medicines, and therapeutic devices. A course or courses with advanced pharmacological content in a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency shall satisfy such requirement;

(2) Completion of a minimum of three hundred clock hours of clinical training by the supervising physician in the prescription of drugs, medicines, and therapeutic devices;

(3) Completion of a minimum of one year of supervised clinical practice or supervised clinical rotations. One year of clinical rotations in a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency, which includes pharmacotherapeutics as a component of its clinical training, shall satisfy such requirement. Proof of such training shall serve to document experience in the prescribing of drugs, medicines, and therapeutic devices;

(4) A physician assistant previously licensed in a jurisdiction where physician assistants are authorized to prescribe controlled substances may obtain a state bureau of narcotics and dangerous drugs registration if a supervising physician can attest that the physician assistant has met the requirements of subdivisions (1) to (3) of this subsection and provides documentation of existing federal Drug Enforcement Agency registration.

337.025. 1. The provisions of this section shall govern the education and experience requirements for

initial licensure as a psychologist for the following persons:

(1) A person who has not matriculated in a graduate degree program which is primarily psychological in nature on or before August 28, 1990; and

(2) A person who is matriculated after August 28, 1990, in a graduate degree program designed to train professional psychologists.

2. Each applicant shall submit satisfactory evidence to the committee that the applicant has received a doctoral degree in psychology from a recognized educational institution, and has had at least one year of satisfactory supervised professional experience in the field of psychology.

3. A doctoral degree in psychology is defined as:

(1) A program accredited, or provisionally accredited, by the American Psychological Association **[**or**] (APA),** the Canadian Psychological Association**, or the Psychological Clinical Science Accreditation System (PCSAS) provided that such program include a supervised practicum, internship, field, or laboratory training appropriate to the practice of psychology**; or

(2) A program designated or approved, including provisional approval, by the Association of State and Provincial Psychology Boards or the Council for the National Register of Health Service Providers in Psychology, or both; or

(3) A graduate program that meets all of the following criteria:

(a) The program, wherever it may be administratively housed, shall be clearly identified and labeled as a psychology program. Such a program shall specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

(b) The psychology program shall stand as a recognizable, coherent organizational entity within the institution of higher education;

(c) There shall be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

(d) The program shall be an integrated, organized, sequence of study;

(e) There shall be an identifiable psychology faculty and a psychologist responsible for the program;

(f) The program shall have an identifiable body of students who are matriculated in that program for a degree;

(g) The program shall include a supervised practicum, internship, field, or laboratory training appropriate to the practice of psychology;

(h) The curriculum shall encompass a minimum of three academic years of full-time graduate study, with a minimum of one year's residency at the educational institution granting the doctoral degree; and

(i) Require the completion by the applicant of a core program in psychology which shall be met by the completion and award of at least one three-semester-hour graduate credit course or a combination of graduate credit courses totaling three semester hours or five quarter hours in each of the following areas:

a. The biological bases of behavior such as courses in: physiological psychology, comparative

psychology, neuropsychology, sensation and perception, psychopharmacology;

b. The cognitive-affective bases of behavior such as courses in: learning, thinking, motivation, emotion, and cognitive psychology;

c. The social bases of behavior such as courses in: social psychology, group processes/dynamics, interpersonal relationships, and organizational and systems theory;

d. Individual differences such as courses in: personality theory, human development, abnormal psychology, developmental psychology, child psychology, adolescent psychology, psychology of aging, and theories of personality;

e. The scientific methods and procedures of understanding, predicting and influencing human behavior such as courses in: statistics, experimental design, psychometrics, individual testing, group testing, and research design and methodology.

4. Acceptable supervised professional experience may be accrued through preinternship, internship, predoctoral postinternship, or postdoctoral experiences. The academic training director or the postdoctoral training supervisor shall attest to the hours accrued to meet the requirements of this section. Such hours shall consist of:

(1) A minimum of fifteen hundred hours of experience in a successfully completed internship to be completed in not less than twelve nor more than twenty-four months; and

(2) A minimum of two thousand hours of experience consisting of any combination of the following:

(a) Preinternship and predoctoral postinternship professional experience that occurs following the completion of the first year of the doctoral program or at any time while in a doctoral program after completion of a master's degree in psychology or equivalent as defined by rule by the committee;

(b) Up to seven hundred fifty hours obtained while on the internship under subdivision (1) of this subsection but beyond the fifteen hundred hours identified in subdivision (1) of this subsection; or

(c) Postdoctoral professional experience obtained in no more than twenty-four consecutive calendar months. In no case shall this experience be accumulated at a rate of more than fifty hours per week. Postdoctoral supervised professional experience for prospective health service providers and other applicants shall involve and relate to the delivery of psychological services in accordance with professional requirements and relevant to the applicant's intended area of practice.

5. Experience for those applicants who intend to seek health service provider certification and who have completed a program in one or more of the American Psychological Association designated health service provider delivery areas shall be obtained under the primary supervision of a licensed psychologist who is also a health service provider or who otherwise meets the requirements for health service provider certification. Experience for those applicants who do not intend to seek health service provider certification shall be obtained under the primary supervision of a licensed psychologist or such other qualified mental health professional approved by the committee.

6. For postinternship and postdoctoral hours, the psychological activities of the applicant shall be performed pursuant to the primary supervisor's order, control, and full professional responsibility. The primary supervisor shall maintain a continuing relationship with the applicant and shall meet with the applicant a minimum of one hour per month in face-to-face individual supervision. Clinical supervision may

be delegated by the primary supervisor to one or more secondary supervisors who are qualified psychologists. The secondary supervisors shall retain order, control, and full professional responsibility for the applicant's clinical work under their supervision and shall meet with the applicant a minimum of one hour per week in face-to-face individual supervision. If the primary supervisor is also the clinical supervisor, meetings shall be a minimum of one hour per week. Group supervision shall not be acceptable for supervised professional experience. The primary supervisor shall certify to the committee that the applicant has complied with these requirements and that the applicant has demonstrated ethical and competent practice of psychology. The changing by an agency of the primary supervisor during the course of the supervised experience shall not invalidate the supervised experience.

7. The committee by rule shall provide procedures for exceptions and variances from the requirements for once a week face-to-face supervision due to vacations, illness, pregnancy, and other good causes.

337.029. 1. A psychologist licensed in another jurisdiction who has had no violations and no suspensions and no revocation of a license to practice psychology in any jurisdiction may receive a license in Missouri, provided the psychologist passes a written examination on Missouri laws and regulations governing the practice of psychology and meets one of the following criteria:

(1) Is a diplomate of the American Board of Professional Psychology;

(2) Is a member of the National Register of Health Service Providers in Psychology;

(3) Is currently licensed or certified as a psychologist in another jurisdiction who is then a signatory to the Association of State and Provincial Psychology Board's reciprocity agreement;

(4) Is currently licensed or certified as a psychologist in another state, territory of the United States, or the District of Columbia and:

(a) Has a doctoral degree in psychology from a program accredited, or provisionally accredited, by the American Psychological Association **or the Psychological Clinical Science Accreditation System,** or that meets the requirements as set forth in subdivision (3) of subsection 3 of section 337.025;

(b) Has been licensed for the preceding five years; and

(c) Has had no disciplinary action taken against the license for the preceding five years; or

(5) Holds a current certificate of professional qualification (CPQ) issued by the Association of State and Provincial Psychology Boards (ASPPB).

2. Notwithstanding the provisions of subsection 1 of this section, applicants may be required to pass an oral examination as adopted by the committee.

3. A psychologist who receives a license for the practice of psychology in the state of Missouri on the basis of reciprocity as listed in subsection 1 of this section or by endorsement of the score from the examination of professional practice in psychology score will also be eligible for and shall receive certification from the committee as a health service provider if the psychologist meets one or more of the following criteria:

(1) Is a diplomate of the American Board of Professional Psychology in one or more of the specialties recognized by the American Board of Professional Psychology as pertaining to health service delivery;

(2) Is a member of the National Register of Health Service Providers in Psychology; or

(3) Has completed or obtained through education, training, or experience the requisite knowledge comparable to that which is required pursuant to section 337.033.

337.033. 1. A licensed psychologist shall limit his or her practice to demonstrated areas of competence as documented by relevant professional education, training, and experience. A psychologist trained in one area shall not practice in another area without obtaining additional relevant professional education, training, and experience through an acceptable program of respecialization.

2. A psychologist may not represent or hold himself or herself out as a state certified or registered psychological health service provider unless the psychologist has first received the psychologist health service provider certification from the committee; provided, however, nothing in this section shall be construed to limit or prevent a licensed, whether temporary, provisional or permanent, psychologist who does not hold a health service provider certificate from providing psychological services so long as such services are consistent with subsection 1 of this section.

3. "Relevant professional education and training" for health service provider certification, except those entitled to certification pursuant to subsection 5 or 6 of this section, shall be defined as a licensed psychologist whose graduate psychology degree from a recognized educational institution is in an area designated by the American Psychological Association as pertaining to health service delivery or a psychologist who subsequent to receipt of his or her graduate degree in psychology has either completed a respecialization program from a recognized educational institution in one or more of the American Psychological Association recognized clinical health service provider areas and who in addition has completed at least one year of postdegree supervised experience in such clinical area or a psychologist who has obtained comparable education and training acceptable to the committee through completion of postdoctoral fellowships or otherwise.

4. The degree or respecialization program certificate shall be obtained from a recognized program of graduate study in one or more of the health service delivery areas designated by the American Psychological Association as pertaining to health service delivery, which shall meet one of the criteria established by subdivisions (1) to (3) of this subsection:

(1) A doctoral degree or completion of a recognized respecialization program in one or more of the American Psychological Association designated health service provider delivery areas which is accredited, or provisionally accredited, **either** by the American Psychological Association **or the Psychological Clinical Science Accreditation System**; or

(2) A clinical or counseling psychology doctoral degree program or respecialization program designated, or provisionally approved, by the Association of State and Provincial Psychology Boards or the Council for the National Register of Health Service Providers in Psychology, or both; or

(3) A doctoral degree or completion of a respecialization program in one or more of the American Psychological Association designated health service provider delivery areas that meets the following criteria:

(a) The program, wherever it may be administratively housed, shall be clearly identified and labeled as being in one or more of the American Psychological Association designated health service provider delivery areas;

(b) Such a program shall specify in pertinent institutional catalogues and brochures its intent to educate

and train professional psychologists in one or more of the American Psychological Association designated health service provider delivery areas.

5. A person who is lawfully licensed as a psychologist pursuant to the provisions of this chapter on August 28, 1989, or who has been approved to sit for examination prior to August 28, 1989, and who subsequently passes the examination shall be deemed to have met all requirements for health service provider certification; provided, however, that such person shall be governed by the provisions of subsection 1 of this section with respect to limitation of practice.

6. Any person who is lawfully licensed as a psychologist in this state and who meets one or more of the following criteria shall automatically, upon payment of the requisite fee, be entitled to receive a health service provider certification from the committee:

(1) Is a diplomate of the American Board of Professional Psychology in one or more of the specialties recognized by the American Board of Professional Psychology as pertaining to health service delivery; or

(2) Is a member of the National Register of Health Service Providers in Psychology."; and

Further amend said bill and page, Section 338.202, Line 16, by inserting after all of said section and line the following:

"374.426. 1. Any entity in the business of delivering or financing health care shall provide data regarding quality of patient care and patient satisfaction to the director of the department of insurance, financial institutions and professional registration. Failure to provide such data as required by the director of the department of insurance, financial institutions and professional registration shall constitute grounds for violation of the unfair trade practices act, sections 375.930 to 375.948.

2. In defining data standards for quality of care and patient satisfaction, the director of the department of insurance, financial institutions and professional registration shall:

(1) Use as the initial data set the HMO Employer Data and Information Set developed by the National Committee for Quality Assurance;

(2) Consult with nationally recognized accreditation organizations, including but not limited to the National Committee for Quality Assurance and the Joint Committee on Accreditation of Health Care Organizations; and

(3) Consult with a state committee of a national committee convened to develop standards regarding uniform billing of health care claims.

3. In defining data standards for quality of care and patient satisfaction, the director of the department of insurance, financial institutions and professional registration shall not require patient scoring of pain control.

4. Beginning August 28, 2018, the director of the department of insurance, financial institutions and professional registration shall discontinue the use of patient satisfaction scores and shall not make them available to the public to the extent allowed by federal law.

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

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

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

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

(4) **Coverage for medication-assisted treatment for substance use disorders, using any drug approved for sale by the Food and Drug Administration for use in treating such patient's condition, including opioid-use and heroin-use disorders. No prior authorization, step therapy, or fail-first therapy shall be required for medication-assisted treatment;**

[(4)**] (5)** The coverages set forth in this subsection may be subject to a separate lifetime frequency cap of not less than ten episodes of treatment, except that such separate lifetime frequency cap shall not apply to medical detoxification in a life-threatening situation as determined by the treating physician and subsequently documented within forty-eight hours of treatment to the reasonable satisfaction of the insurance company or health services corporation; and

[(5)**] (6)** The coverages set forth in this subsection:

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

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

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

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

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

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

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

(4) The coverages set forth in this subsection shall be subject to the same coinsurance, co-payment,

deductible, annual maximum and lifetime maximum factors as apply to physical illness; and

(5) The coverages set forth in this subsection may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

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

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

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

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

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

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

6. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration."; and

Further amend said bill, Page 2, Section 376.1237, Line 18, by inserting after all of said section and line the following:

"376.1550. 1. Notwithstanding any other provision of law to the contrary, each health carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a mental health condition, as defined in this section, and shall comply with the following provisions:

(1) A health benefit plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required by a health carrier or health benefit plan shall be comprehensive for coverage of all health conditions, whether mental or physical;

(2) The coverages set forth is this subsection:

(a) May be administered pursuant to a managed care program established by the health carrier; and

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

(3) A health benefit plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health conditions may provide coverage for treatment of mental health conditions through a managed care organization; provided that the managed care organization is in compliance with rules adopted by the department of insurance, financial institutions and professional registration that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the director shall assure that:

(a) Timely and appropriate access to care is available;

(b) The quantity, location, and specialty distribution of health care providers is adequate; and

(c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured;

(4) Coverage for treatment for chemical dependency shall comply with sections 376.779, 376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term "health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to 376.836, the term "health insurance policy" shall include group coverage.

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

(1) "Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both;

(2) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(3) "Health carrier", the same meaning as such term is defined in section 376.1350;

(4) "Mental health condition", any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders **[**except for chemical dependency**]**;

(5) "Managed care organization", any financing mechanism or system that manages care delivery for its members or subscribers, including health maintenance organizations and any other similar health care delivery system or organization;

(6) "Rate, term, or condition", any lifetime or annual payment limits, deductibles, co-payments, coinsurance, and other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of a health benefit plan that affects the insured.

3. This section shall not apply to a health plan or policy that is individually underwritten or provides such coverage for specific individuals and members of their families pursuant to section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836, a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policies of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

4. Notwithstanding any other provision of law to the contrary, all health insurance policies that cover state employees, including the Missouri consolidated health care plan, shall include coverage for mental illness. Multiyear group policies need not comply until the expiration of their current multiyear term unless the policyholder elects to comply before that time.

5. The provisions of this section shall not be violated if the insurer decides to apply different limits or exclude entirely from coverage the following:

(1) Marital, family, educational, or training services unless medically necessary and clinically appropriate;

(2) Services rendered or billed by a school or halfway house;

(3) Care that is custodial in nature;

(4) Services and supplies that are not immediately nor clinically appropriate; or

(5) Treatments that are considered experimental.

6. The director shall grant a policyholder a waiver from the provisions of this section if the policyholder demonstrates to the director by actual experience over any consecutive twenty-four-month period that compliance with this section has increased the cost of the health insurance policy by an amount that results in a two percent increase in premium costs to the policyholder. The director shall promulgate rules establishing a procedure and appropriate standards for making such a demonstration. 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, 2004, shall be invalid and void.

630.875. 1. This section shall be known and may be cited as the "Improved Access to Treatment for Opioid Addictions Act" or "IATOA Act".

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

(1) "Department", the department of mental health;

(2) "IATOA program", the improved access to treatment for opioid addictions program created

under subsection 3 of this section.

3. Subject to appropriations, the department shall create and oversee an "Improved Access to Treatment for Opioid Addictions Program", which is hereby created and whose purpose is to disseminate information and best practices regarding opioid addiction and to facilitate collaborations to better treat and prevent opioid addiction in this state. The IATOA program shall facilitate partnerships between assistant physicians, physician assistants, and advanced practice registered nurses practicing in federally qualified health centers, rural health clinics, and other health care facilities and physicians practicing at remote facilities located in this state. The IATOA program shall provide resources that grant patients and their treating assistant physicians, physician assistants, advanced practice registered nurses, or physicians access to knowledge and expertise through means such as telemedicine and Extension for Community Healthcare Outcomes (ECHO) programs established under section 191.1140.

4. Assistant physicians, physician assistants, and advanced practice registered nurses who participate in the IATOA program shall complete the necessary requirements to prescribe buprenorphine within at least thirty days of joining the IATOA program.

5. For the purposes of the IATOA program, a remote collaborating or supervising physician working with an on-site assistant physician, physician assistant, or advanced practice registered nurse shall be considered to be on-site. An assistant physician, physician assistant, or advanced practice registered nurse collaborating with a remote physician shall comply with all laws and requirements applicable to assistant physicians, physician assistants, or advanced practice registered nurses with on-site supervision before providing treatment to a patient.

6. An assistant physician, physician assistant, or advanced practice registered nurse collaborating with a physician who is waiver-certified for the use of buprenorphine, may participate in the IATOA program in any area of the state and provide all services and functions of an assistant physician, physician assistant, or advanced practice registered nurse.

7. The department may develop curriculum and benchmark examinations on the subject of opioid addiction and treatment. The department may collaborate with specialists, institutions of higher education, and medical schools for such development. Completion of such a curriculum and passing of such an examination by an assistant physician, physician assistant, advanced practice registered nurse, or physician shall result in a certificate awarded by the department or sponsoring institution, if any.

8. An assistant physician, physician assistant, or advanced practice registered nurse participating in the IATOA program may also:

(1) Engage in community education;

(2) Engage in professional education outreach programs with local treatment providers;

(3) Serve as a liaison to courts;

(4) Serve as a liaison to addiction support organizations;

(5) Provide educational outreach to schools;

(6) Treat physical ailments of patients in an addiction treatment program or considering entering

such a program;

(7) Refer patients to treatment centers;

(8) Assist patients with court and social service obligations;

(9) Perform other functions as authorized by the department; and

(10) Provide mental health services in collaboration with a qualified licensed physician.

The list of authorizations in this subsection is a nonexclusive list, and assistant physicians, physician assistants, or advanced practice registered nurses participating in the IATOA program may perform other actions.

9. When an overdose survivor arrives in the emergency department, the assistant physician, physician assistant, or advanced practice registered nurse serving as a recovery coach or, if the assistant physician, physician assistant, or advanced practice registered nurse is unavailable, another properly trained recovery coach shall, when reasonably practicable, meet with the overdose survivor and provide treatment options and support available to the overdose survivor. The department shall assist recovery coaches in providing treatment options and support to overdose survivors.

10. The provisions of this section shall supersede any contradictory statutes, rules, or regulations. The department shall implement the improved access to treatment for opioid addictions program as soon as reasonably possible using guidance within this section. Further refinement to the improved access to treatment for opioid addictions program may be done through the rules process.

11. The department shall promulgate rules to implement the provisions of the improved access to treatment for opioid addictions act as soon as reasonably possible. 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, 2018, shall be invalid and void.

