FIRST REGULAR SESSION

[PERFECTED**]**

SENATE SUBSTITUTE NO. 2 FOR

SENATE BILL NO. 79

103RD GENERAL ASSEMBLY

INTRODUCED BY SENATOR GREGORY (21).

0769S.09P KRISTINA MARTIN, Secretary

AN ACT

To repeal sections 191.648, 191.1145, 192.769, 208.152, 210.030, and 354.465, RSMo, and to enact in lieu thereof eight new sections relating to health care.

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

Section A. Sections 191.648, 191.1145, 192.769, 208.152, 210.030, and 354.465, RSMo, are repealed and eight new sections enacted in lieu thereof, to be known as sections 191.648, 191.1145, 192.2521, 208.152, 210.030, 354.465, 376.1240, and 376.1850, to read as follows:

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

(1) "Designated sexually transmitted infection", chlamydia, gonorrhea, trichomoniasis, or any other sexually transmitted infection designated as appropriate for expedited partner therapy by the department of health and senior services or for which expedited partner therapy was recommended in the most recent Centers for Disease Control and Prevention guidelines for the prevention or treatment of sexually transmitted infections;

(2) "Expedited partner therapy" **[**means**]**, the practice of treating the sex partners of persons with **[**chlamydia or gonorrhea**] designated sexually transmitted infections**

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

without an intervening medical evaluation or professional prevention counseling;

(3) "Health care professional", a member of any profession regulated by chapter 334 or 335 authorized to prescribe medications.

2. Any licensed physician **or health care professional** may, but shall not be required to, utilize expedited partner therapy for the management of the partners of persons with **[**chlamydia or gonorrhea**]** **designated sexually transmitted infections.** Notwithstanding the requirements of 20 CSR 2150-5.020(5) or any other law to the contrary, a licensed physician **or health care professional** utilizing expedited partner therapy may prescribe and dispense medications for the treatment of **[**chlamydia or gonorrhea**]** **a designated sexually transmitted infection** for an individual who is the partner of a person with **[**chlamydia or gonorrhea**]** **a designated sexually transmitted infection** and who does not have an established physician/patient relationship with such physician **or an established health care professional/patient relationship with such health care professional. [**Any antibiotic medications prescribed and dispensed for the treatment of chlamydia or gonorrhea under this section shall be in pill form.**]**

3. Any licensed physician **or health care professional** utilizing expedited partner therapy for the management of the partners with **[**chlamydia or gonorrhea**]** **designated sexually transmitted infections** shall provide explanation and guidance to **[**a**]** **each** patient **[**diagnosed with chlamydia or gonorrhea**]** of the preventative measures that can be taken by the patient to stop the **[**spread**]** **transmission** of such **[**diagnosis**]** **infection.**

4. Any licensed physician **or health care professional** utilizing expedited partner therapy for the management of partners of persons with **[**chlamydia or gonorrhea**]** **designated sexually transmitted infections** under this section shall have immunity from any civil liability that may otherwise result by reason of such actions, unless such physician **or health care professional** acts negligently, recklessly, in bad faith, or with malicious purpose.

5. The department of health and senior services and the division of professional registration within the department of commerce and insurance shall by rule develop guidelines for the implementation of subsection 2 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, 2010, shall be invalid and void.

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

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

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

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

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

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

(6) "Telehealth" or "telemedicine", the delivery of health care services by means of information and communication technologies, **including audiovisual and audio-only technologies**, which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology. **Health care providers shall not be limited in their choice of electronic platforms used to deliver telehealth or telemedicine, provided that all services delivered are in accordance with the Health Insurance Portability and Accountability Act of 1996.**

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

not be construed to prohibit a health carrier, as defined in section 376.1350, from reimbursing nonclinical staff for services otherwise allowed by law.

