

FIRST REGULAR SESSION
[TRULY AGREED TO AND FINALLY PASSED]
SENATE SUBSTITUTE NO. 2 FOR
SENATE BILL NO. 79
103RD GENERAL ASSEMBLY
2025

0769S.09T

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,
2 210.030, and 354.465, RSMo, are repealed and eight new sections
3 enacted in lieu thereof, to be known as sections 191.648,
4 191.1145, 192.2521, 208.152, 210.030, 354.465, 376.1240, and
5 376.1850, to read as follows:

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

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

11 (2) **"Expedited partner therapy" [means], the practice**
12 **of treating the sex partners of persons with [chlamydia or**
13 **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.

14 without an intervening medical evaluation or professional
15 prevention counseling;

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

19 2. Any licensed physician or health care professional
20 may, but shall not be required to, utilize expedited partner
21 therapy for the management of the partners of persons with
22 [chlamydia or gonorrhea] designated sexually transmitted
23 infections. Notwithstanding the requirements of 20 CSR 2150-
24 5.020(5) or any other law to the contrary, a licensed
25 physician or health care professional utilizing expedited
26 partner therapy may prescribe and dispense medications for
27 the treatment of [chlamydia or gonorrhea] a designated
28 sexually transmitted infection for an individual who is the
29 partner of a person with [chlamydia or gonorrhea] a
30 designated sexually transmitted infection and who does not
31 have an established physician/patient relationship with such
32 physician or an established health care professional/patient
33 relationship with such health care professional. [Any
34 antibiotic medications prescribed and dispensed for the
35 treatment of chlamydia or gonorrhea under this section shall
36 be in pill form.]

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

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

53 5. The department of health and senior services and
54 the division of professional registration within the
55 department of commerce and insurance shall by rule develop
56 guidelines for the implementation of subsection 2 of this
57 section. Any rule or portion of a rule, as that term is
58 defined in section 536.010, that is created under the
59 authority delegated in this section shall become effective
60 only if it complies with and is subject to all of the
61 provisions of chapter 536 and, if applicable, section
62 536.028. This section and chapter 536 are nonseverable and
63 if any of the powers vested with the general assembly
64 pursuant to chapter 536 to review, to delay the effective
65 date, or to disapprove and annul a rule are subsequently
66 held unconstitutional, then the grant of rulemaking
67 authority and any rule proposed or adopted after August 28,
68 2010, shall be invalid and void.

 191.1145. 1. As used in sections 191.1145 and
2 191.1146, the following terms shall mean:

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

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

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

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

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

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

35 2. Any licensed health care provider shall be
36 authorized to provide telehealth services if such services
37 are within the scope of practice for which the health care
38 provider is licensed and are provided with the same standard
39 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

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

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

34 (3) Laboratory and X-ray services;

35 (4) Nursing home services for participants, except to
36 persons with more than five hundred thousand dollars equity
37 in their home or except for persons in an institution for
38 mental diseases who are under the age of sixty-five years,
39 when residing in a hospital licensed by the department of
40 health and senior services or a nursing home licensed by the
41 department of health and senior services or appropriate
42 licensing authority of other states or government-owned
43 and -operated institutions which are determined to conform to
44 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

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

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

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

127 (15) Personal care services which are medically
128 oriented tasks having to do with a person's physical
129 requirements, as opposed to housekeeping requirements, which
130 enable a person to be treated by his or her physician on an
131 outpatient rather than on an inpatient or residential basis
132 in a hospital, intermediate care facility, or skilled
133 nursing facility. Personal care services shall be rendered
134 by an individual not a member of the participant's family
135 who is qualified to provide such services where the services
136 are prescribed by a physician in accordance with a plan of
137 treatment and are supervised by a licensed nurse. Persons
138 eligible to receive personal care services shall be those
139 persons who would otherwise require placement in a hospital,
140 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);

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

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

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

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

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

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

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

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

328 (b) **Dispensed by a hearing instrument specialist, as**
329 **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

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

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

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

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

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

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

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

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

517 13. Nothing in this section shall be construed to
518 abrogate or limit the department's statutory requirement to
519 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.

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

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

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

 376.1240. 1. For purposes of this section, terms
2 shall have the same meanings as ascribed to them in section
3 376.1350, and the term "self-administered hormonal
4 contraceptive" shall mean a drug that is composed of one or
5 more hormones and that is approved by the Food and Drug
6 Administration to prevent pregnancy, excluding emergency
7 contraception. Nothing in this section shall be construed
8 to apply to medications approved by the Food and Drug
9 Administration to terminate an existing pregnancy.

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

19 3. The coverage required under this section shall not
20 be subject to any greater deductible or co-payment than

21 other similar health care services provided by the health
22 benefit plan.

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

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

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

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

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

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

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

31 organization providing contracts for health care benefits
32 shall not be considered to be engaging in the business of
33 insurance for purposes of any provision of chapters 361 to
34 385.

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

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

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

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

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

73 7. (1) Contracts for health care benefits under this
74 section shall include the following written disclaimer on
75 the front of the contract and all related applications and
76 renewal forms in a bold font no smaller than sixteen point:

77 "NOTICE

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

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

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

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

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

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

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

121 11. No qualified membership organization, or other
122 entity on behalf of a qualified membership organization,
123 shall refer to a contract for health care benefits under
124 this section as insurance or health insurance in any
125 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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