632.005. As used in chapter 631 and this chapter, unless the context clearly requires otherwise, the following terms shall mean:

(1) "Comprehensive psychiatric services", any one, or any combination of two or more, of the following services to persons affected by mental disorders other than intellectual disabilities or developmental disabilities: inpatient, outpatient, day program or other partial hospitalization, emergency, diagnostic, treatment, liaison, follow-up, consultation, education, rehabilitation, prevention, screening, transitional living, medical prevention and treatment for alcohol abuse, and medical prevention and treatment for drug abuse;

(2) "Council", the Missouri advisory council for comprehensive psychiatric services;

(3) "Court", the court which has jurisdiction over the respondent or patient;

(4) "Division", the division of comprehensive psychiatric services of the department of mental health;

(5) "Division director", director of the division of comprehensive psychiatric services of the department

of mental health, or his designee;

(6) "Head of mental health facility", superintendent or other chief administrative officer of a mental health facility, or his designee;

(7) "Judicial day", any Monday, Tuesday, Wednesday, Thursday or Friday when the court is open for business, but excluding Saturdays, Sundays and legal holidays;

(8) "Licensed physician", a physician licensed pursuant to the provisions of chapter 334 or a person authorized to practice medicine in this state pursuant to the provisions of section 334.150;

(9) "Licensed professional counselor", a person licensed as a professional counselor under chapter 337 and with a minimum of one year training or experience in providing psychiatric care, treatment, or services in a psychiatric setting to individuals suffering from a mental disorder;

(10) "Likelihood of serious harm" means any one or more of the following but does not require actual physical injury to have occurred:

(a) A substantial risk that serious physical harm will be inflicted by a person upon his own person, as evidenced by recent threats, including verbal threats, or attempts to commit suicide or inflict physical harm on himself. Evidence of substantial risk may also include information about patterns of behavior that historically have resulted in serious harm previously being inflicted by a person upon himself;

(b) A substantial risk that serious physical harm to a person will result or is occurring because of an impairment in his capacity to make decisions with respect to his hospitalization and need for treatment as evidenced by his current mental disorder or mental illness which results in an inability to provide for his own basic necessities of food, clothing, shelter, safety or medical care or his inability to provide for his own mental health care which may result in a substantial risk of serious physical harm. Evidence of that substantial risk may also include information about patterns of behavior that historically have resulted in serious harm to the person previously taking place because of a mental disorder or mental illness which resulted in his inability to provide for his basic necessities of food, clothing, shelter, safety or medical or mental health care; or

(c) A substantial risk that serious physical harm will be inflicted by a person upon another as evidenced by recent overt acts, behavior or threats, including verbal threats, which have caused such harm or which would place a reasonable person in reasonable fear of sustaining such harm. Evidence of that substantial risk may also include information about patterns of behavior that historically have resulted in physical harm previously being inflicted by a person upon another person;

(11) "Mental health coordinator", a mental health professional who has knowledge of the laws relating to hospital admissions and civil commitment and who is authorized by the director of the department, or his designee, to serve a designated geographic area or mental health facility and who has the powers, duties and responsibilities provided in this chapter;

(12) "Mental health facility", any residential facility, public or private, or any public or private hospital, which can provide evaluation, treatment and, inpatient care to persons suffering from a mental disorder or mental illness and which is recognized as such by the department or any outpatient treatment program certified by the department of mental health. No correctional institution or facility, jail, regional center or developmental disability facility shall be a mental health facility within the meaning of this chapter;

(13) "Mental health professional", a psychiatrist, resident in psychiatry, **psychiatric physician assistant, psychiatric assistant physician, psychiatric advanced practice registered nurse,** psychologist, psychiatric nurse, licensed professional counselor, or psychiatric social worker;

(14) "Mental health program", any public or private residential facility, public or private hospital, public or private specialized service or public or private day program that can provide care, treatment, rehabilitation or services, either through its own staff or through contracted providers, in an inpatient or outpatient setting to persons with a mental disorder or mental illness or with a diagnosis of alcohol abuse or drug abuse which is recognized as such by the department. No correctional institution or facility or jail may be a mental health program within the meaning of this chapter;

(15) "Ninety-six hours" shall be construed and computed to exclude Saturdays, Sundays and legal holidays which are observed either by the court or by the mental health facility where the respondent is detained;

(16) "Peace officer", a sheriff, deputy sheriff, county or municipal police officer or highway patrolman;

(17) **"Psychiatric advanced practice registered nurse", a registered nurse who is currently recognized by the board of nursing as an advanced practice registered nurse, who has at least two years of experience in providing psychiatric treatment to individuals suffering from mental disorders;**

(18) "Psychiatric assistant physician", a licensed assistant physician under chapter 334 and who has had at least two years of experience as an assistant physician in providing psychiatric treatment to individuals suffering from mental health disorders;

(19) "Psychiatric nurse", a registered professional nurse who is licensed under chapter 335 and who has had at least two years of experience as a registered professional nurse in providing psychiatric nursing treatment to individuals suffering from mental disorders;

(20) "Psychiatric physician assistant", a licensed physician assistant under chapter 334 and who has had at least two years of experience as a physician assistant in providing psychiatric treatment to individuals suffering from mental health disorders or a graduate of a postgraduate residency or fellowship for physician assistants in psychiatry;

[(18)**] (21)** "Psychiatric social worker", a person with a master's or further advanced degree from an accredited school of social work, practicing pursuant to chapter 337, and with a minimum of one year training or experience in providing psychiatric care, treatment or services in a psychiatric setting to individuals suffering from a mental disorder;

[(19)**] (22)** "Psychiatrist", a licensed physician who in addition has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program certified as equivalent by the department;

[(20)**] (23)** "Psychologist", a person licensed to practice psychology under chapter 337 with a minimum of one year training or experience in providing treatment or services to mentally disordered or mentally ill individuals;

[(21)**] (24)** "Resident in psychiatry", a licensed physician who is in a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program certified as equivalent by the department;

[(22)**]** **(25)** "Respondent", an individual against whom involuntary civil detention proceedings are instituted pursuant to this chapter;

[(23)**]** **(26)** "Treatment", any effort to accomplish a significant change in the mental or emotional conditions or the behavior of the patient consistent with generally recognized principles or standards in the mental health professions.

Section B. Because immediate action is necessary to save the lives of Missouri citizens who are suffering from the opioid crisis, the repeal and reenactment of sections 195.070, 217.364, 334.036, and 374.426 and the enactment of sections 9.192, 195.265, and 630.875 of this act are deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and are hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of sections 195.070, 217.364, 334.036, and 374.426 and the enactment of sections 9.192, 195.265, and 630.875 of this act shall be in full force and effect upon their passage and approval."; 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 Committee Substitute for Senate Bill No. 718, Page 2, Section 376.1237, Line 18, by inserting after all of said section and line the following:

"**630.1010. The department of mental health shall develop a treatment protocol containing best practice guidelines for the treatment of opioid-dependent patients. The treatment protocol shall include the following:**

(1) Appropriate clinical use of all drugs approved by the federal Food and Drug Administration for the treatment of opioid addiction, including, but not limited to, the following:

(a) Opioid maintenance;

(b) Opioid detoxification;

(c) Overdose reversal; and

(d) Long acting, antagonist medication;

(2) Training for prescribers dispensing narcotic drugs for the treatment and management of opiate-dependent patients consistent with the federal Controlled Substances Act, as amended by Section 303 of the Comprehensive Addiction and Recovery Act of 2016; and

(3) Development and adoption of standard processes for obtaining informed consent from patients concerning all available medication-assisted treatment options, including potential benefits and risks."; 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 Committee Substitute for Senate Bill No. 718, Page 1, Section A, Line 2, by inserting after all of said section and line the following:

"**208.183. 1. There shall be established an "Advisory Council on Rare Diseases and Personalized Medicine" within the MO HealthNet division. The advisory council shall serve as an expert advisory**

committee to the drug utilization review board, providing necessary consultation to the board when the board makes recommendations or determinations regarding beneficiary access to drugs or biological products for rare diseases, or when the board itself determines that it lacks the specific scientific, medical, or technical expertise necessary for the proper performance of its responsibilities and such necessary expertise can be provided by experts outside the board. "Beneficiary access", as used in this section, shall mean developing prior authorization and reauthorization criteria for a rare disease drug, including placement on a preferred drug list or a formulary, as well as payment, cost-sharing, drug utilization review, or medication therapy management.

2. The advisory council on rare diseases and personalized medicine shall be composed of the following health care professionals, who shall be appointed by the director of the department of social services:

(1) Two physicians affiliated with a public school of medicine who are licensed and practicing in this state with experience researching, diagnosing, or treating rare diseases;

(2) Two physicians affiliated with private schools of medicine headquartered in this state who are licensed and practicing in this state with experience researching, diagnosing, or treating rare diseases;

(3) A physician who holds a doctor of osteopathy degree, who is active in medical practice, and who is affiliated with a school of medicine in this state with experience researching, diagnosing, or treating rare diseases;

(4) Two medical researchers from either academic research institutions or medical research organizations in this state who have received federal or foundation grant funding for rare disease research;

(5) A registered nurse or advanced practice registered nurse licensed and practicing in this state with experience treating rare diseases;

(6) A pharmacist practicing in a hospital in this state which has a designated orphan disease center;

(7) A professor employed by a pharmacy program in this state that is fully accredited by the Accreditation Council for Pharmacy Education and who has advanced scientific or medical training in orphan and rare disease treatments;

(8) One individual representing the rare disease community or who is living with a rare disease;

(9) One member who represents a rare disease foundation;

(10) A representative from a rare disease center located within one of the state's comprehensive pediatric hospitals;

(11) The chair of the joint committee on the life sciences or the chair's designee; and

(12) The chairperson of the drug utilization review board, or the chairperson's designee, who shall serve as an ex officio, nonvoting member of the advisory council.

3. The director shall convene the first meeting of the advisory council on rare diseases and personalized medicine no later than February 28, 2019. Following the first meeting, the advisory council shall meet upon the call of the chairperson of the drug utilization review board or upon the

request of a majority of the council members.

4. The drug utilization review board, when making recommendations or determinations regarding beneficiary access to drugs and biological products for rare diseases, as defined in the federal Orphan Drug Act of 1983, P.L. 97-414, and drugs and biological products that are approved by the U.S. Food and Drug Administration and within the emerging fields of personalized medicine and noninheritable gene editing therapeutics, shall request and consider information from the advisory council on rare diseases and personalized medicine.

5. The drug utilization review board shall seek the input of the advisory council on rare diseases and personalized medicine to address topics for consultation under this section including, but not limited to:

(1) Rare diseases;

(2) The severity of rare diseases;

(3) The unmet medical need associated with rare diseases;

(4) The impact of particular coverage, cost-sharing, tiering, utilization management, prior authorization, medication therapy management, or other Medicaid policies on access to rare disease therapies;

(5) An assessment of the benefits and risks of therapies to treat rare diseases;

(6) The impact of particular coverage, cost-sharing, tiering, utilization management, prior authorization, medication therapy management, or other policies on patients' adherence to the treatment regimen prescribed or otherwise recommended by their physicians;

(7) Whether beneficiaries who need treatment from or a consultation with a rare disease specialist have adequate access and, if not, what factors are causing the limited access; and

(8) The demographics and the clinical description of patient populations.

6. Nothing in this section shall be construed to create a legal right for a consultation on any matter or to require the drug utilization review board to meet with any particular expert or stakeholder.

7. Recommendations of the advisory council on rare diseases and personalized medicine on an applicable treatment of a rare disease shall be explained in writing to members of the drug utilization review board during public hearings.

8. For purposes of this section, a "rare disease drug" shall mean a drug used to treat a rare medical condition, defined as any disease or condition that affects fewer than two hundred thousand persons in the United States, such as cystic fibrosis, hemophilia, and multiple myeloma.

9. All members of the advisory council on rare diseases and personalized medicine shall annually sign a conflict of interest statement revealing economic or other relationships with entities that could influence a member's decisions, and at least twenty percent of the advisory council members shall not have a conflict of interest with respect to any insurer, pharmaceutical benefits manager, or pharmaceutical manufacturer."; 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 Committee Substitute for Senate Bill No. 718, Page 1, Section A, Line 2, by inserting after all of said section and line the following:

"210.070. **[**Every**] 1. A** physician, midwife**,** or nurse who shall be in attendance upon a newborn infant or its mother**[**,**]** shall drop into the eyes of such infant **[**immediately after delivery,**]** a prophylactic **[**solution**] medication** approved by the state department of health and senior services**[**, and shall within forty-eight hours thereafter, report in writing to the board of health or county physician of the city, town or county where such birth occurs, his or her compliance with this section, stating the solution used by him or her**]**.

2. Administration of such eye drops shall not be required if a parent or legal guardian of such infant objects to the treatment because it is against the religious beliefs of the parent or legal guardian."; 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 Committee Substitute for Senate Bill No. 718, Page 2, Section 376.1237, Line 18, by inserting after all of said section and line the following:

"579.040. 1. A person commits the offense of unlawful distribution, delivery, or sale of drug paraphernalia if he or she unlawfully distributes, delivers, or sells, or possesses with intent to distribute, deliver, or sell drug paraphernalia knowing, or under circumstances in which one reasonably should know, that it will be used to plant, propogate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance or an imitation controlled substance in violation of this chapter. **Any entity registered with the department of health and senior services that possesses, distributes, delivers, or sells hypodermic needles or syringes shall be exempt from the provisions of this section.**

2. The offense of unlawful delivery of drug paraphernalia is a class A misdemeanor, unless done for commercial purposes, in which case it is a class E felony.

579.076. 1. A person commits the offense of unlawful manufacture of drug paraphernalia if he or she unlawfully manufactures with intent to deliver drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance or an imitation controlled substance in violation of this chapter or chapter 195. **Any entity registered with the department of health and senior services that delivers or manufactures hypodermic needles or syringes shall be exempt from the provisions of this section.**

2. The offense of unlawful manufacture of drug paraphernalia is a class A misdemeanor, unless done for commercial purposes, in which case it is a class E felony."; and

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

HOUSE AMENDMENT NO. 11

Amend House Committee Substitute for Senate Committee Substitute for Senate Bill No. 718, Page 1,

Section A, Line 2, by inserting after all of said line the following:

"191.671. 1. No other section of this act shall apply to any insurer, health services corporation, or health maintenance organization licensed by the department of insurance, financial institutions and professional registration which conducts HIV testing only for the purposes of assessing a person's fitness for insurance coverage offered by such insurer, health services corporation, or health maintenance corporation, except that nothing in this section shall be construed to exempt any insurer, health services corporation or health maintenance organization in their capacity as employers from the provisions of section 191.665 relating to employment practices.

2. Upon renewal of any individual or group insurance policy, subscriber contractor health maintenance organization contract covering medical expenses, no insurer, health services corporation or health maintenance organization shall deny or alter coverage to any previously covered individual who has been diagnosed as having HIV infection or any HIV-related condition during the previous policy or contract period only because of such diagnosis, nor shall any such insurer, health services corporation or health maintenance organization exclude coverage for treatment of such infection or condition with respect to any such individual. **The provisions of this subsection shall not apply to short-term major medical policies having a duration of less than one year.**

3. The director of the department of insurance, financial institutions and professional registration shall establish by regulation standards for the use of HIV testing by insurers, health services corporations and health maintenance organizations.

4. A laboratory certified by the U.S. Department of Health and Human Services under the Clinical Laboratory Improvement Act of 1967, permitting testing of specimens obtained in interstate commerce, and which subjects itself to ongoing proficiency testing by the College of American Pathologists, the American Association of Bio Analysts, or an equivalent program approved by the Centers for Disease Control shall be authorized to perform or conduct HIV testing for an insurer, health services corporation or health maintenance organization pursuant to this section.

5. The result or results of HIV testing of an applicant for insurance coverage shall not be disclosed by an insurer, health services corporation or health maintenance organization, except as specifically authorized by such applicant in writing. Such result or results shall, however, be disclosed to a physician designated by the subject of the test. If there is no physician designated, the insurer, health services corporation, or health maintenance organization shall disclose the identity of individuals residing in Missouri having a confirmed positive HIV test result to the department of health and senior services. Provided, further, that no such insurer, health services corporation or health maintenance organization shall be liable for violating any duty or right of confidentiality established by law for disclosing such identity of individuals having a confirmed positive HIV test result to the department of health and senior services. Such disclosure shall be in a manner that ensures confidentiality. Disclosure of test results in violation of this section shall constitute a violation of sections 375.930 to 375.948 regulating trade practices in the business of insurance. Nothing in this subsection shall be construed to foreclose any remedies existing on June 1, 1988."; and

Further amend said bill, Page 1, Section 338.202, Line 16, by inserting after all of said section and line the following:

"**376.008. 1. All short-term major medical policies delivered or issued for delivery in this state shall include on any application for coverage and on the fact page of all policies a conspicuous and clearly**

captioned paragraph stating:

This policy may not cover preexisting conditions, including conditions you may currently have and are unaware of but are not diagnosed until the policy's term. This policy may not cover certain essential health benefits, including prescription drugs, preventative care, and emergency services. Before you realize benefits under this policy, you may be responsible for a deductible and/or coinsurance. Be sure to discuss these items with your insurance broker before purchasing a short-term medical policy.

2. No short-term major medical policy shall be delivered or issued for delivery in this state until the prospective insured has confirmed receipt of a benefit summary statement. As used in this section, "benefit summary statement" shall mean a no more than two-page plain language explanation of the following:

(1) Coverage limits, if any, expressed in dollars for:

(a) Each occurrence;

(b) Each covered benefit including, but not limited to, any benefit that is or was a covered benefit for any duration or dollar amount during the contract period and anything included under subdivision (2) of this subsection; and

(c) Each contract period;

(2) Copayments and deductibles for each covered benefit including, but not limited to:

(a) Inpatient hospital care;

(b) Outpatient hospital care;

(c) Nonhospital inpatient care;

(d) Nonhospital outpatient care;

(e) Prescription drugs; and

(f) Emergency services; and

(3) Any copayment or deductible for an illness or affliction which differs from the copayment or deductible required to be described under subdivision (2) of this subsection.

376.385. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements, to the extent not preempted by federal law, and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1998, shall offer coverage for all physician-prescribed medically appropriate and necessary equipment, supplies and self-management training used in the management and treatment of diabetes. Coverage shall include persons with gestational, type I or type II diabetes. 2. Health care services required by this section shall not be subject to any greater deductible or co-payment than any other health care service provided by the policy, contract or plan.

3. No entity enumerated in subsection 1 of this section may reduce or eliminate coverage due to the

requirements of this section.

4. Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, **short-term major medical policies having a duration of less than one year,** or other limited benefit health insurance policies.

376.429. 1. All health benefit plans, as defined in section 376.1350, that are delivered, issued for delivery, continued or renewed on or after August 28, 2006, and providing coverage to any resident of this state shall provide coverage for routine patient care costs as defined in subsection 7 of this section incurred as the result of phase II, III, or IV of a clinical trial that is approved by an entity listed in subsection 4 of this section and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Health benefit plans may limit coverage for the routine patient care costs of patients in phase II of a clinical trial to those treating facilities within the health benefit plans' provider network; except that, this provision shall not be construed as relieving a health benefit plan of the sufficiency of network requirements under state statute.

2. In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

3. Coverage required by this section shall include coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

4. Subsections 1 and 2 of this section requiring coverage for routine patient care costs shall apply to phase III or IV of clinical trials that are approved or funded by one of the following entities:

(1) One of the National Institutes of Health (NIH);

(2) An NIH cooperative group or center as defined in subsection 7 of this section;

(3) The FDA in the form of an investigational new drug application;

(4) The federal Departments of Veterans' Affairs or Defense;

(5) An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or

(6) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

5. Subsections 1 and 2 of this section requiring coverage for routine patient care costs shall apply to phase II of clinical trials if:

(1) Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and

(2) The person covered under this section is enrolled in the clinical trial. This section shall not apply to persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

6. An entity seeking coverage for treatment, prevention, or early detection in a clinical trial approved by an institutional review board under subdivision (5) of subsection 4 of this section shall maintain and post electronically a list of the clinical trials meeting the requirements of subsections 2 and 3 of this section. This list shall include: the phase for which the clinical trial is approved; the entity approving the trial; the particular disease; and the number of participants in the trial. If the electronic posting is not practical, the entity seeking coverage shall periodically provide payers and providers in the state with a written list of trials providing the information required in this section.

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

(1) "Cooperative group", a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

(2) "Multiple project assurance contract", a contract between an institution and the federal Department of Health and Human Services (DHHS) that defines the relationship of the institution to the DHHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects;

(3) "Routine patient care costs" shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

(a) The investigational item or service itself;

(b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

(c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

8. For the purpose of this section, providers participating in clinical trials shall obtain a patient's informed consent for participation on the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to the health insurer upon request.

9. The provisions of this section shall not apply to a policy, plan or contract paid under Title XVIII or Title XIX of the Social Security Act.

10. Nothing in this section shall apply to any accident-only policy, specified disease policy, hospital indemnity policy, Medicare supplement policy, long-term care policy, short-term major medical policy **[**of six months or less duration**]** **having a duration of less than one year**, or other limited benefit health insurance policies.

11. The provisions of this section regarding phase II of a clinical trial shall not apply automatically to an individually underwritten health benefit plan, but shall be an option to any such plan.

376.446. 1. Health carriers shall permit individuals to learn the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's health benefit plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such

information shall be made available to such individual through an internet website and such other means for individuals without access to the internet. As used in this section, the terms "health carrier" and "health benefit plans" shall have the same meanings assigned to them in section 376.1350.

2. Health carriers shall permit individuals to learn the amount of cost-sharing, including deductibles, copayments, and coinsurance, under an individual's short-term major medical policy, having a duration of less than one year, that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an internet website and such other means for individuals without access to the internet.

[2.**]** 3. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy**[**, short-term major medical policy of six months or less duration**]**, or any other supplemental policy.

[3.**]** **4.** The provisions of subsections 1 and 2 shall become effective on January 1, 2014.

376.452. 1. Except as provided in this section, if a health insurance issuer offers health insurance coverage in the large group market in connection with a group health plan, the health insurance issuer shall renew or continue the coverage in force at the option of the plan sponsor. **The provisions of this subsection shall not apply to short-term major medical policies having a duration of less than one year.**

2. A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the large group market if:

(1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or if the health insurance issuer has not received timely premium payments;

(2) The plan sponsor has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage;

(3) The plan sponsor has failed to comply with the health insurance issuer's minimum participation requirements;

(4) The plan sponsor has failed to comply with the health insurance issuer's employer contribution requirements;

(5) The health insurance issuer is ceasing to offer coverage in the large group market in accordance with subsection 3 of this section;

(6) In the case of a health insurance issuer that offers health insurance coverage in the large group market through a network plan, there is no longer any enrollee under the group health plan who lives, resides, or works in the service area of the health insurance issuer or in the area for which the issuer is authorized to do business;

(7) In the case of health insurance coverage that is made available in the large group market only through one or more bona fide associations, the membership of an employer in the bona fide association ceases, but only if coverage is terminated under this subdivision uniformly without regard to any health status-related factor of any covered individual.