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

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

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

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

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

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

6. No originating site for services or activities provided under this section shall be required to maintain immediate availability of on-site clinical staff during the telehealth services, except as necessary to meet the

standard of care for the treatment of the patient's medical condition if such condition is being treated by an eligible health care provider who is not at the originating site, has not previously seen the patient in person in a clinical setting, and is not providing coverage for a health care provider who has an established relationship with the patient. **Health care providers shall not be limited in their choice of electronic platforms used to deliver telehealth or telemedicine.**

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

192.2521. A specialty hospital is exempt from the provisions of sections 192.2520 and 197.135 if such hospital has a policy for transfer of a victim of a sexual assault to an appropriate hospital with an emergency department. As used in this section, "specialty hospital" means a hospital that has been designated by the department of health and senior services as something other than a general acute care hospital.

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

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide

through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX

of the federal Social Security Act (42 U.S.C. Section **[**301**]** **1396**, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

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

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere, provided, that no funds shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate, as defined in section 188.015, of such abortion facility;

(7) Subject to appropriation, up to twenty visits per year for services limited to examinations, diagnoses, adjustments, and manipulations and treatments of

malpositioned articulations and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand MO HealthNet services;

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

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

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

(11) Home health care services;

(12) Family planning as defined by federal rules and regulations; provided, that no funds shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate, as defined in section 188.015, of such abortion facility; and further provided, however, that such family planning services shall not include abortions or any abortifacient drug or device that is used for the purpose of

inducing an abortion unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term;

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

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

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

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

(16) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section **[**301**]** **1396, et seq.**, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

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

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

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

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

(18) The services of an advanced practice registered nurse with a collaborative practice agreement to the extent

that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

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

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

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

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

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

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

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant

intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(20) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

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

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

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

(24) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(25) **Medically necessary cochlear implants and hearing instruments, as defined in section 345.015, that are:**

(a) Prescribed by an audiologist, as defined in section 345.015; or

(b) Dispensed by a hearing instrument specialist, as defined in section 346.010;

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

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

(1) Dental services;

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

(3) Optometric services as described in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, **[**hearing aids,**]** and wheelchairs;

(5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and

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

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. 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 subdivision 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, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (15) and (16) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of

the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

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

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at

least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated thereunder.

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

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

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

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

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

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

12. If the Missouri Medicaid audit and compliance unit changes any interpretation or application of the requirements for reimbursement for MO HealthNet services from the interpretation or application that has been applied previously by the state in any audit of a MO HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO HealthNet providers five business days before such change shall take effect. Failure of the Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to continue to receive and retain reimbursement until such notification is provided and shall waive any liability of such provider for recoupment or other loss of any payments previously made prior to the five business days after such notice has been sent. Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall agree to receive communications electronically. The notification required under this section shall be delivered in writing by the United States Postal Service or electronic mail to each provider.

13. Nothing in this section shall be construed to abrogate or limit the department's statutory requirement to promulgate rules under chapter 536.

14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems shall be reimbursed utilizing the behavior assessment and intervention reimbursement codes 96150 to 96154 or their successor codes under the Current Procedural Terminology (CPT) coding system. Providers eligible for such reimbursement shall include psychologists.

15. There shall be no payments made under this section for gender transition surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section 191.1720, for the purpose of a gender transition.

210.030. 1. Every licensed physician, midwife, registered nurse and all persons who may undertake, in a professional way, the obstetrical and gynecological care of a pregnant woman in the state of Missouri shall, if the woman consents, take or cause to be taken a sample of venous blood of such woman at the time of the first prenatal examination, or not later than twenty days after the first prenatal examination, **another sample at twenty-eight weeks of pregnancy, and another sample immediately after birth** and subject such **[**sample**]** **samples** to an approved and standard serological test for syphilis**[**, an**]** **and** approved serological **[**test**]** **tests** for hepatitis B, **hepatitis C, human immunodeficiency virus (HIV),** and such other treatable diseases and metabolic disorders as are prescribed by the department of health and senior services. **[**In any area of the state designated as a syphilis outbreak area by the department of health and senior services, if the mother consents, a sample of her venous blood shall be taken later in the course of pregnancy and at delivery for additional

testing for syphilis as may be prescribed by the department**]** **If a mother tests positive for syphilis, hepatitis B, hepatitis C, or HIV, or any combination of such diseases, the physician or person providing care shall administer treatment in accordance with the most recent accepted medical practice.** If a mother tests positive for hepatitis B, the physician or person who professionally undertakes the pediatric care of a newborn shall also administer the appropriate doses of hepatitis B vaccine and hepatitis B immune globulin (HBIG) in accordance with the current recommendations of the Advisory Committee on Immunization Practices (ACIP). If the mother's hepatitis B status is unknown, the appropriate dose of hepatitis B vaccine shall be administered to the newborn in accordance with the current ACIP recommendations. If the mother consents, a sample of her venous blood shall be taken. If she tests positive for hepatitis B, hepatitis B immune globulin (HBIG) shall be administered to the newborn in accordance with the current ACIP recommendations.