3. A health insurance issuer shall not discontinue offering a particular type of group health insurance coverage offered in the large group market unless:

(1) The issuer provides notice to each plan sponsor, participant and beneficiary provided coverage of this type in the large group market of the discontinuation at least ninety days prior to the date of the discontinuation of the coverage;

(2) The issuer offers to each plan sponsor being provided coverage of this type in the large group market the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in the large group market; and

(3) The issuer acts uniformly without regard to the claims experience of those plan sponsors or any health status-related factor of any participant or beneficiary covered or new participant or beneficiary who may become eligible for such coverage.

4. (1) A health insurance issuer shall not discontinue offering all health insurance coverage in the large group market unless:

(a) The issuer provides notice of discontinuation to the director and to each plan sponsor, participant and beneficiary covered at least one hundred eighty days prior to the date of the discontinuation of coverage; and

(b) All health insurance issued or delivered for issuance in Missouri in the large group market is discontinued and coverage under such health insurance is not renewed.

(2) In the case of a discontinuation under this subsection, the health insurance issuer shall not provide for the issuance of any health insurance coverage in the large group market for a period of five years beginning on the date of the discontinuation of the last health insurance coverage not renewed.

5. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan in the large group market. For purposes of this subsection, renewal shall be deemed to occur not more often than annually on the anniversary of the effective date of the group health plan's health insurance coverage unless a longer term is specified in the policy or contract.

6. In the case of health insurance coverage that is made available by a health insurance issuer only through one or more bona fide associations, a reference to plan sponsor in this section is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

376.454. 1. Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual. **The provisions of this subsection shall not apply to short-term major medical policies having a duration of less than one year.**

2. A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) The individual has performed an act or practice that constitutes fraud or made an intentional

misrepresentation of material fact under the terms of the coverage;

(3) The issuer is ceasing to offer coverage in the individual market in accordance with subsection 4 of this section;

(4) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area or in an area for which the issuer is authorized to do business but only if such coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals;

(5) In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association on the basis of which the coverage is provided ceases, but only if such coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

3. In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if:

(1) The issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage;

(2) The issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(3) In exercising the option to discontinue coverage of this type and in offering the option of coverage under subdivision (2) of this subsection, the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

4. (1) In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in the state, health insurance coverage may be discontinued by the issuer only if:

(a) The issuer provides notice to the director and to each individual of such discontinuation at least one hundred eighty days prior to the date of the expiration of such coverage; and

(b) All health insurance issued or delivered for issuance in the state in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.

(2) In the case of a discontinuation under subdivision (1) of this subsection, the issuer shall not provide for the issuance of any health insurance coverage in the individual market for a five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

5. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with applicable law and effective on a uniform basis among all individuals with that policy form. For purposes of this subsection, renewal shall be deemed to occur not more often than annually on the anniversary of the effective date of the individual's health insurance coverage or as specified in the policy or contract.

6. In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an individual is deemed to include a reference to such an association of which the individual is a member.

7. An insurer shall provide a certification of creditable coverage as required by Public Law 104-191 and regulations pursuant thereto.

376.779. 1. All health plans or policies that are individually underwritten or provide for such coverage for specific individuals and the members of their families, which provide for hospital treatment, shall provide coverage, while confined in a hospital or in a residential or nonresidential facility certified by the department of mental health, for treatment of alcoholism on the same basis as coverage for any other illness, except that coverage may be limited to thirty days in any policy or contract benefit period. All Missouri individual contracts issued on or after January 1, 2005, shall be subject to this section. Coverage required by this section shall be included in the policy or contract and payment provided as for other coverage in the same policy or contract notwithstanding any construction or relationship of interdependent contracts or plans affecting coverage and payment of reimbursement prerequisites under the policy or contract.

2. Insurers, corporations or groups providing coverage may approve for payment or reimbursement vendors and programs providing services or treatment required by this section. Any vendor or person offering services or treatment subject to the provisions of this section and seeking approval for payment or reimbursement shall submit to the department of mental health a detailed description of the services or treatment program to be offered. The department of mental health shall make copies of such descriptions available to insurers, corporations or groups providing coverage under the provisions of this section. Each insurer, corporation or group providing coverage shall notify the vendor or person offering service or treatment as to its acceptance or rejection for payment or reimbursement; provided, however, payment or reimbursement shall be made for any service or treatment program certified by the department of mental health. Any notice of rejection shall contain a detailed statement of the reasons for rejection and the steps and procedures necessary for acceptance. Amended descriptions of services or treatment programs to be offered may be filed with the department of mental health. Any vendor or person rejected for approval of payment or reimbursement may modify their description and treatment program and submit copies of the amended description to the department of mental health and to the insurer, corporation or group which rejected the original description.

3. The department of mental health may issue rules necessary to carry out the provisions of this section. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024. 4. All substance abuse treatment programs in Missouri receiving funding from the Missouri department of mental health must be certified by the department.

5. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy **[**of six months or less duration**]** **having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.781. 1. All group health insurance policies providing coverage on an expense-incurred basis, all group service or indemnity contracts issued by a not-for-profit health service corporation, all self-insured

group health benefit plans of any type or description, and all such health plans or policies that are individually underwritten or provide for such coverage for specific individuals and the members of their families as nongroup policies, which provide for hospital treatment, shall offer coverage for the necessary care and treatment of loss or impairment of speech or hearing subject to the same durational limits, dollar limits, deductibles and coinsurance factors as other covered services in such policies or contracts. All Missouri group contracts issued or renewed on or after December 31, 1984, shall be subject to this section. Notwithstanding any construction or relationship of interdependent contracts or plans affecting coverage and payment of reimbursement prerequisites under the policy or contract, coverage required by this section shall be included in the policy or contract and payment provided as for other coverage in the same policy or contract.

2. The offer of benefits under subsection 1 of this section shall be in writing and may be rejected by the individual or group policyholder.

3. Nothing in this section shall prohibit the insurance company or not-for-profit health service corporation from including any coverage for loss or impairment of speech, language or hearing as standard coverage in their policies or contracts, but same shall not contain terms contrary to this section.

4. The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and which fall within the scope of his or her license or certification.

5. Any provision in a health insurance policy contrary to or in conflict with the provisions of this section shall, to the extent of the conflict, be void, but such invalidity shall not offset the validity of the other provisions of such policy.

6. The department of insurance, financial institutions and professional registration may issue rules necessary to carry out the provisions of this section. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024.

7. This section shall not apply to short-term major medical policies having a duration of less than one year.

376.782. 1. As used in this section, the term "low-dose mammography screening" means the X-ray examination of the breast using equipment specifically designed and dedicated for mammography, including the X-ray tube, filter, compression device, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, and any fee charged by a radiologist or other physician for reading, interpreting or diagnosing based on such X-ray.

2. All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed on or after August 28, 1991, and providing coverage to any resident of this state shall provide benefits or coverage for low-dose mammography screening for any nonsymptomatic woman covered under such policy or contract which meets the minimum requirements of this section. Such benefits or coverage shall include at least the

following:

(1) A baseline mammogram for women age thirty-five to thirty-nine, inclusive;

(2) A mammogram for women age forty to forty-nine, inclusive, every two years or more frequently based on the recommendation of the patient's physician;

(3) A mammogram every year for women age fifty and over;

(4) A mammogram for any woman, upon the recommendation of a physician, where such woman, her mother or her sister has a prior history of breast cancer.

3. Coverage and benefits related to mammography as required by this section shall be at least as favorable and subject to the same dollar limits, deductibles, and co-payments as other radiological examinations.

4. The provisions of this section shall not apply to short-term major medical policies having a duration of less than one year.

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

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

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

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

(4) The coverages set forth in this subsection may be subject to a separate lifetime frequency cap of not less than ten episodes of treatment, except that such separate lifetime frequency cap shall not apply to medical detoxification in a life-threatening situation as determined by the treating physician and subsequently documented within forty-eight hours of treatment to the reasonable satisfaction of the insurance company or health services corporation; and

(5) The coverages set forth in this subsection:

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

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

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

2. In addition to the coverages set forth in subsection 1 of this section, every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health

insurance policies, benefits or coverages for recognized mental illness, excluding chemical dependency, meeting the following minimum standards:

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

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

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

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

(5) The coverages set forth in this subsection may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

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

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

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

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

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

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

provided in sections 376.825 to 376.836.

6. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy **[**of six months or less duration**]** **having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.845. 1. For the purposes of this section the following terms shall mean:

(1) "Eating disorder", pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge eating disorder, other specified feeding or eating disorder, and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association where diagnosed by a licensed physician, psychiatrist, psychologist, clinical social worker, licensed marital and family therapist, or professional counselor duly licensed in the state where he or she practices and acting within their applicable scope of practice in the state where he or she practices;

(2) "Health benefit plan", shall have the same meaning as such term is defined in section 376.1350; however, for purposes of this section "health benefit plan" does not include 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**]** **having a duration of less than one year**, or any other supplemental policy;

(3) "Health carrier", shall have the same meaning as such term is defined in section 376.1350;

(4) "Medical care", health care services needed to diagnose, prevent, treat, cure, or relieve physical manifestations of an eating disorder, and shall include inpatient hospitalization, partial hospitalization, residential care, intensive outpatient treatment, follow-up outpatient care, and counseling;

(5) "Pharmacy care", medications prescribed by a licensed physician for an eating disorder and includes any health-related services deemed medically necessary to determine the need or effectiveness of the medications, but only to the extent that such medications are included in the insured's health benefit plan;

(6) "Psychiatric care" and "psychological care", direct or consultative services provided during inpatient hospitalization, partial hospitalization, residential care, intensive outpatient treatment, follow-up outpatient care, and counseling provided by a psychiatrist or psychologist licensed in the state of practice;

(7) "Therapy", medical care and behavioral interventions provided by a duly licensed physician, psychiatrist, psychologist, professional counselor, licensed clinical social worker, or family marriage therapist where said person is licensed or registered in the states where he or she practices;

(8) "Treatment of eating disorders", therapy provided by a licensed treating physician, psychiatrist, psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed physician's, psychiatrist's, psychologist's, professional counselor's, clinical social worker's, or licensed marital and family therapist's license in the state where he or she practices for an individual diagnosed with an eating disorder.

2. In accordance with the provisions of section 376.1550, all health benefit plans that are delivered, issued for delivery, continued or renewed on or after January 1, 2017, if written inside the state of Missouri, or written outside the state of Missouri but covering Missouri residents, shall provide coverage for the diagnosis and treatment of eating disorders as required in section 376.1550.

3. Coverage provided under this section is limited to medically necessary treatment that is provided by a licensed treating physician, psychiatrist, psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed physician's, psychiatrist's, psychologist's, professional counselor's, clinical social worker's, or licensed marital and family therapist's license and acting within their applicable scope of coverage, in accordance with a treatment plan.

4. The treatment plan, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

5. Coverage of the treatment of eating disorders may be subject to other general exclusions and limitations of the contract or benefit plan not in conflict with the provisions of this section, such as coordination of benefits, and utilization review of health care services, which includes reviews of medical necessity and care management. Medical necessity determinations and care management for the treatment of eating disorders shall consider the overall medical and mental health needs of the individual with an eating disorder, shall not be based solely on weight, and shall take into consideration the most recent Practice Guideline for the Treatment of Patients with Eating Disorders adopted by the American Psychiatric Association in addition to current standards based upon the medical literature generally recognized as authoritative in the medical community.

376.1192. 1. As used in this section, "health benefit plan" and "health carrier" shall have the same meaning as such terms are defined in section 376.1350.

2. Beginning September 1, 2013, the oversight division of the joint committee on legislative research shall perform an actuarial analysis of the cost impact to health carriers, insureds with a health benefit plan, and other private and public payers if state mandates were enacted to provide health benefit plan coverage for the following:

(1) Orally administered anticancer medication that is used to kill or slow the growth of cancerous cells charged at the same co-payment, deductible, or coinsurance amount as intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health carrier administering the health benefit plan;

(2) Diagnosis and treatment of eating disorders that include anorexia nervosa, bulimia, binge eating, eating disorders nonspecified, and any other severe eating disorders contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The actuarial analysis shall assume the following are included in health benefit plan coverage:

(a) Residential treatment for eating disorders, if such treatment is medically necessary in accordance with the Practice Guidelines for the Treatment of Patients with Eating Disorders, as most recently published by the American Psychiatric Association; and

(b) Access to medical treatment that provides coverage for integrated care and treatment as

recommended by medical and mental health care professionals, including but not limited to psychological services, nutrition counseling, physical therapy, dietician services, medical monitoring, and psychiatric monitoring.

3. By December 31, 2013, the director of the oversight division of the joint committee on legislative research shall submit a report of the actuarial findings prescribed by this section to the speaker of the house of representatives, the president pro tempore of the senate, and the chairpersons of the house of representatives committee on health insurance and the senate small business, insurance and industry committee, or the committees having jurisdiction over health insurance issues if the preceding committees no longer exist.

4. For the purposes of this section, the actuarial analysis of health benefit plan coverage shall assume that such coverage:

(1) Shall not be subject to any greater deductible or co-payment than other health care services provided by the health benefit plan; and

(2) 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 policies **[**of six months' or less duration**] having a duration of less than one year**, or any other supplemental policy.

5. The cost for each actuarial analysis shall not exceed thirty thousand dollars and the oversight division of the joint committee on legislative research may utilize any actuary contracted to perform services for the Missouri consolidated health care plan to perform the analysis required under this section.

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

376.1199. 1. Each health carrier or health benefit plan that offers or issues health benefit plans providing obstetrical/gynecological benefits and pharmaceutical coverage, which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002, shall:

(1) Notwithstanding the provisions of subsection 4 of section 354.618, provide enrollees with direct access to the services of a participating obstetrician, participating gynecologist or participating obstetrician/gynecologist of her choice within the provider network for covered services. The services covered by this subdivision shall be limited to those services defined by the published recommendations of the accreditation council for graduate medical education for training an obstetrician, gynecologist or obstetrician/gynecologist, including but not limited to diagnosis, treatment and referral for such services. A health carrier shall not impose additional co-payments, coinsurance or deductibles upon any enrollee who seeks or receives health care services pursuant to this subdivision, unless similar additional co-payments, coinsurance or deductibles are imposed for other types of health care services received within the provider network. Nothing in this subsection shall be construed to require a health carrier to perform, induce, pay for, reimburse, guarantee, arrange, provide any resources for or refer a patient for an abortion, as defined in section 188.015, other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed, or to supersede or conflict with section 376.805; and

(2) Notify enrollees annually of cancer screenings covered by the enrollees' health benefit plan and the current American Cancer Society guidelines for all cancer screenings or notify enrollees at intervals consistent with current American Cancer Society guidelines of cancer screenings which are covered by the

enrollees' health benefit plans. The notice shall be delivered by mail unless the enrollee and health carrier have agreed on another method of notification; and

(3) Include coverage for services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and surgery in this state, for individuals with a condition or medical history for which bone mass measurement is medically indicated for such individual. In determining whether testing or treatment is medically appropriate, due consideration shall be given to peer-reviewed medical literature. A policy, provision, contract, plan or agreement may apply to such services the same deductibles, coinsurance and other limitations as apply to other covered services; and

(4) If the health benefit plan also provides coverage for pharmaceutical benefits, provide coverage for contraceptives either at no charge or at the same level of deductible, coinsurance or co-payment as any other covered drug.

No such deductible, coinsurance or co-payment shall be greater than any drug on the health benefit plan's formulary. As used in this section, "contraceptive" shall include all prescription drugs and devices approved by the federal Food and Drug Administration for use as a contraceptive, but shall exclude all drugs and devices that are intended to induce an abortion, as defined in section 188.015, which shall be subject to section 376.805. Nothing in this subdivision shall be construed to exclude coverage for prescription contraceptive drugs or devices ordered by a health care provider with prescriptive authority for reasons other than contraceptive or abortion purposes.

2. For the purposes of this section, "health carrier" and "health benefit plan" shall have the same meaning as defined in section 376.1350.

3. 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**]** **having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

4. Notwithstanding the provisions of subdivision (4) of subsection 1 of this section to the contrary:

(1) Any health carrier shall offer and issue to any person or entity purchasing a health benefit plan, a health benefit plan that excludes coverage for contraceptives if the use or provision of such contraceptives is contrary to the moral, ethical or religious beliefs or tenets of such person or entity;

(2) Upon request of an enrollee who is a member of a group health benefit plan and who states that the use or provision of contraceptives is contrary to his or her moral, ethical or religious beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that excludes coverage for contraceptives. Any administrative costs to a group health benefit plan associated with such exclusion of coverage not offset by the decreased costs of providing coverage shall be borne by the group policyholder or group plan holder;

(3) Any health carrier which is owned, operated or controlled in substantial part by an entity that is operated pursuant to moral, ethical or religious tenets that are contrary to the use or provision of contraceptives shall be exempt from the provisions of subdivision (4) of subsection 1 of this section. For purposes of this subsection, if new premiums are charged for a contract, plan or policy, it shall be determined to be a new contract, plan or policy.

5. Except for a health carrier that is exempted from providing coverage for contraceptives pursuant to this section, a health carrier shall allow enrollees in a health benefit plan that excludes coverage for contraceptives pursuant to subsection 4 of this section to purchase a health benefit plan that includes coverage for contraceptives.

6. Any health benefit plan issued pursuant to subsection 1 of this section shall provide clear and conspicuous written notice on the enrollment form or any accompanying materials to the enrollment form and the group health benefit plan application and contract:

(1) Whether coverage for contraceptives is or is not included;

(2) That an enrollee who is a member of a group health benefit plan with coverage for contraceptives has the right to exclude coverage for contraceptives if such coverage is contrary to his or her moral, ethical or religious beliefs;

(3) That an enrollee who is a member of a group health benefit plan without coverage for contraceptives has the right to purchase coverage for contraceptives;

(4) Whether an optional rider for elective abortions has been purchased by the group contract holder pursuant to section 376.805; and

(5) That an enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs.

For purposes of this subsection, if new premiums are charged for a contract, plan, or policy, it shall be determined to be a new contract, plan, or policy.

7. Health carriers shall not disclose to the person or entity who purchased the health benefit plan the names of enrollees who exclude coverage for contraceptives in the health benefit plan or who purchase a health benefit plan that includes coverage for contraceptives. Health carriers and the person or entity who purchased the health benefit plan shall not discriminate against an enrollee because the enrollee excluded coverage for contraceptives in the health benefit plan or purchased a health benefit plan that includes coverage for contraceptives.

8. The departments of health and senior services and insurance, financial institutions and professional registration may promulgate rules necessary to implement the provisions of this section. No rule or portion of a rule promulgated pursuant to this section shall become effective unless it has been promulgated pursuant to chapter 536. 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, 2001, shall be invalid and void.

376.1200. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care

delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1996, shall offer coverage for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants. The offer of benefits under this section shall be in writing and must be accepted in writing by the individual or group policyholder or contract holder.

2. Such health care service shall not be subject to any greater deductible or co-payment than any other health care service provided by the policy, contract or plan, except that the policy, contract or plan may contain a provision imposing a lifetime benefit maximum of not less than one hundred thousand dollars, for dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for breast cancer treatment.

3. Benefits may be administered for such health care service through a managed care program of exclusive and/or preferred contractual arrangements with one or more providers rendering such health care service. These contractual arrangements may provide that the provider shall hold the patient harmless for the cost of rendering such health care service if it is subsequently found by the entity authorized to resolve disputes that:

(1) Such care did not qualify under the protocols established for the providing of care for such health care service;

(2) Such care was not medically appropriate; or

(3) The provider otherwise failed to comply with the utilization management or other managed care provision agreed to in any contract between the entity and the provider.

4. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies **[**of not more than seven months duration**]** **having a duration of less than one year**.

5. Nothing in this section shall prohibit an entity from including all or part of such health care services as standard coverage in its policies, contracts or plans.

376.1209. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law, and all managed health care delivery entities of any type or description, that provide coverage for the surgical procedure known as a mastectomy, and which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1998, shall provide coverage for prosthetic devices or reconstructive surgery necessary to restore symmetry as recommended by the oncologist or primary care physician for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the same deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits with the exception that no time limit shall be imposed on an individual for the receipt of prosthetic devices or reconstructive surgery and if such individual changes his or her insurer, then the new policy subject to the federal Women's Health and Cancer Rights Act (Sections 901-903 of P.L. 105-277), as amended, shall provide coverage consistent with the federal Women's Health and Cancer Rights Act

(Sections 901-903 of P.L. 105-277), as amended, and any regulations promulgated pursuant to such act.

2. As used in this section, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a physician licensed pursuant to chapter 334.

3. 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**, short-term major medical policy having a duration of less than one year,** or long-term care policy.

376.1210. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law, and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1997, and providing for maternity benefits, shall provide coverage for a minimum of forty-eight hours of inpatient care following a vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean section for a mother and her newly born child in a hospital as defined in section 197.020 or any other health care facility licensed to provide obstetrical care under the provisions of chapter 197.

2. Notwithstanding the provisions of subsection 1 of this section, any entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law, and all managed health care delivery entities of any type or description that are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1997, and providing for maternity benefits, may authorize a shorter length of hospital stay for services related to maternity and newborn care if:

(1) A shorter hospital stay meets with the approval of the attending physician after consulting with the mother. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization; and

(2) The entity providing the individual or group health insurance policy provides coverage for post-discharge care to the mother and her newborn.

3. Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared

by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending physician as medically appropriate.

4. For the purposes of this section, "attending physician" shall include the attending obstetrician, pediatrician, or other physician attending the mother or newly born child.

5. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description shall provide notice to policyholders, insured persons and participants regarding the coverage required by this section. Such notice shall be in writing and prominently positioned in the policy, certificate of coverage or summary plan description.

6. Such health care service shall not be subject to any greater deductible or co-payment than other similar health care services provided by the policy, contract or plan.

7. No insurer may provide financial disincentives to, or deselect, terminate the services of, require additional documentation from, require additional utilization review, or reduce payments to, or otherwise penalize the attending physician in retaliation solely for ordering care consistent with the provisions of this section.

8. **The provisions of this section shall not apply to short-term major medical policies having a duration of less than one year.**

9. The department of insurance, financial institutions and professional registration shall adopt rules and regulations to implement and enforce the provisions of this section. No rule or portion of a rule promulgated pursuant to this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024.

376.1215. 1. All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization and all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description shall provide coverage for immunizations of a child from birth to five years of age as provided by department of health and senior services regulations.

2. Such coverage shall not be subject to any deductible or co-payment limits.

3. The contract issued by a health maintenance organization may provide that the benefits required pursuant to this section shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization, except that the health maintenance organization shall, as a condition of participation, comply with the immunization requirements of state or federally funded health programs.

4. This section shall not apply to supplemental insurance policies, including life care contracts, accident-only policies, specified disease policies, hospital policies providing a fixed daily benefit only, Medicare supplement policies, long-term care policies, coverage issued as a supplement to liability insurance, short-

term major medical policies **[**of six months or less duration**]** **having a duration of less than one year,** and other supplemental policies as determined by the department of insurance, financial institutions and professional registration. 5. The department of health and senior services shall promulgate rules and regulations to determine which immunizations shall be covered by policies, plans or contracts described in this section. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024. 6. No health care provider shall charge more than one hundred percent of the reasonable and customary charges for providing any immunization.

376.1218. 1. Any health carrier or health benefit plan that offers or issues health benefit plans, other than Medicaid health benefit plans, which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2006, shall provide coverage for early intervention services described in this section that are delivered by early intervention specialists who are health care professionals licensed by the state of Missouri and acting within the scope of their professions for children from birth to age three identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Such coverage shall be limited to three thousand dollars for each covered child per policy per calendar year, with a maximum of nine thousand dollars per child.

2. As used in this section, "health carrier" and "health benefit plan" shall have the same meaning as such terms are defined in section 376.1350.

3. In the event that any health benefit plan is found not to be required to provide coverage under subsection 1 of this section because of preemption by a federal law, including but not limited to the act commonly known as ERISA contained in Title 29 of the United States Code, or in the event that subsection 1 of this section is found to be unconstitutional, then the lead agency shall be responsible for payment and provision of any benefit provided under this section.

4. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Early intervention services shall include services under an active individualized family service plan that enhance functional ability without effecting a cure. An individualized family service plan is a written plan for providing early intervention services to an eligible child and the child's family that is adopted in accordance with 20 U.S.C. Section 1436. The Part C early intervention system, on behalf of its contracted regional Part C early intervention system centers and providers, shall be considered the rendering provider of services for purposes of this section.

5. No payment made for specified early intervention services shall be applied by the health carrier or health benefit plan against any maximum lifetime aggregate specified in the policy or health benefit plan if the carrier opts to satisfy its obligations under this section under subdivision (2) of subsection 7 of this section. A health benefit plan shall be billed at the applicable Medicaid rate at the time the covered benefit is delivered, and the health benefit plan shall pay the Part C early intervention system at such rate for benefits covered by this section. Services under the Part C early intervention system shall be delivered as prescribed by the individualized family service plan and an electronic claim filed in accordance with the carrier's or plan's standard format. Beginning January 1, 2007, such claims' payments shall be made in

accordance with the provisions of sections 376.383 and 376.384.

6. The health care service required by this section shall not be subject to any greater deductible, co-payment, or coinsurance than other similar health care services provided by the health benefit plan.

7. (1) Subject to the provisions of this section, payments made during a calendar year by a health carrier or group of carriers affiliated by or under common ownership or control to the Part C early intervention system for services provided to children covered by the Part C early intervention system shall not exceed one-half of one percent of the direct written premium for health benefit plans as reported to the department of insurance, financial institutions and professional registration on the health carrier's most recently filed annual financial statement.

(2) In lieu of reimbursing claims under this section, a carrier or group of carriers affiliated by or under common ownership or control may, on behalf of all of the carrier's or carriers' health benefit plan or plans providing coverage under this section, directly pay the Part C early intervention system by January thirty-first of the calendar year an amount equal to one-half of one percent of the direct written premium for health benefit plans as reported to the department of insurance, financial institutions and professional registration on the health carrier's most recently filed annual financial statement, or five hundred thousand dollars, whichever is less, and such payment shall constitute full and complete satisfaction of the health benefit plan's obligation for the calendar year. Nothing in this subsection shall require a health carrier or health benefit plan providing coverage under this section to amend or modify any provision of an existing policy or plan relating to the payment or reimbursement of claims by the health carrier or health benefit plan.

8. This section shall not apply to a supplemental insurance policy, including a life care contract, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, hospitalization-surgical care policy, policy that is individually underwritten or provides such coverage for specific individuals and members of their families, long-term care policy, or short-term major medical policies **[**of six months or less duration**]** **having a duration of less than one year**.

9. Except for health carriers or health benefit plans making payments under subdivision (2) of subsection 7 of this section, the department of insurance, financial institutions and professional registration shall collect data related to the number of children receiving private insurance coverage under this section and the total amount of moneys paid on behalf of such children by private health carriers or health benefit plans. The department shall report to the general assembly regarding the department's findings no later than January 30, 2007, and annually thereafter.

10. Notwithstanding the provisions of section 23.253 to the contrary, the provisions of this section shall not sunset.

376.1219. 1. Each policy issued by an entity offering individual and group health insurance which provides coverage on an expense-incurred basis, individual and group health service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group health arrangements to the extent not preempted by federal law, and all health care plans provided by managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed in this state on or after September 1, 1997, shall provide coverage for formula and low protein modified food products recommended by a physician for the treatment of a patient with phenylketonuria or any inherited disease of amino and organic acids who is covered under the policy, contract, or plan and who is less than six years of age.

2. For purposes of this section, "low protein modified food products" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

3. The coverage required by this section may be subject to the same deductible for similar health care services provided by the policy, contract, or plan as well as a reasonable coinsurance or co-payment on the part of the insured, which shall not be greater than fifty percent of the cost of the formula and food products, and may be subject to an annual benefit maximum of not less than five thousand dollars per covered child. Nothing in this section shall prohibit a carrier from using individual case management or from contracting with vendors of the formula and food products.

4. 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 having a duration of less than one year,** or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1220. 1. Each policy issued by an entity offering individual and group health insurance which provides coverage on an expense-incurred basis, individual or group health service, or indemnity contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group health arrangements to the extent not preempted by federal law, and all health care plans provided by managed health care delivery entities of any type or description that are delivered, issued for delivery, continued or renewed in this state shall provide coverage for newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.

2. The health care service required by this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the policy, contract or plan.

3. 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 policies **[**of six months or less duration**]** **having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

4. Coverage for newborn hearing screening and any necessary rescreening and audiological assessment shall be provided to newborns eligible for medical assistance pursuant to section 208.151, and the children's health program pursuant to sections 208.631 to 208.660, with payment for the newborn hearing screening required in section 191.925, and any necessary rescreening, audiological assessment and follow-up, and amplification as described in section 191.928.

376.1224. 1. For purposes of this section, the following terms shall mean:

(1) "Applied behavior analysis", the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior;

(2) "Autism service provider":

(a) Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or

(b) Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst;

(3) "Autism spectrum disorders", a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;

(4) "Diagnosis of autism spectrum disorders", medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder;

(5) "Habilitative or rehabilitative care", professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual;

(6) "Health benefit plan", shall have the same meaning ascribed to it as in section 376.1350;

(7) "Health carrier", shall have the same meaning ascribed to it as in section 376.1350;

(8) "Line therapist", an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst;

(9) "Pharmacy care", medications used to address symptoms of an autism spectrum disorder prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan;

(10) "Psychiatric care", direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

(11) "Psychological care", direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

(12) "Therapeutic care", services provided by licensed speech therapists, occupational therapists, or physical therapists;

(13) "Treatment for autism spectrum disorders", care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

(a) Psychiatric care;

(b) Psychological care;

(c) Habilitative or rehabilitative care, including applied behavior analysis therapy;

(d) Therapeutic care;

(e) Pharmacy care.

2. All group health benefit plans that are delivered, issued for delivery, continued, or renewed on or after January 1, 2011, if written inside the state of Missouri, or written outside the state of Missouri but insuring Missouri residents, shall provide coverage for the diagnosis and treatment of autism spectrum disorders to the extent that such diagnosis and treatment is not already covered by the health benefit plan.

3. With regards to a health benefit plan, a health carrier shall not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual or their dependent because the individual is diagnosed with autism spectrum disorder.

4. (1) Coverage provided under this section is limited to medically necessary treatment that is ordered by the insured's treating licensed physician or licensed psychologist, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, in accordance with a treatment plan.

(2) The treatment plan, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

(3) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, a health carrier shall have the right to review the treatment plan not more than once every six months unless the health carrier and the individual's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism spectrum disorders by a physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

5. Coverage provided under this section for applied behavior analysis shall be subject to a maximum benefit of forty thousand dollars per calendar year for individuals through eighteen years of age. Such maximum benefit limit may be exceeded, upon prior approval by the health benefit plan, if the provision of applied behavior analysis services beyond the maximum limit is medically necessary for such individual. Payments made by a health carrier on behalf of a covered individual for any care, treatment, intervention, service or item, the provision of which was for the treatment of a health condition unrelated to the covered individual's autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection. Any coverage required under this section, other than the coverage for applied behavior analysis, shall not be subject to the age and dollar limitations described in this subsection.

6. The maximum benefit limitation for applied behavior analysis described in subsection 5 of this section shall be adjusted by the health carrier at least triennially for inflation to reflect the aggregate increase in the general price level as measured by the Consumer Price Index for All Urban Consumers for the United States, or its successor index, as defined and officially published by the United States Department of Labor, or its successor agency. Beginning January 1, 2012, and annually thereafter, the current value of the maximum benefit limitation for applied behavior analysis coverage adjusted for inflation in accordance with this subsection shall be calculated by the director of the department of insurance, financial institutions and professional registration. The director shall furnish the calculated value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021.

7. Subject to the provisions set forth in subdivision (3) of subsection 4 of this section, coverage provided

under this section shall not be subject to any limits on the number of visits an individual may make to an autism service provider, except that the maximum total benefit for applied behavior analysis set forth in subsection 5 of this section shall apply to this subsection. 8. This section shall not be construed as limiting benefits which are otherwise available to an individual under a health benefit plan. The health care coverage required by this section shall not be subject to any greater deductible, coinsurance, or co-payment than other physical health care services provided by a health benefit plan. Coverage of services may be subject to other general exclusions and limitations of the contract or benefit plan, not in conflict with the provisions of this section, such as coordination of benefits, exclusions for services provided by family or household members, and utilization review of health care services, including review of medical necessity and care management; however, coverage for treatment under this section shall not be denied on the basis that it is educational or habilitative in nature.

9. To the extent any payments or reimbursements are being made for applied behavior analysis, such payments or reimbursements shall be made to either:

(1) The autism service provider, as defined in this section; or

(2) The entity or group for whom such supervising person, who is certified as a board-certified behavior analyst by the Behavior Analyst Certification Board, works or is associated.

Such payments or reimbursements under this subsection to an autism service provider or a board-certified behavior analyst shall include payments or reimbursements for services provided by a line therapist under the supervision of such provider or behavior analyst if such services provided by the line therapist are included in the treatment plan and are deemed medically necessary.

10. Notwithstanding any other provision of law to the contrary, health carriers shall not be held liable for the actions of line therapists in the performance of their duties.

11. The provisions of this section shall apply to any health care plans issued to employees and their dependents under the Missouri consolidated health care plan established pursuant to chapter 103 that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2011. The terms "employees" and "health care plans" shall have the same meaning ascribed to them in section 103.003.

12. The provisions of this section shall also apply to the following types of plans that are established, extended, modified, or renewed on or after January 1, 2011:

(1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section 1002(32);

(2) All self-insured group arrangements, to the extent not preempted by federal law;

(3) All plans provided through a multiple employer welfare arrangement, or plans provided through another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, or any waiver or exception to that act provided under federal law or regulation; and

(4) All self-insured school district health plans.

13. The provisions of this section shall not automatically apply to an individually underwritten health benefit plan, but shall be offered as an option to any such plan.

14. 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**]** **having a duration of less than one year**, or any other supplemental policy.

15. Any health carrier or other entity subject to the provisions of this section shall not be required to provide reimbursement for the applied behavior analysis delivered to a person insured by such health carrier or other entity to the extent such health carrier or other entity is billed for such services by any Part C early intervention program or any school district for applied behavior analysis rendered to the person covered by such health carrier or other entity. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education plan, or an individualized service plan. This section shall not be construed as affecting any obligation to provide reimbursement pursuant to section 376.1218.

16. The provisions of sections 376.383, 376.384, and 376.1350 to 376.1399 shall apply to this section.

17. The director of the department of insurance, financial institutions and professional registration shall grant a small employer with a group health plan, as that term is defined in section 379.930, a waiver from the provisions of this section if the small employer demonstrates to the director by actual claims experience over any consecutive twelve-month period that compliance with this section has increased the cost of the health insurance policy by an amount of two and a half percent or greater over the period of a calendar year in premium costs to the small employer.

18. The provisions of this section shall not apply to the Mo HealthNet program as described in chapter 208.

19. (1) By February 1, 2012, and every February first thereafter, the department of insurance, financial institutions and professional registration shall submit a report to the general assembly regarding the implementation of the coverage required under this section. The report shall include, but shall not be limited to, the following:

(a) The total number of insureds diagnosed with autism spectrum disorder;

(b) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this section;

(c) The cost of such coverage per insured per month; and

(d) The average cost per insured for coverage of applied behavior analysis;

(2) All health carriers and health benefit plans subject to the provisions of this section shall provide the department with the data requested by the department for inclusion in the annual report.

376.1225. 1. All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed on or after August 28, 1998, shall provide coverage for administration of general anesthesia and hospital charges for dental care provided to the following covered persons:

(1) A child under the age of five;

(2) A person who is severely disabled; or

(3) A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

2. Each plan as described in this section must provide coverage for administration of general anesthesia and hospital or office charges for treatment rendered by a dentist, regardless of whether the services are provided in a participating hospital or surgical center or office.

3. Nothing in this section shall prevent a health carrier from requiring prior authorization for hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

4. Nothing in this section shall apply to accident-only, dental-only plans or other specified disease, hospital indemnity, Medicare supplement or long-term care policies, or short-term major medical policies **[**of six months or less in duration**]** **having a duration of less than one year**.

376.1230. 1. Every policy issued by a health carrier, as defined in section 376.1350, shall provide coverage for chiropractic care delivered by a licensed chiropractor acting within the scope of his or her practice as defined in chapter 331. The coverage shall include initial diagnosis and clinically appropriate and medically necessary services and supplies required to treat the diagnosed disorder, subject to the terms and conditions of the policy. The coverage may be limited to chiropractors within the health carrier's network, and nothing in this section shall be construed to require a health carrier to contract with a chiropractor not in the carrier's network nor shall a carrier be required to reimburse for services rendered by a nonnetwork chiropractor unless prior approval has been obtained from the carrier by the enrollee. An enrollee may access chiropractic care within the network for a total of twenty-six chiropractic physician office visits per policy period, but may be required to provide the health carrier with notice prior to any additional visit as a condition of coverage. A health carrier may require prior authorization or notification before any follow-up diagnostic tests are ordered by a chiropractor or for any office visits for treatment in excess of twenty-six in any policy period. The certificate of coverage for any health benefit plan issued by a health carrier shall clearly state the availability of chiropractic coverage under the policy and any limitations, conditions, and exclusions.

2. A health benefit plan shall provide coverage for treatment of a chiropractic care condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a chiropractic care condition than for access to treatment for another physical health condition.

3. The provisions of this section shall not apply to any health plan or contract that is individually underwritten.

4. The provisions of this section shall not apply to benefits provided under the Medicaid program.

5. 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**]** **having a duration of less than one year**, or any other similar supplemental policy.

376.1232. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2010, shall offer coverage for prosthetic devices and services, including original and replacement devices, as prescribed by

a physician acting within the scope of his or her practice. 2. For the purposes of this section, "health carrier" and "health benefit plan" shall have the same meaning as defined in section 376.1350.

3. The amount of the benefit for prosthetic devices and services under this section shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under the health benefit plan. If the health benefit plan does not include any annual or lifetime maximums applicable to basic health care services, the amount of the benefit for prosthetic devices and services shall not be subject to an annual or lifetime maximum benefit level. Any co-payment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for prosthetic devices and services shall be no more than the most common amounts applied to the basic health care services required to be provided under the health benefit plan.

4. 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 policies **[**of six months or less duration**]** **having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1235. 1. No health carrier or health benefit plan, as defined in section 376.1350, shall impose a co-payment or coinsurance percentage charged to the insured for services rendered for each date of service by a physical therapist licensed under chapter 334 or an occupational therapist licensed under chapter 324, for services that require a prescription, that is greater than the co-payment or coinsurance percentage charged to the insured for the services of a primary care physician licensed under chapter 334 for an office visit.

2. A health carrier or health benefit plan shall clearly state the availability of physical therapy and occupational therapy coverage under its plan and all related limitations, conditions, and exclusions.

3. Beginning September 1, 2016, the oversight division of the joint committee on legislative research shall perform an actuarial analysis of the cost impact to health carriers, insureds with a health benefit plan, and other private and public payers if the provisions of this section regarding occupational therapy coverage were enacted. By December 31, 2016, the director of the oversight division of the joint committee on legislative research shall submit a report of the actuarial findings prescribed by this section to the speaker, the president pro tem, and the chairpersons of both the house of representatives and senate standing committees having jurisdiction over health insurance matters. If the fiscal note cost estimation is less than the cost of an actuarial analysis, the actuarial analysis requirement shall be waived.

4. This section shall not apply to short-term major medical policies having a duration of less than one year."; and

Further amend said bill, Page 2, Section 376.1237, Lines 12-17, by deleting said lines and inserting in lieu thereof the following:

"4. 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 policies **[**of six months' or less duration**]** **having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration."; and

Further amend said bill, page, and section, Line 18, by inserting after all of said section and line the following:

"376.1250. 1. All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed on or after August 28, 1999, and providing coverage to any resident of this state shall provide benefits or coverage for:

(1) A pelvic examination and pap smear for any nonsymptomatic woman covered under such policy or contract, in accordance with the current American Cancer Society guidelines;

(2) A prostate examination and laboratory tests for cancer for any nonsymptomatic man covered under such policy or contract, in accordance with the current American Cancer Society guidelines; and

(3) A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic person covered under such policy or contract, in accordance with the current American Cancer Society guidelines.

2. Coverage and benefits related to the examinations and tests as required by this section shall be at least as favorable and subject to the same dollar limits, deductible, and co-payments as other covered benefits or services.

3. Nothing in this act shall apply to accident-only, hospital indemnity, Medicare supplement, long-term care, or other limited benefit health insurance policies.

4. The provisions of this section shall not apply to short-term major medical policies **[**of six months or less duration**]** **having a duration of less than one year**.

5. The attending physician shall advise the patient of the advantages, disadvantages, and risks, including cancer, associated with breast implantation prior to such operation.

6. Nothing in this section shall alter, impair or otherwise affect claims, rights or remedies available pursuant to law.

376.1253. 1. Each physician attending any patient with a newly diagnosed cancer shall inform the patient that the patient has the right to a referral for a second opinion by an appropriate board-certified specialist prior to any treatment. If no specialist in that specific cancer diagnosis area is in the provider network, a referral shall be made to a nonnetwork specialist in accordance with this section.

2. Each health carrier or health benefit plan, as defined in section 376.1350, that offers or issues health benefit plans which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2003, shall provide coverage for a second opinion rendered by a specialist in that specific cancer diagnosis area when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician. Such coverage shall be subject to the same deductible and coinsurance conditions applied to other specialist referrals and all other terms and conditions applicable to other benefits, including the prior authorization and/or referral authorization requirements as specified in the applicable health insurance policy.

3. 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 policies **[**of six months' or less duration**]** **having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1257. 1. As used in this section the following terms shall mean:

(1) "Anticancer medications", medications used to kill or slow the growth of cancerous cells;

(2) "Covered person", a policyholder, subscriber, enrollee, or other individual enrolled in or insured by a health benefit plan for health insurance coverage;

(3) "Health benefit plan", shall have the same meaning as defined in section 376.1350.

2. Any health benefit plan that provides coverage and benefits for cancer treatment shall provide coverage of prescribed orally administered anticancer medications on a basis no less favorable than intravenously administered or injected anticancer medications.