2. The department of health and senior services shall**[**, in consultation with the Missouri genetic disease advisory committee,**]** make such rules pertaining to such tests as shall be dictated by accepted medical practice, and tests shall be of the types approved **or accepted** by the **[**department of health and senior services. An approved and standard test for syphilis, hepatitis B, and other treatable diseases and metabolic disorders shall mean a test made in a laboratory approved by the department of health and senior services**] United States Food and Drug Administration.** No individual shall be denied testing by the department of health and senior services because of inability to pay.

3. All persons providing care under this section shall do so pursuant to the provisions of section 431.061.

354.465. 1. The director, or any duly appointed representative, may make an examination of the affairs of any health maintenance organization as often as he deems it necessary for the protection of the interests of the people of this state**[**, but not less frequently than once every five years**]**.

2. All costs incurred by the state as a result of making examinations under this section shall be paid by the organization being examined and remitted as provided in section 374.160.

376.1240. 1. For purposes of this section, terms shall have the same meanings as ascribed to them in section 376.1350, and the term "self-administered hormonal contraceptive" shall mean a drug that is composed of one or more hormones and that is approved by the Food and Drug Administration to prevent pregnancy, excluding emergency contraception. Nothing in this section shall be construed to apply to medications approved by the Food and Drug Administration to terminate an existing pregnancy.

2. Any health benefit plan delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2026, that provides coverage for self-administered hormonal contraceptives shall provide coverage to reimburse a health care provider or dispensing entity for the dispensing of a supply of self-administered hormonal contraceptives intended to last up to ninety days, or intended to last up to one hundred eighty days for generic self-administered hormonal contraceptives.

3. The coverage required under 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.

376.1850. 1. As used in this section, the following terms mean:

(1) "Contract for health care benefits", a self-funded contractual arrangement made in accordance with this section between a qualified membership organization and its members to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(2) "Farm bureau", a nonprofit agricultural membership organization first incorporated in this state at least one hundred years ago, or an affiliate designated by the nonprofit agricultural membership organization;

(3) "Health care service", the same meaning as is ascribed to such term in section 376.1350;

(4) "Member of a qualified membership organization", a natural person who pays periodic dues or fees, other than payments for a contract for health care benefits, for membership in a qualified membership organization, and the natural person's spouse or dependent children under the age of twenty-six;

(5) "Qualified membership organization", a farm bureau, or an entity with at least one hundred thousand dues paying members, that is governed by a council of its members, that has at least five hundred million dollars in assets, and that exists to serve its members beyond solely offering health coverage.

2. The provisions of this chapter relating to health insurance, health maintenance organizations, health benefit plans, group health services, and health carriers shall not apply to contracts for health care benefits provided by a qualified membership organization. A qualified membership

organization providing contracts for health care benefits shall not be considered to be engaging in the business of insurance for purposes of any provision of chapters 361 to 385.

3. It is unlawful to provide a contract for health care benefits under this section unless the qualified membership organization providing the contract is registered with the department of commerce and insurance as provided in this subsection. To register as a qualified membership organization, an applicant shall file information with the director demonstrating it meets the requirements of this section and pay an application fee of two hundred and fifty dollars. A registration is valid for five years and may be renewed for additional five year terms if the qualified membership organization continues to meet the requirements of this section and pays a renewal fee of two hundred and fifty dollars. All amounts collected as registration or renewal fees shall be deposited into the insurance dedicated fund established under section 374.150.