3. Coverage of orally administered anticancer medication shall not be subject to any prior authorization, dollar limit, co-payment, deductible, or other out-of-pocket expense that does not apply to intravenously administered or injected anticancer medication, regardless of formulation or benefit category determination by the company administering the health benefit plan.

4. The health benefit plan shall not reclassify or increase any type of cost-sharing to the covered person for anticancer medications in order to achieve compliance with this section. Any change in health insurance coverage, which otherwise increases an out-of-pocket expense to anticancer medications, shall be applied to the majority of comparable medical or pharmaceutical benefits covered by the health benefit plan.

5. Notwithstanding the provisions of subsections 2, 3, and 4 of this section, a health benefit plan that limits the total amounts paid by a covered person through all cost-sharing requirements to no more than seventy-five dollars per thirty-day supply for any orally administered anticancer medication shall be considered in compliance with this section. On January 1, 2016, and on January first of each year thereafter, a health benefit plan may adjust such seventy-five dollar limit. The adjustment shall not exceed the Consumer Price Index for All Urban Consumers Midwest Region for that year. For purposes of this subsection "cost-sharing requirements" shall include co-payments, coinsurance, deductibles, and any other amounts paid by the covered person for that prescription.

6. For a health benefit plan that meets the definition of "high deductible health plan" as defined by 26 U.S.C. 223(c)(2), the provisions of subsection 5 of this section shall only apply after a covered person's deductible has been satisfied for the year.

7. **The provisions of this section shall not apply to short-term major medical policies having a duration of less than one year.**

8. The provisions of this section shall become effective January 1, 2015.

376.1275. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2003, shall include coverage for their members for the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. The testing must be performed in a facility which is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C.

Section 263a, as amended, and is accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics (ASHI) or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists. At the time of testing, the person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor Program. The health benefit plan may limit each enrollee to one such testing per lifetime to be reimbursed at a cost of no greater than seventy-five dollars by the health carrier or health benefit plan.

2. For the purposes of this section, "health carrier" and "health benefit plan" shall have the same meaning as defined in section 376.1350.

3. The health care service required by this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the health benefit plan.

4. 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 policies **[**of six months' or less duration**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1290. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements, to the extent not preempted by federal law, and all managed health care delivery entities of any type or description that are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002, shall offer coverage for testing pregnant women for lead poisoning and for all testing for lead poisoning authorized by sections 701.340 to 701.349 or by rule of the department of health and senior services promulgated pursuant to sections 701.340 to 701.349.

2. Health care services required by this section shall not be subject to any greater deductible or co-payment than any other health care service provided by the policy, contract or plan.

3. No entity enumerated in subsection 1 of this section shall reduce or eliminate coverage as a result of the requirements of this section.

4. Nothing in this section shall apply to **short-term major medical policies having a duration of one year or less, or to** accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

376.1400. 1. Every health insurance carrier offering policies of insurance in this state shall use standardized information for the explanation of benefits given to the health care provider whenever a claim is paid or denied. As used in this section, the term "health insurance carrier" shall have the meaning given to "health carrier" in section 376.1350. Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, short-term major medical policies **[**of six months or less duration**] having a duration of less than one year**, other limited benefit health insurance policies.

2. The standardized information shall contain the following:

(1) The name of the insured;

(2) The insured's identification number;

(3) The date of service;

(4) Amount of charge;

(5) Explanation for any denial;

(6) The amount paid;

(7) The patient's full name;

(8) The name and address of the insurer; and

(9) The phone number to contact for questions on explanation of benefits.

3. All health insurance carriers shall use the standard explanation of benefits information after January 1, 2002.

376.1550. 1. Notwithstanding any other provision of law to the contrary, each health carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a mental health condition, as defined in this section, and shall comply with the following provisions:

(1) A health benefit plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required by a health carrier or health benefit plan shall be comprehensive for coverage of all health conditions, whether mental or physical;

(2) The coverages set forth is this subsection:

(a) May be administered pursuant to a managed care program established by the health carrier; and

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

(3) A health benefit plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health conditions may provide coverage for treatment of mental health conditions through a managed care organization; provided that the managed care organization is in compliance with rules adopted by the department of insurance, financial institutions and professional registration that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the director shall assure that:

(a) Timely and appropriate access to care is available;

(b) The quantity, location, and specialty distribution of health care providers is adequate; and

(c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment

for any insured;

(4) Coverage for treatment for chemical dependency shall comply with sections 376.779, 376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term "health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to 376.836, the term "health insurance policy" shall include group coverage.

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

(1) "Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both;

(2) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(3) "Health carrier", the same meaning as such term is defined in section 376.1350;

(4) "Mental health condition", any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for chemical dependency;

(5) "Managed care organization", any financing mechanism or system that manages care delivery for its members or subscribers, including health maintenance organizations and any other similar health care delivery system or organization;

(6) "Rate, term, or condition", any lifetime or annual payment limits, deductibles, co-payments, coinsurance, and other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of a health benefit plan that affects the insured.

3. This section shall not apply to a health plan or policy that is individually underwritten or provides such coverage for specific individuals and members of their families pursuant to section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836, a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policies **[**of six months or less duration**]** **having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

4. Notwithstanding any other provision of law to the contrary, all health insurance policies that cover state employees, including the Missouri consolidated health care plan, shall include coverage for mental illness. Multiyear group policies need not comply until the expiration of their current multiyear term unless the policyholder elects to comply before that time.

5. The provisions of this section shall not be violated if the insurer decides to apply different limits or exclude entirely from coverage the following:

(1) Marital, family, educational, or training services unless medically necessary and clinically appropriate;

(2) Services rendered or billed by a school or halfway house;

(3) Care that is custodial in nature;

(4) Services and supplies that are not immediately nor clinically appropriate; or

(5) Treatments that are considered experimental.

6. The director shall grant a policyholder a waiver from the provisions of this section if the policyholder demonstrates to the director by actual experience over any consecutive twenty-four-month period that compliance with this section has increased the cost of the health insurance policy by an amount that results in a two percent increase in premium costs to the policyholder. The director shall promulgate rules establishing a procedure and appropriate standards for making such a demonstration. 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, 2004, shall be invalid and void.

376.1900. 1. As used in this section, the following terms shall mean:

(1) "Electronic visit", or "e-visit", an online electronic medical evaluation and management service completed using a secured web-based or similar electronic-based communications network for a single patient encounter. An electronic visit shall be initiated by a patient or by the guardian of a patient with the health care provider, be completed using a federal Health Insurance Portability and Accountability Act (HIPAA)-compliant online connection, and include a permanent record of the electronic visit;

(2) "Health benefit plan" shall have the same meaning ascribed to it in section 376.1350;

(3) "Health care provider" shall have the same meaning ascribed to it in section 376.1350;

(4) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a physical or mental health condition, illness, injury or disease;

(5) "Health carrier" shall have the same meaning ascribed to it in section 376.1350;

(6) "Telehealth" shall have the same meaning ascribed to it in section 208.670.

2. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2014, shall not deny coverage for a health care service on the basis that the health care service is provided through telehealth if the same service would be covered if provided through face-to-face diagnosis, consultation, or treatment.

3. A health carrier may not exclude an otherwise covered health care service from coverage solely because the service is provided through telehealth rather than face-to-face consultation or contact between a health care provider and a patient.

4. A health carrier shall not be required to reimburse a telehealth provider or a consulting provider for site origination fees or costs for the provision of telehealth services; however, subject to correct coding, a health carrier shall reimburse a health care provider for the diagnosis, consultation, or treatment of an insured or enrollee when the health care service is delivered through telehealth on the same basis that the health carrier covers the service when it is delivered in person.

5. A health care service provided through telehealth shall not be subject to any greater deductible, co-

payment, or coinsurance amount than would be applicable if the same health care service was provided through face-to-face diagnosis, consultation, or treatment.

6. A health carrier shall not impose upon any person receiving benefits under this section any co-payment, coinsurance, or deductible amount, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services that is not equally imposed upon all terms and services covered under the policy, contract, or health benefit plan. 7. Nothing in this section shall preclude a health carrier from undertaking utilization review to determine the appropriateness of telehealth as a means of delivering a health care service, provided that the determinations shall be made in the same manner as those regarding the same service when it is delivered in person.

8. A health carrier or health benefit plan may limit coverage for health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier.

9. Nothing in this section shall be construed to require a health care provider to be physically present with a patient where the patient is located unless the health care provider who is providing health care services by means of telehealth determines that the presence of a health care provider is necessary.

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 policies **[**of six months' or less duration**]** **having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration. "; and

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

HOUSE AMENDMENT NO. 1 TO
HOUSE AMENDMENT NO. 12

Amend House Amendment No. 12 to House Committee Substitute for Senate Committee Substitute for Senate Bill No. 718, Page 1, Line 4, by inserting immediately before the number "208.909" the following:

"**191.250. 1. This section shall be known and may be cited as "Simon's Law".**

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

(1) "End-of-life medical decision order for a child under juvenile or family court jurisdiction", a decision issued by a juvenile or family court pertaining to life-sustaining treatment, including do-not-resuscitate orders, provided on behalf of and in the best interests of a child under juvenile or family court jurisdiction under section 211.031;

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

3. For a child who is not under juvenile or family court jurisdiction under section 211.031, no health care facility, nursing home, physician, nurse, or medical staff shall institute a do-not-resuscitate order or similar physician's order, either orally or in writing, without the written or oral consent of at least one parent or legal guardian of the patient or resident under eighteen years of age who is not emancipated. If consent to implement a do-not-resuscitate order or similar physician's order is granted orally, two witnesses other than the parent, legal guardian, or physician shall be

present and willing to attest to the consent given by the legal guardian of the patient or at least one parent of the patient. The provision of such consent shall be immediately recorded in the patient's medical record, specifying who provided the information, to whom the information was provided, which parent or legal guardian gave the consent, who the witnesses were, and the date and time the consent was obtained.

4. The requirements of subsection 3 of this section shall not apply if a reasonably diligent effort of at least forty-eight hours without success has been made to contact and inform each known parent or legal guardian of the intent to implement a do-not-resuscitate order or similar physician's order.

5. Consent previously given under subsection 3 of this section may be revoked orally or in writing by the parent or legal guardian of the patient or resident who granted the original permission. Such revocation of prior consent shall take precedence over any prior consent to implement a do-not-resuscitate order or similar physician's order and shall be immediately recorded in the patient's or resident's medical records, specifying who provided the information, to whom the information was provided, which parent or legal guardian revoked consent, who the witnesses were, and the date and time the revocation was obtained.

6. For a child under juvenile court jurisdiction under section 211.031, a juvenile or family court may issue an end-of-life medical decision order, a physician's order, or any other medical decision order, or may appoint a guardian for the child for that purpose. The children's division shall not be appointed as guardian for a child to make end-of-life medical decisions, including do-not-resuscitate orders. In the event a child under the jurisdiction of a juvenile or family court under section 211.031 is returned to the custody of the legal guardian or parent, the legal guardian or parent may revoke the consent for the end-of-life medical decisions, or similar physician's orders ordered by the court, including do-not-resuscitate orders for the child. Revocation may be orally or in writing and shall be immediately recorded in the patient's medical records, specifying who provided the information, to whom the information was provided, which parent or legal guardian revoked consent, who the witnesses were, and the date and time the revocation was obtained.

7. For the purposes of this section, a relative caregiver under the provisions of section 431.058 shall have the same authority given to a parent or legal guardian of a nonemancipated patient or resident under eighteen years of age, provided that such a patient or resident is not under juvenile or family court jurisdiction under section 211.031.

8. Nothing in this section shall be construed to require any health care facility, nursing home, physician, nurse, or medical staff to provide or continue any treatment, including resuscitative efforts, food, medication, oxygen, intravenous fluids, or nutrition that would be:

(1) Medically inappropriate because, in reasonable medical judgement, providing such treatment would create a greater risk of causing or hastening the death of the patient; or

(2) Medically inappropriate because, in reasonable medical judgement, providing such treatment would be potentially harmful or cause unnecessary pain, suffering, or injury to the patient.

9. Nothing in this section shall require health care providers to continue cardiopulmonary resuscitation or manual ventilation beyond a time in which, in their reasonable medical judgment, there is no further benefit to the patient or likely recovery of the patient."; and

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

HOUSE AMENDMENT NO. 12

Amend House Committee Substitute for Senate Committee Substitute for Senate Bill No. 718, Page 1, Section A, Line 2, by inserting after all of said section and line the following:

"208.909. 1. Consumers receiving personal care assistance services shall be responsible for:

(1) Supervising their personal care attendant;

(2) Verifying wages to be paid to the personal care attendant;

(3) Preparing and submitting time sheets, signed by both the consumer and personal care attendant, to the vendor on a biweekly basis;

(4) Promptly notifying the department within ten days of any changes in circumstances affecting the personal care assistance services plan or in the consumer's place of residence;

(5) Reporting any problems resulting from the quality of services rendered by the personal care attendant to the vendor. If the consumer is unable to resolve any problems resulting from the quality of service rendered by the personal care attendant with the vendor, the consumer shall report the situation to the department; **[**and**]**

(6) Providing the vendor with all necessary information to complete required paperwork for establishing the employer identification number**; and**

(7) Allowing the vendor to comply with its quality assurance and supervision process, which shall include, but not be limited to, bi-annual face-to-face home visits and monthly case management activities.

2. Participating vendors shall be responsible for:

(1) Collecting time sheets or reviewing reports of delivered services and certifying the accuracy thereof;

(2) The Medicaid reimbursement process, including the filing of claims and reporting data to the department as required by rule;

(3) Transmitting the individual payment directly to the personal care attendant on behalf of the consumer;

(4) Monitoring the performance of the personal care assistance services plan. **Such monitoring shall occur during the bi-annual face-to-face home visits under section 208.918. The vendor shall document whether the attendant was present and if services are being provided to the consumer as set forth in the plan of care.**

3. No state or federal financial assistance shall be authorized or expended to pay for services provided to a consumer under sections 208.900 to 208.927, if the primary benefit of the services is to the household unit, or is a household task that the members of the consumer's household may reasonably be expected to share or do for one another when they live in the same household, unless such service is above and beyond typical activities household members may reasonably provide for another household member without a disability.

4. No state or federal financial assistance shall be authorized or expended to pay for personal care assistance services provided by a personal care attendant who is listed on any of the background check lists in the family care safety registry under sections 210.900 to **[**210.937**]** **210.936**, unless a good cause waiver is first obtained from the department in accordance with section 192.2495.

5. (1) All vendors shall, by July 1, 2015, have, maintain, and use a telephone tracking system for the purpose of reporting and verifying the delivery of consumer-directed services as authorized by the department of health and senior services or its designee. **[**Use of such a system prior to July 1, 2015, shall be voluntary.**]** The telephone tracking system shall be used to process payroll for employees and for submitting claims for reimbursement to the MO HealthNet division. At a minimum, the telephone tracking system shall:

(a) Record the exact date services are delivered;

(b) Record the exact time the services begin and exact time the services end;

(c) Verify the telephone number from which the services are registered;

(d) Verify that the number from which the call is placed is a telephone number unique to the client;

(e) Require a personal identification number unique to each personal care attendant;

(f) Be capable of producing reports of services delivered, tasks performed, client identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service; and

(g) Be capable of producing reimbursement requests for consumer approval that assures accuracy and compliance with program expectations for both the consumer and vendor.

(2) **[**The department of health and senior services, in collaboration with other appropriate agencies, including centers for independent living, shall establish telephone tracking system pilot projects, implemented in two regions of the state, with one in an urban area and one in a rural area. Each pilot project shall meet the requirements of this section and section 208.918. The department of health and senior services shall, by December 31, 2013, submit a report to the governor and general assembly detailing the outcomes of these pilot projects. The report shall take into consideration the impact of a telephone tracking system on the quality of the services delivered to the consumer and the principles of self-directed care.

(3)**]** As new technology becomes available, the department may allow use of a more advanced tracking system, provided that such system is at least as capable of meeting the requirements of this subsection.

[(4)**]** **(3)** The department of health and senior services shall promulgate by rule the minimum necessary criteria of the telephone tracking system. 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, 2010, shall be invalid and void.

[6. In the event that a consensus between centers for independent living and representatives from the executive branch cannot be reached, the telephony report issued to the general assembly and governor shall

include a minority report which shall detail those elements of substantial dissent from the main report.

7. No interested party, including a center for independent living, shall be required to contract with any particular vendor or provider of telephony services nor bear the full cost of the pilot program.**]**

208.918. 1. In order to qualify for an agreement with the department, the vendor shall have a philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical disabilities, and shall demonstrate the ability to provide, directly or through contract, the following services:

(1) Orientation of consumers concerning the responsibilities of being an employer**[**,**]** **and** supervision of personal care attendants including the preparation and verification of time sheets**. Such orientation shall include notifying consumers that falsification of personal care attendant time sheets shall be considered fraud and shall be reported to the department**;

(2) Training for consumers about the recruitment and training of personal care attendants;

(3) Maintenance of a list of persons eligible to be a personal care attendant;

(4) Processing of inquiries and problems received from consumers and personal care attendants;

(5) Ensuring the personal care attendants are registered with the family care safety registry as provided in sections 210.900 to **[**210.937**]** **210.936**; and

(6) The capacity to provide fiscal conduit services through a telephone tracking system by the date required under section 208.909.

2. In order to maintain its agreement with the department, a vendor shall comply with the provisions of subsection 1 of this section and shall:

(1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports **[**and annual audit**]** submitted to the department; **[**and**]**

(2) **Attest that all adequate documentation for all information is provided on reports, and billing records have sufficient required documentation to support the amounts claimed;**

(3) Demonstrate a positive impact on consumer outcomes regarding the provision of personal care assistance services as evidenced on accurate quarterly and annual service reports submitted to the department;

[(3)**]** **(4)** Implement a quality assurance and supervision process that ensures program compliance and accuracy of records**:**

(a) The department of health and senior services shall promulgate by rule a consumer-directed services division provider certification manager course; and

(b) The vendor shall perform with the consumer at least bi-annual face-to-face home visits to provide ongoing monitoring of the provision of services in the plan of care and assess the quality of care being delivered. The bi-annual face-to-face home visits do not preclude the vendor's responsibility from its ongoing diligence of case management oversight; **[**and

(4)**]** **(5)** Comply with all provisions of sections 208.900 to 208.927, and the regulations promulgated thereunder**; and**

(6) Maintain a proper business location, the criteria for which shall be defined by the department of health and senior services by rule.

3. No state or federal funds shall be authorized or expended if the owner, primary operator, certified manager, or any direct employee of the consumer-directed services vendor is also the personal care attendant.

208.924. A consumer's personal care assistance services may be discontinued under circumstances such as the following:

(1) The department learns of circumstances that require closure of a consumer's case, including one or more of the following: death, admission into a long-term care facility, no longer needing service, or inability of the consumer to consumer-direct personal care assistance service;

(2) The consumer has falsified records**; provided false information of his or her condition, functional capacity, or level of care needs;** or committed fraud;

(3) The consumer is noncompliant with the plan of care. Noncompliance requires persistent actions by the consumer which negate the services provided in the plan of care;

(4) The consumer or member of the consumer's household threatens or abuses the personal care attendant or vendor to the point where their welfare is in jeopardy and corrective action has failed;

(5) The maintenance needs of a consumer are unable to continue to be met because the plan of care hours exceed availability; and

(6) The personal care attendant is not providing services as set forth in the personal care assistance services plan and attempts to remedy the situation have been unsuccessful."; and

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

HOUSE AMENDMENT NO. 13

Amend House Committee Substitute for Senate Committee Substitute for Senate Bill No. 718, Page 1, Section A, Line 2, by inserting the following after all of said section and line:

"**208.1070. 1. For purposes of this section, the term "long-acting reversible contraceptive (LARC)" shall include, but not be limited to, intrauterine devices (IUDs) and birth control implants.**

2. Notwithstanding any other provision of law, any LARC that is prescribed to and obtained for a MO HealthNet participant may be transferred to another MO HealthNet participant if the LARC was not delivered to, implanted in, or used on the original MO HealthNet participant to whom the LARC was prescribed. In order to be transferred to another MO HealthNet participant under the provisions of this section, the LARC shall:

(1) Be in the original, unopened package;

(2) Have been in the possession of the health care provider for at least twelve weeks. The provisions of this subdivision may be waived upon the written consent of the original MO HealthNet participant to whom the LARC was prescribed;

(3) Not have left the possession of the health care provider who originally prescribed the LARC; and

(4) Be medically appropriate and not contraindicated for the MO HealthNet participant to whom the LARC is being transferred."; and

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

HOUSE AMENDMENT NO. 14

Amend House Committee Substitute for Senate Committee Substitute for Senate Bill No. 718, Page 1, Section A, Line 2, by inserting immediately after said line the following:

"**334.1000. As used in sections 334.1000 to 334.1030, the following terms shall mean:**

(1) "Advisory committee", the Missouri radiologic imaging and radiation therapy advisory committee;

(2) "Board", the state board of registration for the healing arts;

(3) "Certification organization", a certification organization that specializes in the certification and registration of radiologic imaging or radiation therapy technical personnel that is accredited by the National Commission for Certifying Agencies, American National Standards Institute, or other accreditation organization recognized by the board;

(4) "Ionizing radiation", radiation that may consist of alpha particles, beta particles, gamma rays, x-rays, neutrons, high-speed electrons, high-speed protons, or other particles capable of producing ions. Ionizing radiation does not include non-ionizing radiation, such as radiofrequency or microwaves, visible infrared or ultraviolet light, or ultrasound;

(5) "Licensed practitioner", a person licensed to practice medicine, chiropractic medicine, podiatry, or dentistry in this state with education and specialist training in the medical or dental use of radiation who is deemed competent to independently perform or supervise radiologic imaging or radiation therapy procedures by their respective state licensure board;

(6) "Limited x-ray machine operator", a person who is licensed to perform only x-ray or bone densitometry procedures not involving the administration or utilization of contrast media on selected specific parts of human anatomy under the supervision of a licensed practitioner;

(7) "Nuclear medicine technologist", a person who is licensed to perform a variety of nuclear medicine and molecular imaging procedures using sealed and unsealed radiation sources, ionizing radiation, adjunctive medicine and pharmaceuticals associated with nuclear medicine procedures, and therapeutic procedures using unsealed radioactive sources;

(8) "Radiation therapist", a person who is licensed to administer ionizing radiation to human beings for therapeutic purposes;

(9) "Radiation therapy", the use of ionizing radiation for the purpose of treating disease;

(10) "Radiographer", a person who is licensed to perform a comprehensive set of diagnostic radiographic procedures using external ionizing radiation to produce radiographic, fluoroscopic, or digital images;

(11) "Radiologic imaging", any procedure or article intended for use in the diagnosis or visualization of disease or other medical conditions in human beings, including, but not limited to

computed tomography, fluoroscopy, nuclear medicine, radiography, and other procedures using ionizing radiation;

(12) "Radiologist", a physician licensed in this state and certified by or board-eligible to be certified by the American Board of Radiology, the American Osteopathic Board of Radiology, the British Royal College of Radiology, or the Canadian College of Physicians and Surgeons in that medical specialty;

(13) "Radiologist assistant", a person who is licensed to perform a variety of activities under the supervision of a radiologist in the areas of patient care, patient management, radiologic imaging, or interventional procedures guided by radiologic imaging, and who does not interpret images, render diagnoses or prescribe medications or therapies.

334.1005. 1. Except as provided in this section, after January 1, 2020, only a person licensed under the provisions of sections 334.1000 to 334.1030 or a licensed practitioner may perform radiologic imaging or radiation therapy procedures on humans for diagnostic or therapeutic purposes.

2. The board shall issue licenses to persons certified by a certification organization to perform nuclear medicine technology, radiation therapy, radiography, and radiologist assistant procedures and to limited x-ray machine operators meeting licensure standards established by the board.

3. No person, corporation, or facility shall knowingly employ a person who does not hold a license or who is not exempt from the provisions of sections 334.1000 to 334.1030 to perform radiologic imaging or radiation therapy procedures for more than one hundred eighty days.

4. Nothing in this section relating to radiologic imaging or radiation therapy shall limit or enlarge the practice of a licensed practitioner.

5. The provisions of section 334.1000 to 334.1030 shall not apply to the following:

(1) A dental hygienist or dental assistant licensed by this state;

(2) A resident physician enrolled in and attending a school or college of medicine, chiropractic, podiatry, dentistry, radiologic imaging, or radiation therapy who performs radiologic imaging or radiation therapy procedures on humans;

(3) A student enrolled in and attending a school or college of medicine, chiropractic, podiatry, dentistry, radiologic imaging, or radiation therapy who performs radiologic imaging or radiation therapy procedures on humans while under the supervision of a licensed practitioner or a person holding a nuclear medicine technologist, radiation therapist, radiographer, or radiologist assistant license;

(4) A person who is employed by the United States government when performing radiologic imaging or radiation therapy associated with that employment; or

(5) A person performing radiologic imaging procedures on nonhuman subjects or cadavers.

334.1010. 1. There is hereby created the "Missouri Radiologic Imaging and Radiation Therapy Advisory Committee". The board shall provide administrative support to the advisory committee. The advisory committee shall guide, advise, and make recommendations to the board, and shall consist of five members appointed by the director of the division of professional registration, a

majority of whom shall be licensed practitioners, individuals certified or registered by a certification organization, or individuals licensed under sections 334.1000 to 334.1030.

2. The board, based on recommendations, guidance, and advice from the advisory committee, shall:

(1) Establish scopes of practice for limited x-ray machine operators, nuclear medicine technologists, radiation therapists, radiographers, and radiologist assistants;

(2) Promulgate rules for issuance of licenses;

(3) Establish minimum requirements for the issuance of licenses and recognition of licenses issued by other states;

(4) Establish minimum requirements for continuing education;

(5) Determine fees and requirements for the issuance of new licenses and renewal of licenses;

(6) Contract to use a competency based examination that shall provide for a virtually administered option for the determination of limited x-ray machine operator qualifications for licensure;

(7) Promulgate rules for acceptance of certification and registration by a certification organization recognized by the board as qualification for licensure;

(8) Promulgate rules for issuance of licenses to retired military personnel and spouses of active-duty military personnel;

(9) Establish ethical, moral, and practice standards; and

(10) Promulgate rules and procedures for the denial or refusal to renew a license, and the suspension, revocation, or other discipline of active licensees.

3. The board shall create alternative licensure requirements for individuals working in rural health clinics as defined in P.L. 95-210 and for areas of this state that the board deems too remote to contain a sufficient number of qualified persons licensed under sections 334.1000 to 334.1030 to perform radiologic imaging or radiation therapy procedures.

4. All fees payable pursuant to the provisions of sections 334.1000 to 334.1030 shall be collected by the division of professional registration, which shall transmit such funds to the department of revenue for deposit in the state treasury to the credit of the board of registration for the healing arts fund. The division of professional registration and the board of registration for the healing arts may use these funds as necessary for the administration of sections 334.1000 to 334.1030.

5. The fee charged for a limited x-ray machine operator examination shall not exceed the actual cost to administer the examination.

334.1015. 1. To be eligible for licensure by the board, at the time of application an applicant shall be at least eighteen years of age.

2. The board shall accept nuclear medicine technology, radiation therapy, radiography, or radiologist assistant certification and registration by a certification organization recognized by the board as a qualification for licensure.

3. The board may issue limited x-ray machine operator licenses in the following areas:

(1) Chest radiography: radiography of the thorax, heart, and lungs;

(2) Extremity radiography: radiography of the upper and lower extremities, including the pectoral girdle;

(3) Spine radiography: radiography of the vertebral column;

(4) Skull/sinus radiography: radiography of the skull and facial structures;

(5) Podiatric radiography: radiography of the foot, ankle, and lower leg below the knee;

(6) Bone densitometry: performance and analysis of bone density scans; or

(7) Other areas the board deems necessary to ensure necessary services throughout the state.

4. The board may require a limited x-ray machine operator to verify training in x-ray procedures at their place of employment, including a minimum of one hundred hours of supervised experience performing x-ray procedures.

(1) The hours shall be sufficient for individuals to be licensed in any limited machine operator area for which they pass an examination;

(2) The hours shall be documented by the licensee and verified by the licensee's supervisor.

5. Individuals shall be licensed in any limited machine operator area for which they successfully pass an examination as defined by the board.

6. The board shall not require, but may recommend, any advance class work, either remote or in person, prior to a limited x-ray machine operator candidate taking such examination.

7. No additional testing requirements or other stipulations shall be imposed after the initial examination for limited x-ray machine operator licensure provided the licensee maintain required continuing education and is not disciplined under rules promulgated pursuant to subdivision (10) of subsection 2 of section 334.1010.

8. The board shall require limited x-ray machine operators to complete a minimum of twelve hours biannually of continuing education that may be fulfilled by approved continuing education activities at the licensee's place of employment.

9. The board may accept certification from the American Chiropractic Registry of Radiologic Technologists for persons applying for a limited x-ray machine operator license in spine radiography.

10. The board may accept certification from the American Society of Podiatric Medical Assistants for persons applying for a limited x-ray machine operator license in podiatric radiography.

11. The board may accept certification from the International Society of Clinical Densitometry for persons applying for a limited x-ray machine operator license in bone densitometry.

334.1020. 1. A licensee who violates any provision of sections 334.1000 to 334.1030 shall be guilty of a class A misdemeanor. Each act of such unlawful practice shall constitute a distinct and separate offense.

2. The board may assess a civil penalty not in excess of two hundred dollars for each violation of sections 334.1000 to 334.1030 or any rules adopted by the board. The clear proceeds of any civil penalty assessed under this section shall be remitted to the credit of the public school fund of the state.

334.1025. A person who has been engaged in the practice of radiologic imaging and radiation therapy, other than a radiologist assistant, and who does not hold a current certification and registration by a certification organization recognized by the board may continue to practice in the radiologic imaging or radiation therapy modality in which they are currently employed, provided that such person:

(1) Registers with the board on or before January 1, 2020;

(2) Does not change the scope of their current practice or current place of employment;

(3) Completes all continuing education requirements for their modality biennially as prescribed by the board;

(4) Practices only under the supervision of a licensed practitioner; and

(5) Meets all licensure requirements of sections 334.1000 to 334.1030 and the rules adopted by the board and obtains a license from the board on or before October 1, 2023.

334.1030. The board may promulgate rules to implement the provisions of sections 334.1000 to 334.1030. 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, 2018, shall be invalid and void."; and

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

HOUSE AMENDMENT NO. 1 TO
HOUSE AMENDMENT NO. 15

Amend House Amendment No. 15 to House Committee Substitute for Senate Committee Substitute for Senate Bill No. 718, Page 5, Lines 6 through 9, by deleting all of said lines and inserting in lieu thereof the following:

"3. **[**This section shall not be construed to limit the rights provided under law for a patient to bring a civil action for damages against a physician, hospital, registered or licensed practical nurse, pharmacist, any other individual or entity providing health care services, or an employee of any entity listed in this subsection**]** **Notwithstanding the provisions of section 538.210 or any other law to the contrary, any physician licensed under chapter 334, any hospital licensed under chapter 197, any pharmacist licensed under chapter 338, any nurse licensed under chapter 335, or any other person employed or directed by any of the above, which provides care, treatment or professional services to any patient under section 192.945 shall not be liable for any civil damages for acts or omissions unless the damages were occasioned by gross negligence or by willful or wanton acts or omissions by such physician, hospital, pharmacist, nurse or person in rendering such care and treatment.**"; and

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

HOUSE AMENDMENT NO. 15

Amend House Committee Substitute for Senate Committee Substitute for Senate Bill No. 718, Page 1, Section A, Line 2, by inserting after said section and line the following:

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

(1) **"Dispensing organization", an entity licensed under chapter 261 to distribute medical cannabis;**

(2) "Eligible patient", a person who meets all of the following:

(a) Has a terminal illness;

(b) Has considered all other treatment options currently approved by the **[**United States**]** **federal** Food and Drug Administration and all relevant clinical trials conducted in this state;

(c) Has received a prescription or recommendation from the person's physician for an investigational drug, biological product, or device;

(d) Has given written informed consent which shall be at least as comprehensive as the consent used in clinical trials for the use of the investigational drug, biological product, or device or, if the patient is a minor or lacks the mental capacity to provide informed consent, a parent or legal guardian has given written informed consent on the patient's behalf; and

(e) Has documentation from the person's physician that the person has met the requirements of this subdivision;

[(2)**] (3)** "Investigational drug, biological product, or device", a drug, biological product, or device, any of which are used to treat the patient's terminal illness, that has successfully completed phase one of a clinical trial but has not been approved for general use by the **[**United States**]** **federal** Food and Drug Administration and remains under investigation in a clinical trial. The term shall not include Schedule I controlled substances **except for medical cannabis. The term shall include medical cannabis from a dispensing organization**;

[(3)**] (4)** "Terminal illness", a disease that without life-sustaining procedures will result in death in the near future or a state of permanent unconsciousness from which recovery is unlikely.

2. A **dispensing organization or** manufacturer of an investigational drug, biological product, or device may make available the **dispensing organization's or** manufacturer's investigational drug, biological product, or device to eligible patients under this section. This section does not require that a **dispensing organization or** manufacturer make available an investigational drug, biological product, or device to an eligible patient. A **dispensing organization or** manufacturer may:

(1) Provide an investigational drug, biological product, or device to an eligible patient without receiving compensation; or

(2) Require an eligible patient to pay the costs of or associated with the manufacture of the investigational drug, biological product, or device.

3. This section does not require a health care insurer to provide coverage for the cost of any

investigational drug, biological product, or device. A health care insurer may provide coverage for an investigational drug, biological product, or device.

4. This section does not require the department of corrections to provide coverage for the cost of any investigational drug, biological product, or device.

5. Notwithstanding any other provision of law to the contrary, no state agency or regulatory board shall revoke, fail to renew, or take any other action against a physician's license issued under chapter 334 based solely on the physician's recommendation to an eligible patient regarding prescription for or treatment with an investigational drug, biological product, or device. Action against a health care provider's Medicare certification based solely on the health care provider's recommendation that a patient have access to an investigational drug, biological product, or device is prohibited.

6. **[**If a provision of this section or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this section that can be given effect without the invalid provision or application, and to this end the provisions of this section are severable**]** **Notwithstanding any other provision of law to the contrary, no state agency or regulatory board shall revoke, fail to renew, or take any other action against a dispensing organization's license issued under chapter 261 based solely on the dispensing organization's sale of medical cannabis to an eligible patient under this section**.

7. If the clinical trial is closed due to lack of efficacy or toxicity, the drug shall not be offered. If notice is given on a drug, product, or device taken by a patient outside of a clinical trial, the pharmaceutical company or patient's physician shall notify the patient of the information from the safety committee of the clinical trial.

8. Except in the case of gross negligence or willful misconduct, any person who manufactures, imports, distributes, prescribes, dispenses, or administers an investigational drug or device to an eligible patient with a terminal illness in accordance with this section shall not be liable in any action under state law for any loss, damage, or injury arising out of, relating to, or resulting from:

(1) The design, development, clinical testing and investigation, manufacturing, labeling, distribution, sale, purchase, donation, dispensing, prescription, administration, or use of the drug or device; or

(2) The safety or effectiveness of the drug or device.

9. Any official, employee, or agent of this state who blocks or attempts to block access of an eligible patient to an investigational drug, biological product, or device is guilty of a class A misdemeanor.

10. If any provision of this section or its application to any person or circumstance is held invalid, such determination shall not affect the provisions or applications of this section which may be given effect without the invalid provision or application, and to that end the provisions of this section are severable.

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

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

(2) "Hemp extract", as such term is defined in section 195.207;

(3) "Hemp extract registration card", a card issued by the department under this section;

(4) "Intractable epilepsy", epilepsy that as determined by a neurologist does not respond to three or more treatment options overseen by the neurologist;

(5) "Medical cannabis", as such term is defined in section 195.207;

(6) "Medical cannabis registration card", a card issued by the department under this section;

[(5)**] (7)** "Neurologist", a physician who is licensed under chapter 334 and board certified in neurology;

[(6)**] (8)** "Parent", a parent or legal guardian of a minor who is responsible for the minor's medical care;

[(7)**] (9)** "Registrant", an individual to whom the department issues a hemp extract **or medical cannabis** registration card under this section**;**

(10) "Terminal illness", a disease or condition as defined in section 191.480.

2. The department shall issue a hemp extract **or medical cannabis** registration card to an individual who:

(1) Is eighteen years of age or older;

(2) Is a Missouri resident;

(3) Provides the department with a statement signed by a neurologist **or physician** that:

(a) Indicates that the individual suffers from intractable epilepsy and may benefit from treatment with hemp extract **or that the individual suffers from a terminal illness and may benefit from treatment with medical cannabis at the same dosage and with the same method of smokeless administration used in a clinical trial**; **[**and**]**

(b) **Indicates that the individual has considered all other treatment options currently approved by the federal Food and Drug Administration and all relevant clinical trials conducted in this state; and**

(c) Is consistent with a record from the neurologist **or physician** concerning the individual contained in the database described in subsection **[**9**] 11** of this section;

(4) Pays the department a fee in an amount established by the department under subsection **[**6**] 8** of this section; and

(5) Submits an application to the department on a form created by the department that contains:

(a) The individual's name and address;

(b) A copy of the individual's valid photo identification; and

(c) Any other information the department considers necessary to implement the provisions of this section.

3. The department shall issue a hemp extract **or medical cannabis** registration card to a parent who:

(1) Is eighteen years of age or older;

(2) Is a Missouri resident;

(3) Provides the department with a statement signed by a neurologist **or physician** that:

(a) Indicates that a minor in the parent's care suffers from intractable epilepsy and may benefit from treatment with hemp extract **or suffers from a terminal illness and may benefit from medical cannabis at the same dosage and with the same method of smokeless administration used in a clinical trial**; **[**and**]**

(b) **Indicates that the individual has considered all other treatment options currently approved by the federal Food and Drug Administration and all relevant clinical trials conducted in this state; and**

(c) Is consistent with a record from the neurologist **or physician** concerning the minor contained in the database described in subsection **[**9**] 11** of this section;

(4) Pays the department a fee in an amount established by the department under subsection **[**6**] 8** of this section; and

(5) Submits an application to the department on a form created by the department that contains:

(a) The parent's name and address;

(b) The minor's name;

(c) A copy of the parent's valid photo identification; and

(d) Any other information the department considers necessary to implement the provisions of this section.

4. The department shall maintain a record of the name of each registrant and the name of each minor receiving care from a registrant.

5. The department shall promulgate rules to:

(1) Implement the provisions of this section including establishing the information the applicant is required to provide to the department and establishing in accordance with recommendations from the department of public safety the form and content of the hemp extract **and medical cannabis** registration **[**card**] cards**; and

(2) Regulate the distribution of hemp extract from a cannabidiol oil care center **and medical cannabis from a cannabis care center, as defined in section 261.265,** to a registrant, which shall be in addition to any other state or federal regulations**[**; and**].**

6. The department shall publish a list of diseases and conditions for which a medical cannabis registration card may be issued. The list shall only contain terminal illnesses as defined under section 191.480. The department shall publish a list of diseases and conditions for which a hemp extract registration card may be issued. The list shall only contain intractable epilepsy.

7. The department may promulgate rules to authorize clinical trials involving hemp extract **and medical cannabis**.

[6.**] 8.** The department shall establish fees that are no greater than the amount necessary to cover the cost the department incurs to implement the provisions of this section.

[7.**] 9.** The registration cards issued under this section shall be valid for one year and renewable if at the time of renewal the registrant meets the requirements of either subsection 2 or 3 of this section.

[8.**] 10.** The neurologist **or physician** who signs the statement described in subsection 2 or 3 of this section shall:

(1) Keep a record of the neurologist's **or physician's** evaluation and observation of a patient who is a registrant or minor under a registrant's care including the patient's response to hemp extract **or medical cannabis**; and

(2) Transmit the record described in subdivision (1) of this subsection to the department.

[9.**] 11.** The department shall maintain a database of the records described in subsection **[**8**] 10** of this section and treat the records as identifiable health data.

[10.**] 12.** The department may share the records described in subsection **[**9**] 11** of this section with a higher education institution for the purpose of studying hemp extract **or medical cannabis**.

[11.**] 13.** 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 July 14, 2014, shall be invalid and void.

192.947. 1. No individual or health care entity organized under the laws of this state shall be subject to any adverse action by the state or any agency, board, or subdivision thereof, including civil or criminal prosecution, denial of any right or privilege, the imposition of a civil or administrative penalty or sanction, or disciplinary action by any accreditation or licensing board or commission if such individual or health care entity, in its normal course of business and within its applicable licenses and regulations, acts in good faith upon or in furtherance of any order or recommendation by a neurologist **or physician** authorized under section 192.945 relating to the medical use and administration of hemp extract **or medical cannabis** with respect to an eligible patient.

2. The provisions of subsection 1 of this section shall apply to the recommendation, possession, handling, storage, transfer, destruction, dispensing, or administration of hemp extract **and medical cannabis**, including any act in preparation of such dispensing or administration.

3. This section shall not be construed to limit the rights provided under law for a patient to bring a civil action for damages against a physician, hospital, registered or licensed practical nurse, pharmacist, any other individual or entity providing health care services, or an employee of any entity listed in this subsection.

195.207. 1. As used in sections 192.945, 261.265, 261.267, and this section, the term **[**"hemp extract"**] "medical cannabis"** shall mean **[**an**] a noncombustible** extract from a cannabis plant or a **noncombustible** mixture or preparation containing cannabis plant material**. "Hemp extract" shall mean the same, except** that **it**:

(1) Is composed of no more than three-tenths percent tetrahydrocannabinol by weight;

(2) Is composed of at least five percent cannabidiol by weight; and

(3) Contains no other psychoactive substance.

2. Notwithstanding any other provision of this chapter, an individual who has been issued a valid hemp extract **or medical cannabis** registration card under section 192.945, or is a minor under a registrant's care, and possesses or uses hemp extract **or medical cannabis** is not subject to the penalties described in this chapter for possession or use of the hemp extract **or medical cannabis** if the individual:

(1) Possesses or uses the hemp extract only to treat intractable epilepsy **or medical cannabis only to treat a terminal illness,** as **such terms are** defined in section 192.945;

(2) Originally obtained the hemp extract **or medical cannabis** from a sealed container with a label indicating the hemp extract's **or medical cannabis'** place of origin and a number that corresponds with a certificate of analysis **and a warning label with all possible side effects**;

(3) Possesses, in close proximity to the hemp extract **or medical cannabis**, a certificate of analysis that:

(a) Has a number that corresponds with the number on the label described in subdivision (2) of this subsection;

(b) Indicates the hemp extract's **or medical cannabis'** ingredients including its percentages of tetrahydrocannabinol and cannabidiol **and all other cannabinoid compounds, terpenes, and solvents** by weight;

(c) Is created by a laboratory that is not affiliated with the producer of the hemp extract **or medical cannabis** and is licensed in the state where the hemp extract **or medical cannabis** was produced; and

(d) Is transmitted by the laboratory to the department of health and senior services; and

(4) Has a current hemp extract **or medical cannabis** registration card issued by the department of health and senior services under section 192.945.