4. Contracts for health care benefits provided under this section shall be offered only to members of a qualified membership organization who have been members of the organization for at least thirty days; and shall be sold, solicited, or negotiated only by insurance producers licensed under chapter 375 to produce accident and health or sickness coverage.

5. Notwithstanding any provision of law to the contrary, a qualified membership organization providing a contract for health care benefits under this section shall use the services of an administrator permitted to provide services in accordance with sections 376.1075 to 376.1095, and shall agree in the contract with such administrator to

utilize processes for benefit determinations and claims payment procedures in accordance with the requirements applicable to health carriers and health benefit plans under sections 376.383, 376.690, and 376.1367. A contract for health care benefits provided under this section shall not be subject to the laws of this state relating to insurance or insurance companies except as specified in this section.

6. The risk under contracts provided in accordance with this section may be reinsured in accordance with section 375.246.

7. (1) Contracts for health care benefits under this section shall include the following written disclaimer on the front of the contract and all related applications and renewal forms in a bold font no smaller than sixteen point:

"NOTICE

This contract is not health insurance and is not subject to federal or state laws relating to health insurance. This contract offers fewer benefits than an ACA-compliant health plan and may exclude coverage for preexisting conditions. You may qualify for income-based subsidies through the ACA Health Insurance Marketplace. This contract is not covered by the Missouri Insurance Guaranty Association. You may be financially responsible for costs of medical treatment that may not be covered under this contract.".

(2) The written disclaimers required by subdivision (1) of this subsection on applications and renewal forms shall be signed by the member entering into or renewing the contract, specifically acknowledging that the coverage is

not considered insurance and is not subject to regulation by the department of commerce and insurance.

(3) The qualified membership organization providing the contract shall retain a copy of written acknowledgements required under subdivision (2) of this subsection for the duration for which claims may be submitted under the contract, and shall provide a copy of the acknowledgement to the member upon the member's request.

8. Contracts provided under this section shall not be subject to individual post-claim medical underwriting while coverage remains in effect, and no member covered under a contract provided under this section shall be subject to cancellation, nonrenewal, modification, or increase in premium for reason of a medical event.

9. Notwithstanding subsection 2 of this section, the department of commerce and insurance shall receive and review complaints and inquiries from members of a qualified membership organization, pursuant to section 374.085, subject to section 374.071.

10. By March thirty-first of each year, each qualified membership organization providing a contract for health care benefits under this section, or its administrator, shall pay to the director a fee equal to one percent of the Missouri claims paid under this section during the immediately preceding year. Funds collected by the director shall be deposited in the insurance dedicated fund established under section 374.150.

11. No qualified membership organization, or other entity on behalf of a qualified membership organization, shall refer to a contract for health care benefits under this section as insurance or health insurance in any marketing, advertising, or other communication with the

public or members of the qualified membership organization. Violation of this subsection shall be an unlawful practice under section 407.020.

12. Contracts for health care benefits provided under this section:

(1) Shall include coverage for:

(a) Ambulatory patient services;

(b) Hospitalization;

(c) Emergency services, as defined in section 376.1350; and

(d) Laboratory services; and

(2) Shall not be subject to an annual limit of less than two million dollars per year.

[192.769. 1. On completion of a mammogram, a mammography facility certified by the United States Food and Drug Administration (FDA) or by a certification agency approved by the FDA shall provide to the patient the following notice:

"If your mammogram demonstrates that you have dense breast tissue, which could hide abnormalities, and you have other risk factors for breast cancer that have been identified, you might benefit from supplemental screening tests that may be suggested by your ordering physician. Dense breast tissue, in and of itself, is a relatively common condition. Therefore, this information is not provided to cause undue concern, but rather to raise your awareness and to promote discussion with your physician regarding the presence of other risk factors, in addition to dense breast tissue. A report of your

mammography results will be sent to you and your physician. You should contact your physician if you have any questions or concerns regarding this report.".

2. Nothing in this section shall be construed to create a duty of care beyond the duty to provide notice as set forth in this section.

3. The information required by this section or evidence that a person violated this section is not admissible in a civil, judicial, or administrative proceeding.

4. A mammography facility is not required to comply with the requirements of this section until January 1, 2015.**]**

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