3. Notwithstanding any other provision of this chapter, an individual who possesses hemp extract **or medical cannabis** lawfully under subsection 2 of this section and administers hemp extract **or medical cannabis** to a minor suffering from intractable epilepsy **or a terminal illness** is not subject to the penalties described in this chapter for administering the hemp extract **or medical cannabis** to the minor if:

(1) The individual is the minor's parent or legal guardian; and

(2) The individual is registered with the department of health and senior services as the minor's parent under section 192.945.

4. An individual who has been issued a valid hemp extract **or medical cannabis** registration card under section 192.945, or is a minor under a registrant's care, may possess up to twenty ounces of hemp extract **or medical cannabis** pursuant to this section. Subject to any rules or regulations promulgated by the department of health and senior services, an individual may apply for a waiver if a physician provides a substantial medical basis in a signed, written statement asserting that, based on the patient's medical history, in the physician's professional judgment, twenty ounces is an insufficient amount to properly alleviate the patient's medical condition or symptoms associated with such medical condition.

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

(1) "Cannabidiol oil care center", the premises specified in an application for a cultivation and production facility license in which the licensee is authorized to distribute processed hemp extract to persons possessing a hemp extract registration card issued under section 192.945;

(2) **"Cannabis care center", the premises specified in an application for a cultivation and production facility license in which the licensee is authorized to distribute processed medical cannabis to persons possessing a medical cannabis registration card issued under section 192.945;**

(3) "Cannabis cultivation and production facility", the land and premises in which the licensee is authorized to distribute processed medical cannabis to persons possessing a medical cannabis registration card issued under section 192.945;

(4) "Cannabis cultivation and production facility license", a license that authorizes the licensee to grow, cultivate, process, and possess medical cannabis;

(5) "Cannabis grower", an entity issued a cultivation and production facility license by the department of agriculture that produces medical cannabis for the treatment of terminal illnesses;

(6) "Department", the department of agriculture;

(7) "Hemp":

(a) All nonseed parts and varieties of the cannabis sativa plant, whether growing or not, that contain a crop-wide average tetrahydrocannabinol (THC) concentration that does not exceed the lesser of:

a. Three-tenths of one percent on a dry weight basis; or

b. The percent based on a dry weight basis determined by the federal Controlled Substances Act under 21 U.S.C. Section 801, et seq.; and

(b) Any cannabis sativa seed that is:

a. Part of a growing crop;

b. Retained by a grower for future planting; or

c. For processing into or use as agricultural hemp seed.

This term shall not include industrial hemp commodities or products;

(8) "**Hemp** cultivation and production facility", the land and premises specified in an application for a cultivation and production facility license on which the licensee is authorized to grow, cultivate, process, and possess hemp and hemp extract;

[(3)**] (9)** "**Hemp** cultivation and production facility license", a license that authorizes the licensee to grow, cultivate, process, and possess hemp and hemp extract, and distribute hemp extract to its cannabidiol oil care centers;

[(4) "Department", the department of agriculture;

(5)**] (10)** "**Hemp** grower", a nonprofit entity issued a cultivation and production facility license by the department of agriculture that produces hemp extract for the treatment of intractable epilepsy;

[(6) "Hemp":

(a) All nonseed parts and varieties of the cannabis sativa plant, whether growing or not, that contain a crop-wide average tetrahydrocannabinol (THC) concentration that does not exceed the lesser of:

a. Three-tenths of one percent on a dry weight basis; or

b. The percent based on a dry weight basis determined by the federal Controlled Substances Act under 21 U.S.C. Section 801, et seq.;

(b) Any cannabis sativa seed that is:

a. Part of a growing crop;

b. Retained by a grower for future planting; or

c. For processing into or use as agricultural hemp seed.

This term shall not include industrial hemp commodities or products;**]**

[(7)**] (11)** "Hemp monitoring system", an electronic tracking system that includes, but is not limited to, testing and data collection established and maintained by the cultivation and production facility and is available to the department for the purposes of documenting the hemp extract production and retail sale of the hemp extract**;**

(12) "Medical cannabis":

(a) All nonseed parts and varieties of the cannabis plant, whether growing or not; and

(b) Any cannabis seed that is:

a. Part of a growing crop;

b. Retained by a grower for future planting; or

c. For processing into or use as agricultural cannabis seed.

2. **The department shall issue a cultivation and production facility license to an entity to grow or cultivate the cannabis plant used to make medical cannabis, as defined in subsection 1 of section 195.207, on the entity's property if the entity has submitted to the department an application as required by the department under subsection 9 of this section and the entity meets all requirements of this section and the department's rules.**

3. A cannabis grower may produce, manufacture, and distribute medical cannabis as defined in section 195.207 for the treatment of persons suffering from a terminal illness consistent with any and all state and local regulations regarding the production, manufacture, or distribution of such product.

4. The department shall issue a **hemp** cultivation and production facility license to a nonprofit entity to grow or cultivate the cannabis plant used to make hemp extract as defined in subsection 1 of section 195.207 or hemp on the entity's property if the entity has submitted to the department an application as required by the department under subsection **[**7**] 9** of this section**[**,**] and** the entity meets all requirements of this section and the department's rules**[**, and there are fewer than two licensed cultivation and production facilities operating in the state**]**.

[3.**] 5.** A **hemp** grower may produce and manufacture hemp and hemp extract, and distribute hemp extract as defined in section 195.207 for the treatment of persons suffering from intractable epilepsy as defined in section 192.945 consistent with any and all state or federal regulations regarding the production, manufacture, or distribution of such product. **[**The department shall not issue more than two cultivation and

production facility licenses for the operation of such facilities at any one time.**]**

[4.**] 6.** The department shall maintain a list of growers.

[5.**] 7.** All growers shall keep records in accordance with rules adopted by the department. Upon at least three days' notice, the director of the department may audit the required records during normal business hours. The director may conduct an audit for the purpose of ensuring compliance with this section.

[6.**] 8.** In addition to an audit conducted in accordance with subsection **[**5**] 7** of this section, the director may inspect independently, or in cooperation with the state highway patrol or a local law enforcement agency, any hemp **or medical cannabis** crop during the crop's growth phase and take a representative composite sample for field analysis. If a **hemp** crop contains an average tetrahydrocannabinol (THC) concentration exceeding the lesser of:

(1) Three-tenths of one percent on a dry weight basis; or

(2) The percent based on a dry weight basis determined by the federal Controlled Substances Act under 21 U.S.C. Section 801, et seq.,

the director may detain, seize, or embargo the **hemp** crop.

[7.**] 9.** The department shall promulgate rules including, but not limited to:

(1) Application requirements for licensing, including requirements for the submission of fingerprints and the completion of a criminal background check;

(2) Security requirements for cultivation and production facility premises, including, at a minimum, lighting, physical security, video and alarm requirements;

(3) Rules relating to hemp **and cannabis** monitoring systems as defined in this section;

(4) Other procedures for internal control as deemed necessary by the department to properly administer and enforce the provisions of this section, including reporting requirements for changes, alterations, or modifications of the premises;

(5) Requirements that any hemp extract **or medical cannabis** received from a legal source be submitted to a testing facility designated by the department to ensure that such hemp extract **or medical cannabis** complies with the provisions of section 195.207 and to ensure that the hemp extract **or medical cannabis** does not contain any pesticides. **The department shall only designate testing facilities that maintain internal standard operating procedures, maintain quality control and quality assurance programs, and are certified by the International Organization for Standardization and agree to have the inspections and reports of the International Organization for Standardization made available to the department. The department or an independent third party authorized by the department may conduct an inspection of the practices, procedures, and programs adopted, followed, and maintained pursuant to this subdivision and inspect all records of the independent testing facility that are related to the inspection.** Any hemp extract **or medical cannabis** that is not submitted for testing or which after testing is found not to comply with the provisions of section 195.207 shall not be distributed or used and shall be submitted to the department for destruction; [and]

(6) Requirements that each independent testing facility shall:

(a) Follow the most recent version of the Cannabis Inflorescence: Standards of Identity, Analysis,

and Quality Control monograph published by the American Herbal Pharmacopoeia; or

(b) Notify the department of the alternative testing methodology that the facility is following for each quality assurance test it conducts. The department may require the independent testing facility to have the testing methodology followed under this paragraph validated by an independent third party to ensure that the methodology followed by the facility produces scientifically accurate results before the facility may use the methodology when conducting testing services;

(7) Rules for an independent testing facility to have its basic proficiency to execute correctly the analytical testing methodologies used by the facility validated and monitored on an ongoing basis by an independent third party; and

[(6)**] (8)** Rules regarding the manufacture, storage, and transportation of hemp**,** [and] hemp extract**, and medical cannabis**, which shall be in addition to any other state or federal regulations.

[8.**] 10.** 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 July 14, 2014.

[9.**] 11.** All hemp **and cannabis** waste from the production of hemp extract **or medical cannabis** shall either be destroyed, recycled by the licensee at the hemp **or medical cannabis** cultivation and production facility, or donated to the department or an institution of higher education for research purposes, and shall not be used for commercial purposes.

[10.**] 12.** In addition to any other liability or penalty provided by law, the director may revoke or refuse to issue or renew a cultivation and production facility license and may impose a civil penalty on a grower for any violation of this section, or section 192.945 or 195.207. The director may not impose a civil penalty under this section that exceeds two thousand five hundred dollars.

13. Notwithstanding any other provision of law to the contrary, a person who commits any acts that are unlawful under section 191.480, 192.945, 192.947, 195.207, 261.265, or 263.250 with the intent to distribute medical cannabis to minors shall be guilty of a class D felony.

14. Any manufacturing, storage, or testing of medical cannabis or any medical cannabis product shall meet all requirements of the department of health and senior services and all local health departments.

263.250. 1. The plant "marijuana", botanically known as cannabis sativa, is hereby declared to be a noxious weed and all owners and occupiers of land shall destroy all such plants growing upon their land. Any person who knowingly allows such plants to grow on his land or refuses to destroy such plants after being notified to do so shall allow any sheriff or such other persons as designated by the county commission to enter upon any land in this state and destroy such plants.

2. Entry to such lands shall not be made, by any sheriff or other designated person to destroy such plants, until fifteen days' notice by certified mail shall be given the owner or occupant to destroy such plants or a search warrant shall be issued on probable cause shown. In all such instances, the county commission shall bear the cost of destruction and notification.

3. The provisions of this section shall not apply to the licensed production of hemp oil or medical cannabis under chapter 261."; and

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

HOUSE AMENDMENT NO. 16

Amend House Committee Substitute for Senate Committee Substitute for Senate Bill No. 718, Page 1, Section A, Line 2, by inserting after all of said section and line the following:

"**21.790. 1. There is hereby established a joint committee of the general assembly, which shall be known as the "Joint Committee on Substance Abuse Prevention and Treatment". The committee shall be composed of six members from the house of representatives, six members from the senate, and four members appointed by the governor. The senate members of the committee shall be appointed by the president pro tempore of the senate and the house members by the speaker of the house of representatives. There shall be at least two members from the minority party of the senate and at least two members from the minority party of the house of representatives. The members appointed by the governor shall include one member from the health care industry, one member who is a first responder or law enforcement officer, one member who is a member of the judiciary or a prosecuting attorney, and one member representing a substance abuse prevention advocacy group.**

2. The committee shall select a chairperson and a vice-chairperson, one of whom shall be a member of the senate and one a member of the house of representatives. A majority of the members shall constitute a quorum. The committee shall meet at least once during each legislative session and at all other times as the chairperson may designate.

3. The committee shall:

(1) Conduct hearings on current and estimated future drug and substance use and abuse within the state;

(2) Explore solutions to substance abuse issues; and

(3) Draft or modify legislation as necessary to effectuate the goals of finding and funding education and treatment solutions to curb drug and substance use and abuse.

4. The committee shall report annually to the general assembly and the governor. The report shall include recommendations for legislation pertaining to substance abuse prevention and treatment.

190.096. 1. This section shall be known and may be cited as the "Tactical Response to Traumatic Injuries Act".

2. For purposes of this section, "trauma public access kit" or "trauma PAK" means a first aid response kit that contains at least all of the following:

(1) Two tourniquets;

(2) Two pressure dressings that are inspected for replacement no less than every three years;

(3) Four chest seals that are inspected for replacement no less than every three years;

(4) Medical materials and equipment similar to those described in subdivisions (1), (2), and (3) of this subsection, and any additional items that are approved by local law enforcement or first

responders, that adequately treat a traumatic injury, and can be stored in a readily available kit; and

(5) Instructional documents based upon nationally or internationally recognized evidence-based treatment recommendations, guidelines, and programs.

3. In order to ensure public safety, a person or entity that supplies a trauma kit may provide the person or entity that acquires the trauma kit with all information governing the use, installation, operation, training, and maintenance of the trauma kit.

4. The placement of trauma PAKs in public or private buildings, facilities, or structures is voluntary, but this shall not preclude any state agency or political subdivision from adopting mandatory building standards requiring the placement of PAKs in public buildings, facilities, or structures. If any person or entity places or requires the placement of PAKs in private buildings, facilities, or structures, then such persons or entities shall comply with the requirements of subsection 5 of this section in order for such person or entity, or any agents thereof, to claim immunity from civil damages under subsection 6 of this section.

5. In order to ensure public safety, the entity responsible for managing the building, facility, or tenants of a structure in which a trauma PAK is placed that is an occupied structure shall do all of the following:

(1) Comply with all regulations governing the placement of a trauma PAK;

(2) Inspect all trauma PAKs acquired and placed on the premises of a building, facility, or structure every three years from the date of installation to ensure that all materials, supplies, and equipment contained in the trauma PAK are not expired, and replace any expired materials, supplies, and equipment as necessary;

(3) Restock the trauma PAK after each use and replace any materials, supplies, and equipment as necessary to ensure that all materials, supplies, and equipment required to be contained in the trauma PAK are contained in the trauma PAK;

(4) At least once per year, notify tenants of the building, facility, or structure of the location of the trauma PAK and provide information to tenants regarding contact information for training in the use of the trauma PAK; and

(5) Provide tenants with instructions in the use of the trauma PAK from the training programs described in subdivision (5) of subsection 2 of this section.

6. Notwithstanding any other provision of law, a person or entity that acquires and places a trauma kit for emergency care in a structure shall not be liable for any civil damages resulting from any acts or omissions in the rendering of emergency care by use of the trauma kit if that person or entity has complied with subsection 5 of this section.

7. Any person who gratuitously and in good faith renders emergency care or treatment by the use of a trauma PAK at the scene of an emergency shall not be held liable for any civil damages as a result of such care or treatment, unless the person acts in a willful and wanton or reckless manner in providing the care or treatment. The person or entity who provides appropriate training to the person using the trauma PAK, the person or entity responsible for the site where the trauma PAK is located, the person or entity that owns the trauma PAK, the person or entity that provided clinical protocol

for trauma PAK sites or programs, and the person or entity that reviews and approves the clinical protocol shall likewise not be held liable for civil damages resulting from the use of a trauma PAK. Nothing in this section shall affect any claims brought pursuant to chapter 537 or 538. The protections specified in this section shall not apply in the case of personal injury or wrongful death that results from the gross negligence or willful or wanton misconduct of the person who renders emergency care or treatment by the use of a trauma PAK."; and

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

Emergency clause adopted.

Titling change adopted.

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 **HCS** for **SB 687**, entitled:

An Act to repeal sections 160.530 and 304.060, RSMo, and to enact in lieu thereof two new sections relating to student transportation.

With House Amendment Nos. 1 and 2.

HOUSE AMENDMENT NO. 1

Amend House Committee Substitute for Senate Bill No. 687, Page 3, Section 160.530, Line 82, by inserting immediately after said line the following:

"162.064. **1.** Each school district shall have on file a statement from a medical examiner which indicates that the driver is physically qualified to operate a school bus for the purpose of transporting pupils. Such statement shall be made on an annual basis**, unless a statement is issued by a department of transportation certified medical examiner, in which case such examiner may issue a statement for up to a two-year duration, subject to rules promulgated by the department of transportation**. The term "medical examiner" includes, but is not limited to, doctors of medicine, doctors of osteopathy, physician assistants, advanced practice nurses, and doctors of chiropractic. For new drivers, such statement shall be on file prior to the driver's initial operation of a school bus. This section shall apply to drivers employed by the school district or under contract with the school district.

2. The director of the department of transportation may promulgate all necessary rules and regulations for the administration 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, 2018, shall be invalid and void."; and

Further amend said bill, Page 4, Section 304.060, Line 34, by inserting immediately after said line the following:

"302.272. 1. No person shall operate any school bus owned by or under contract with a public school or the state board of education unless such driver has qualified for a school bus endorsement under this section and complied with the pertinent rules and regulations of the department of revenue and any final rule issued by the secretary of the United States Department of Transportation or has a valid school bus endorsement on a valid commercial driver's license issued by another state. A school bus endorsement shall be issued to any applicant who meets the following qualifications:

(1) The applicant has a valid state license issued under this chapter;

(2) The applicant is at least twenty-one years of age; and

(3) The applicant has successfully passed an examination for the operation of a school bus as prescribed by the director of revenue. The examination shall include any examinations prescribed by the secretary of the United States Department of Transportation, and a driving test in the type of vehicle to be operated. The test shall be completed in the appropriate class of vehicle to be driven. For purposes of this section classes of school buses shall comply with the Commercial Motor Vehicle Safety Act of 1986 (Title XII of Pub. Law 99-570). For drivers who are at least seventy years of age, such examination**, excluding the pre-trip inspection portion of the commercial driver's license skills test,** shall be completed annually **to retain the school bus endorsement**.

2. The director of revenue, to the best of the director's knowledge, shall not issue or renew a school bus endorsement to any applicant whose driving record shows that such applicant's privilege to operate a motor vehicle has been suspended, revoked or disqualified or whose driving record shows a history of moving vehicle violations.

3. The director may adopt any rules and regulations necessary to carry out 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, 2004, shall be invalid and void.

4. Notwithstanding the requirements of this section, an applicant who resides in another state and possesses a valid driver's license from his or her state of residence with a valid school bus endorsement for the type of vehicle being operated shall not be required to obtain a Missouri driver's license with a school bus endorsement."; 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 Bill No. 687, Page 3, Section 160.530, Line 82, by inserting after all of said section and line the following:

"168.133. 1. The school district shall ensure that a criminal background check is conducted on any person employed after January 1, 2005, authorized to have contact with pupils and prior to the individual having contact with any pupil. Such persons include, but are not limited to, administrators, teachers, aides, paraprofessionals, assistants, secretaries, custodians, cooks, and nurses. The school district shall also ensure that a criminal background check is conducted for school bus drivers. The district may allow such drivers

to operate buses pending the result of the criminal background check. For bus drivers, the school district shall be responsible for conducting the criminal background check on drivers employed by the school district. For drivers employed by a pupil transportation company**, a municipality, or any other entity** under contract with the school district, the criminal background check shall be conducted pursuant to section 43.540 and conform to the requirements established in the National Child Protection Act of 1993, as amended by the Volunteers for Children Act. Personnel who have successfully undergone a criminal background check and a check of the family care safety registry as part of the professional license application process under section 168.021 and who have received clearance on the checks within one prior year of employment shall be considered to have completed the background check requirement. A criminal background check under this section shall include a search of any information publicly available in an electronic format through a public index or single case display.

2. In order to facilitate the criminal history background check, the applicant shall submit a set of fingerprints collected pursuant to standards determined by the Missouri highway patrol. The fingerprints shall be used by the highway patrol to search the criminal history repository and shall be forwarded to the Federal Bureau of Investigation for searching the federal criminal history files.

3. The applicant shall pay the fee for the state criminal history record information pursuant to section 43.530 and sections 210.900 to 210.936 and pay the appropriate fee determined by the Federal Bureau of Investigation for the federal criminal history record when he or she applies for a position authorized to have contact with pupils pursuant to this section. The department shall distribute the fees collected for the state and federal criminal histories to the Missouri highway patrol.

4. The department of elementary and secondary education shall facilitate an annual check of employed persons holding current active certificates under section 168.021 against criminal history records in the central repository under section 43.530, the sexual offender registry under sections 589.400 to **[**589.475**]** **589.426**, and child abuse central registry under sections 210.109 to 210.183. The department of elementary and secondary education shall facilitate procedures for school districts to submit personnel information annually for persons employed by the school districts who do not hold a current valid certificate who are required by subsection 1 of this section to undergo a criminal background check, sexual offender registry check, and child abuse central registry check. The Missouri state highway patrol shall provide ongoing electronic updates to criminal history background checks of those persons previously submitted, both those who have an active certificate and those who do not have an active certificate, by the department of elementary and secondary education. This shall fulfill the annual check against the criminal history records in the central repository under section 43.530.

5. The school district may adopt a policy to provide for reimbursement of expenses incurred by an employee for state and federal criminal history information pursuant to section 43.530.

6. If, as a result of the criminal history background check mandated by this section, it is determined that the holder of a certificate issued pursuant to section 168.021 has pled guilty or nolo contendere to, or been found guilty of a crime or offense listed in section 168.071, or a similar crime or offense committed in another state, the United States, or any other country, regardless of imposition of sentence, such information shall be reported to the department of elementary and secondary education.

7. Any school official making a report to the department of elementary and secondary education in conformity with this section shall not be subject to civil liability for such action.

8. For any teacher who is employed by a school district on a substitute or part-time basis within one year of such teacher's retirement from a Missouri school, the state of Missouri shall not require such teacher to be subject to any additional background checks prior to having contact with pupils. Nothing in this subsection shall be construed as prohibiting or otherwise restricting a school district from requiring additional background checks for such teachers employed by the school district.

9. A criminal background check and fingerprint collection conducted under subsections 1 and 2 of this section shall be valid for at least a period of one year and transferrable from one school district to another district. A school district may, in its discretion, conduct a new criminal background check and fingerprint collection under subsections 1 and 2 for a newly hired employee at the district's expense. A teacher's change in type of certification shall have no effect on the transferability or validity of such records.

10. Nothing in this section shall be construed to alter the standards for suspension, denial, or revocation of a certificate issued pursuant to this chapter.

11. The state board of education may promulgate rules for criminal history background checks made pursuant to 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 January 1, 2005, shall be invalid and void."; and

Further amend said bill, Page 4, Section 304.060, Line 25, by inserting after all of said line the following:

"**3. Notwithstanding the provisions of subsection 1 of this section, any school board in the state of Missouri may contract with any municipality for the purpose of transporting school children attending a grade or grades not lower than the ninth nor higher than the twelfth grade. Such contract shall require the presence of an adult supervisor who is approved by the school board on any municipal vehicle while such vehicle is transporting children under this subsection. Any time school children are being transported by a municipal vehicle under this subsection, such vehicle shall include a section of seating designated solely for use by school children. Municipalities entering into any such contract shall comply with the requirements of this section and sections 162.064, 162.065, 168.133, and 307.375.**"; and

Further amend said bill and section, by renumbering subsequent subsections accordingly; 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 **HCS** for **SB 806**, entitled:

An Act to repeal sections 473.730, 473.770, 473.771, 475.010, 475.016, 475.050, 475.060, 475.061, 475.062, 475.070, 475.075, 475.078, 475.079, 475.080, 475.082, 475.083, 475.094, 475.120, 475.123,

475.125, 475.130, 475.145, 475.230, 475.270, 475.276, 475.290, 475.320, 475.322, 475.355, and 630.005, RSMo, and to enact in lieu thereof thirty-seven new sections relating to guardianship proceedings.

With House Amendment Nos. 1, 2, 3, 5 and 6.

HOUSE AMENDMENT NO. 1

Amend House Committee Substitute for Senate Bill No. 806, Page 18, Section 475.075, Line 112, by deleting the words "**with such assistance**"; and

Further amend said bill, Page 23, Section 475.082, Line 28, by inserting immediately after the word "guardian;" the word "**and**"; and

Further amend said bill, page, and section, Line 29, by deleting the number "**(9)**"; and

Further amend said bill, page, and section, Line 30, by deleting said line; and

Further amend said bill, page, and section, Lines 31-34, by deleting said lines and inserting in lieu thereof the following:

"**(9) A summarized plan for the coming year. If an individual support plan, treatment plan, or plan of care is in place, such plan may be submitted in lieu of the requirements of this subdivision.**"; and

Further amend said bill, Page 27, Section 475.094, Lines 44-46, by deleting said lines and inserting in lieu thereof the following:

"**durable power of attorney of which the protectee is the principal.**"; and

Further amend said bill, Page 28, Section 475.123, Lines 1-5, by deleting said lines and inserting in lieu thereof the following:

"1. No medical or surgical procedure shall be performed on any ward unless consent is obtained from the guardian of his person except as provided in subsections 2 and 3 hereof."; and

Further amend said bill and section, Pages 28-29, Lines 18-34, by deleting said lines; and

Further amend said bill and section, Page 29, Line 35, by deleting the number "**(2)**" and inserting in lieu thereof the number "**5.**"; and

Further amend said bill, page, and section, Line 38, by deleting the number "**8.**" and inserting in lieu thereof the number "**6.**"; and

Further amend said bill, Page 31, Section 475.130, Lines 61-63, by deleting said lines; and

Further amend said bill, page, and section, Line 64, by deleting said line and inserting in lieu thereof the following:

"**(12) Deposit funds in a bank;**"; and

Further amend said bill, page, and section, Lines 65-67, by deleting said lines; and

Further amend said bill, page, and section, by renumbering subsequent subdivisions accordingly; and

Further amend said bill and section, Page 32, Lines 70-73, by deleting said lines; and

Further amend said bill, page, and section, Lines 75-76, by deleting said lines and inserting in lieu thereof the words "**protection of estate assets;**"; and

Further amend said bill, page, and section, by renumbering subsequent subdivisions accordingly; and

Further amend said bill, Page 33, Section 475.270, Lines 31-32, by deleting said lines and inserting in lieu thereof the following:

"**(7) A plan for the coming year; and**"; and

Further amend said bill, Pages 35-36, Section 475.322, Lines 1-46, by deleting all of said section and lines from the bill; and

Further amend said bill, Pages 37-38, Section 475.344, Lines 1-13, by deleting all of said section and lines from the bill; 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 Bill No. 806, Page 10, Section 475.050, Lines 19-20, by deleting said lines and inserting in lieu thereof the following:

"**disabled person. If the incapacitated or disabled person is a minor under the care of the children's division and is entering adult guardianship or conservatorship, it shall be a rebuttable presumption that he or she has no relative suitable and willing to serve as guardian or conservator.**"; and

Further amend said bill, Page 16, Section 475.075, Lines 23-27, by deleting said lines from the bill; 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 Bill No. 806, Page 1, Section A, Line 9, by inserting after all of said section and line the following:

"473.397. All claims and statutory allowances against the estate of a decedent shall be divided into the following classes:

(1) Costs;

(2) Expenses of administration;

(3) Exempt property, family and homestead allowances;

(4) Funeral expenses;

(5) Debts and taxes due the United States of America;

(6) **Debts for medical assistance due to the state of Missouri under section 473.398;**

(7) Expenses of the last sickness, wages of servants, claims for medicine and medical attendance during the last sickness, and the reasonable cost of a tombstone;

[(7)**] (8)** Debts and taxes due the state of Missouri, any county, or any political subdivision of the state

of Missouri;

[(8)**] (9)** Judgments rendered against the decedent in his lifetime and judgments rendered upon attachments levied upon property of decedent during his lifetime;

[(9)**] (10)** All other claims not barred by section 473.360.

473.398. 1. Upon the death of a person, who has been a participant of aid, assistance, care, services, or who has had moneys expended on his behalf by the department of health and senior services, department of social services, or the department of mental health, or by a county commission, the total amount paid to the decedent or expended upon his behalf after January 1, 1978, shall be a debt due the state or county, as the case may be, from the estate of the decedent. The debt shall be collected as provided by the probate code of Missouri, chapters 472, 473, 474 and 475.

2. Procedures for the allowance of such claims shall be in accordance with this chapter, and such claims shall be allowed as a claim of **[**the seventh**] either the sixth or eighth** class under **[**subdivision (7)**] subdivisions (6) and (8)** of section 473.397.

3. Such claim shall not be filed or allowed if it is determined that:

(1) The cost of collection will exceed the amount of the claim;

(2) The collection of the claim will adversely affect the need of the surviving spouse or dependents of the decedent to reasonable care and support from the estate.

4. Claims consisting of moneys paid on the behalf of a participant as defined in 42 U.S.C. 1396 shall be allowed, except as provided in subsection 3 of this section, upon the showing by the claimant of proof of moneys expended. Such proof may include but is not limited to **[**the following items which are deemed to be competent and substantial evidence of payment:

(1)**]** computerized records maintained by any governmental entity as described in subsection 1 of this section of a request for payment for services rendered to the participant**[**; and

(2) The certified statement of the treasurer or his designee that the payment was made**], which shall be deemed to be competent and substantial evidence of payment**.

5. The provisions of this section shall not apply to any claims, adjustments or recoveries specifically prohibited by federal statutes or regulations duly promulgated thereunder. Further, the federal government shall receive from the amount recovered any portion to which it is entitled.

6. Before any probate estate may be closed under this chapter, with respect to a decedent who, at the time of death, was enrolled in MO HealthNet, the personal representative of the estate shall file with the clerk of the court exercising probate jurisdiction a release from the MO HealthNet division evidencing payment of all MO HealthNet benefits, premiums, or other such costs due from the estate under law, unless waived by the MO HealthNet division.”; 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 Bill No. 806, Page 25, Section 475.083, Line 59, by inserting immediately after said section and line the following:

"**475.084. If a guardian has been appointed for a minor under the provisions of subdivision (2) of subsection 4 of section 475.030, then a parent of the minor may petition the court for periods of visitation. The court may order visitation if visitation is in the best interest of the child.**"; 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 Bill No. 806, Page 1, Section A, Line 9, by inserting immediately after all of said section and line the following:

"451.090. 1. No recorder shall, in any event except as herein provided, issue a license authorizing the marriage of any person under **[**fifteen**]** **seventeen** years of age; provided, however, that such license may be issued on order of a circuit or associate circuit judge of the county in which the license is applied for, such license being issued only **[**for good cause shown and by reason of such unusual conditions as to**]** **after a hearing has been held in which the parties present evidence to the court that would** make such marriage advisable. **The court, in its order, shall determine that there is no evidence of coercion or abuse of either person entering the marriage.**

2. No recorder shall issue a license authorizing the marriage of any male under the age of eighteen years or of any female under the age of eighteen years, except with the consent of his or her custodial parent or guardian, which consent shall be given at the time, in writing, stating the residence of the person giving such consent, signed and sworn to before an officer authorized to administer oaths. **In no instance shall a license be issued authorizing the marriage of any person twenty-one years of age or older if the other party to the marriage is under seventeen years of age or if either party is under fifteen years of age.**

3. The recorder shall state in every license whether the parties applying for same, one or either or both of them, are of age, or whether the male is under the age of eighteen years or the female under the age of eighteen years, and if the male is under the age of eighteen years or the female is under the age of eighteen years, the name of the custodial parent or guardian consenting to such marriage. **Applicants shall provide proof of age to the recorder in the form of a certified copy of the applicant's birth certificate, passport, or other government-issued identification, which shall then be documented by the recorder.**"; 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.

CONFERENCE COMMITTEE APPOINTMENTS

President Pro Tem Richard appointed the following conference committee to act with a like committee from the House on **SCS** for **SB 892**, with **HA 1**, **HA 2**, **HA 3**, **HA 4** and **HA 5**: Senators Walsh, Sifton, Munzlinger, Cunningham and Crawford.

REFERRALS

President Pro Tem Richard referred **SCR 55** to the Committee on Rules, Joint Rules, Resolutions and Ethics.

President Pro Tem Richard referred **HCS** for **HB 1456**, with **SCS**; **HCS** for **HB 1872**; **HB 1516**; **HCS** for **HB 1388**, with **SCS**; and **HB 1719**, with **SCS**, to the Committee on Fiscal Oversight.

INTRODUCTION OF GUESTS

Senator Kehoe introduced to the Senate, Ella Glaser, Jefferson City.

Senator Walsh introduced to the Senate, Brett A. Combs, Wichita, Kansas; and Nickolas Allison, Eldorado Springs.

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

SENATE CALENDAR

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SIXTY-SIXTH DAY–TUESDAY, MAY 8, 2018

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FORMAL CALENDAR

HOUSE BILLS ON SECOND READING

HB 2538-Pietzman
HB 2499-Hansen
HB 2438-Remole
HCS for HB 2407
HCS for HB 1739
HCS for HB 1554
HCB 23-Dogan
HCS for HB 2019

THIRD READING OF SENATE BILLS

SS for SB 579-Libla (In Fiscal Oversight)
SS for SB 699-Sifton (In Fiscal Oversight)

SENATE BILLS FOR PERFECTION

1. SJR 36-Schatz, with SCS
2. SB 678-Eigel
3. SB 1102-Kehoe, with SCS
4. SB 1015-Wieland, with SCS
5. SB 709-Schatz, with SCS
6. SB 640-Sater
7. SB 963-Wieland, with SCS
8. SB 952-Rowden
9. SB 864-Hoskins
10. SB 998-Schatz, with SCS
11. SB 703-Hegeman
12. SB 915-Crawford
13. SB 934-Hegeman
14. SB 988-Rowden, with SCS
15. SB 790-Cierpiot, with SCS
16. SB 734-Schatz, with SCS

HOUSE BILLS ON THIRD READING

1. HB 1267-Lichtenegger (Munzlinger)
2. HB 1415-Lauer (Wasson)
3. HB 1968-Grier (Schatz)
4. HB 2330-Beck (Sifton)
5. HB 1887-Bahr (Onder)
6. HB 1247-Pike (Onder)
7. HB 1831-Ruth (Wieland)
8. HCS for HB 1635, with SCS (Wallingford)

9. HCS for HB 2171 (Sater)
10. HCS for HB 1364, with SCS (Munzlinger) (In Fiscal Oversight)
11. HB 1646-Eggleston (Hegeman)
12. HB 1809-Tate (Schatz)
13. HB 1252-Plocher (Riddle)
14. HCS for HB 1251, with SCS (Crawford)
15. HCS#2 for HB 1503, with SCS (Hoskins)
16. HCS for HB 1614 (Hegeman)
17. HCS for HB 1264 (Hegeman)
18. HCS for HB 1611 (Riddle)
19. HCS for HB 2119 (Rowden)
20. HCS for HB 2079, with SCS (Crawford)
21. HCS for HB 1710, with SCS (Eigel)
22. HB 1484-Brown (57) (Romine)
23. HJR 59-Brown (57) (Romine)
24. HCS for HB 2017 (Brown)
25. HCS for HB 2018 (Brown)
26. HB 2183-Bondon (Crawford)
27. HCS for HB 2216, with SCS (Emery)
28. HCS for HB 1456, with SCS (Wallingford) (In Fiscal Oversight)
29. HCS for HB 1872 (Hegeman) (In Fiscal Oversight)
30. HB 1998-Bondon, with SCS (Emery)
31. HB 1516-Wiemann (Riddle) (In Fiscal Oversight)
32. HCS for HB 1388, with SCS (Schatz) (In Fiscal Oversight)
33. HB 1719-Grier, with SCS (Riddle) (In Fiscal Oversight)
34. HB 2179-Richardson (Kehoe)
35. HB 2043-Tate (Wasson)
36. HB 1558-Neely, with SCS (Romine)
37. HB 1389-Fitzpatrick, with SCS (Schatz)
38. HB 1633-Corlew, with SCS (Dixon)
39. HB 1250-Plocher, with SCS (Dixon)
40. HCS for HB 2042, with SCS (Dixon)
41. HCS for HB 1868, with SCS (Riddle)
42. HCS for HB 2249, with SCS (Riddle)
43. HCS for HB 2540, with SCS (Eigel)
44. HCS for HB 2129 (Romine)
45. HB 1446-Eggleston, with SCS (Sater)
46. HCS for HBs 2337 & 2272, with SCS (Wieland)
47. HCS for HBs 2277 & 1983, with SCS
48. HCS for HB 2031 (Hoskins)

INFORMAL CALENDAR

THIRD READING OF SENATE BILLS

SS#2 for SCS for SBs 617, 611 & 667-Eigel (In Fiscal Oversight)

SENATE BILLS FOR PERFECTION

SB 546-Munzlinger, with SS#4 (pending)
SB 550-Wasson, with SCS
SBs 555 & 609-Brown, with SCS
SB 556-Brown, with SA 1 (pending)
SB 561-Sater, with SA 1 (pending)
SB 567-Cunningham, with SCS, SS for SCS, SA 1 & SA 1 to SA 1 (pending)
SB 578-Romine
SB 591-Hegeman, with SCS
SB 596-Riddle, with SCS
SB 599-Schatz
SB 602-Onder, with SCS
SB 612-Koenig, with SCS, SS#2 for SCS, SA 2, SSA 1 for SA 2 & SA 1 to SSA 1 for SA 2 (pending)
SB 663-Schatz, with SCS, SS for SCS & SA 1 (pending)
SB 730-Wallingford, with SCS & SA 1 (pending)
SB 751-Schatz

SB 767-Hoskins, with SCS, SS for SCS & SA 2 (pending)
SB 774-Munzlinger
SB 813-Riddle, with SCS & SA 1 (pending)
SB 822-Hegeman, with SCS & SS for SCS (pending)
SB 832-Rowden, with SCS, SS#2 for SCS & point of order (pending)
SB 837-Rowden
SB 848-Riddle
SB 849-Kehoe and Schupp, with SCS, SA 1 & SA 1 to SA 1 (pending)
SB 859-Koenig, with SCS & SS for SCS (pending)
SB 860-Koenig, with SCS, SS for SCS & SA 1 (pending)
SB 861-Hegeman, with SCS
SB 865-Kehoe
SB 893-Sater, with SCS, SS for SCS & SA 1 (pending)
SB 912-Rowden, with SCS & SS#3 for SCS (pending)
SB 920-Riddle, with SS & SA 2 (pending)
SB 928-Onder, with SCS
SB 949-Emery, with SCS, SS for SCS & SA 2 (pending)
SB 1003-Wasson, with SS & SA 1 (pending)
SB 1021-Dixon and Wallingford, with SCS

HOUSE BILLS ON THIRD READING

HCS for HBs 1288, 1377 & 2050, with SCS (Dixon)
HB 1303-Alferman, with SCS (Rowden)
HB 1329-Remole, with SCS, SS for SCS & SA 5 (pending) (Munzlinger)
SS for SCS for HB 1350-Smith (163) (Rowden)
SS for SCS for HB 1355-Phillips (Schatz)
HB 1409-Fitzpatrick (Kehoe)
HB 1413-Taylor, with SCS, SS for SCS & SA 1 (pending) (Onder)
HB 1428-Muntzel, with SS, SA 1 & SSA 1 for SA 1 (pending) (Munzlinger)
HB 1442-Alferman, with SCS, SS for SCS & SA 1 (pending) (Schatz)
HCS for HB 1443, with SCS (Sater)
HCS for HB 1461 (Rowden)
HB 1578-Kolkmeyer (Munzlinger)
HCS for HB 1597, with SCS (Dixon)
HCS for HB 1605, with SCS (Kehoe)
SS for HCS for HB 1606 (Romine) (In Fiscal Oversight)
HCS for HB 1617, with SCS, SS#2 for SCS & SA 1 (pending) (Onder)
HB 1630-Evans (Rowden)
HCS for HB 1645 (Rowden)
HB 1691-Miller, with SCS & SS for SCS (pending) (Emery)
HCS for HBs 1729, 1621 & 1436 (Brown)
HB 1769-Mathews, with SCS (Schatz)
HCS for HB 1796, with SS (pending) (Rowden)
HCS for HB 1991, with SCS (Rowden)
HB 2026-Wilson, with SCS (Rowden)
HB 2044-Taylor, with SCS (pending) (Dixon)
HB 2122-Engler, with SCS (Schatz)

SENATE BILLS WITH HOUSE AMENDMENTS

SB 660-Riddle, with HCS, as amended
SB 687-Sater, with HCS, as amended
SCS for SB 718-Eigel, with HCS, as amended
SB 768-Hoskins, with HA 1 & HA 2, as amended
SB 806-Crawford, with HCS, as amended

BILLS IN CONFERENCE AND BILLS CARRYING REQUEST MESSAGES

In Conference

SB 569-Cunningham, with HCS, as amended
SS for SB 608-Hoskins, with HCS
SS for SCS for SB 707-Schatz, with HCS, as amended
SS for SCS for SB 775-Brown, with HCS, as amended
SS for SCS for SB 826-Sater, with HCS, as amended
SS for SB 870-Hegeman, with HCS, as amended
SCS for SB 892-Walsh, with HA 1, HA 2, HA 3, HA 4 & HA 5
HB 1291-Henderson, with SS for SCS, as amended (Romine)
(House adopted CCR and passed CCS)
HB 1858-Christofanelli, with SS (Eigel)
HCS for HB 1879, with SS for SCS, as amended (Cunningham)
HCS for HB 2002, with SCS (Brown)
HCS for HB 2003, with SCS (Brown)
HCS for HB 2004, with SCS (Brown)
HCS for HB 2005, with SCS (Brown)
HCS for HB 2006, with SCS, as amended (Brown)
HCS for HB 2007, with SCS, as amended (Brown)
HCS for HB 2008, with SCS (Brown)
HCS for HB 2009, with SCS (Brown)
HCS for HB 2010, with SS for SCS (Brown)
HCS for HB 2011, with SCS (Brown)
HCS for HB 2012, with SCS (Brown)
HCS for HB 2013, with SCS (Brown)

RESOLUTIONS

SR 1137-Walsh, with SS (pending)
SR 1487-Schaaf

Reported from Committee

SCR 30-Wallingford, with SA 1 (pending)
SCR 35-Hegeman
SCR 50-Hegeman
SCR 52-Emery
HCR 70-Franks, Jr. (Nasheed)

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