FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

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# SENATE BILL NOS. 70 & 128

## 100TH GENERAL ASSEMBLY

0572H.12C DANA RADEMAN MILLER, Chief Clerk

## AN ACT

To repeal sections 192.007, 192.667, 195.080, 198.082, 208.909, 208.918, 208.924, 335.175, 344.030, and 376.690, RSMo, and to enact in lieu thereof eighteen new sections relating to the administration of health care services, with a penalty provision.

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

Section A. Sections 192.007, 192.667, 195.080, 198.082, 208.909, 208.918, 208.924, 335.175, 344.030, and 376.690, RSMo, are repealed and eighteen new sections enacted in lieu thereof, to be known as sections 191.1164, 191.1165, 191.1167, 191.1168, 192.007, 192.667, 195.080, 197.108, 198.082, 208.909, 208.918, 208.924, 208.935, 217.930, 221.125, 335.175, 344.030, and 376.690, to read as follows:

**191.1164. 1. Sections 191.1164 to 191.1168 shall be known and may be cited as the "Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act".**

**2. As used in sections 191.1164 to 191.1168, the following terms shall mean:**

**(1) "Behavioral therapy", an individual, family, or group therapy designed to help patients engage in the treatment process, modify their attitudes and behaviors related to substance use, and increase healthy life skills;**

**(2) "Department of insurance", the department of insurance, financial institutions & professional registration, that has jurisdiction regulating health insurers;**

**(3) "Financial requirements", deductibles, co-payments, coinsurance, or out-of-pocket maximums;**

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

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

**(5) "Health insurance plan", an individual or group plan that provides, or pays the cost of, health care items or services;**

**(6) "Health insurer", any person or entity that issues, offers, delivers, or administers a health insurance plan;**

**(7) "Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)", the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 found at 42 U.S.C. 300gg-26 and its implementing and related regulations found at 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115;**

**(8) "Nonquantitative treatment limitation" or "NQTL", any limitation on the scope or duration of treatment that is not expressed numerically;**

**(9) "Pharmacologic therapy", a prescribed course of treatment that may include methadone, buprenorphine, naltrexone, or other FDA-approved or evidence-based medications for the treatment of substance use disorder;**

**(10) "Pharmacy benefits manager", an entity that contracts with pharmacies on behalf of health carriers or any health plan sponsored by the state or a political subdivision of the state;**

**(11) "Prior authorization", the process by which the health insurer or the pharmacy benefits manager determines the medical necessity of otherwise covered health care services prior to the rendering of such health care services. "Prior authorization" also includes any health insurer's or utilization review entity's requirement that a subscriber or health care provider notify the health insurer or utilization review entity prior to receiving or providing a health care service;**

**(12) "Quantitative treatment limitation" or "QTL", numerical limits on the scope or duration of treatment, which include annual, episode, and lifetime day and visit limits;**

**(13) "Step therapy", a protocol or program that establishes the specific sequence in which prescription drugs for a medical condition that are medically appropriate for a particular patient are authorized by a health insurer or prescription drug management company;**

**(14) "Urgent health care service", a health care service with respect to which the application of the time period for making a non-expedited prior authorization, in the opinion of a physician with knowledge of the enrollee's medical condition:**

**(a) Could seriously jeopardize the life or health of the subscriber or the ability of the enrollee to regain maximum function; or**

**(b) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.**

**3. For the purpose of this section, "urgent health care service" shall include services provided for the treatment of substance use disorders.**

**191.1165. 1. Medication-assisted treatment (MAT) shall include pharmacologic therapies. A formulary used by a health insurer or managed by a pharmacy benefits manager, or medical benefit coverage in the case of medications dispensed through an opioid treatment program, shall include:**

**(1) Buprenorphine tablets;**

**(2) Methadone;**

**(3) Naloxone;**

**(4) Extended-release injectable naltrexone; and**

**(5) Buprenorphine/naloxone combination.**

**2. All MAT medications required for compliance in this section shall be placed on the lowest cost-sharing tier of the formulary managed by the health insurer or the pharmacy benefits manager.**

**3. MAT medications provided for in this section shall not be subject to any of the following:**

**(1) Any annual or lifetime dollar limitations;**

**(2) Financial requirements and quantitative treatment limitations that do not comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), specifically 45 CFR 146.136(c)(3);**

**(3) Step therapy or other similar drug utilization strategy or policy when it conflicts or interferes with a prescribed or recommended course of treatment from a licensed health care professional; and**

**(4) Prior authorization for MAT medications as specified in this section.**

**4. MAT medications outlined in this section shall apply to all health insurance plans delivered in the state of Missouri.**

**5. Any entity that holds itself out as a treatment program or that applies for licensure by the state to provide clinical treatment services for substance use disorders shall be required to disclose the MAT services it provides, as well as which of its levels of care have been certified by an independent, national, or other organization that has competencies in the use of the applicable placement guidelines and level of care standards.**

**6. The MO HealthNet program shall cover the MAT medications and services provided for in this section and include those MAT medications in its preferred drug lists for the treatment of substance use disorders and prevention of overdose and death. The**

**preferred drug list shall include all current and new formulations and medications that are approved by the U.S. Food and Drug Administration for the treatment of substance use disorders.**

**7. Drug courts or other diversion programs that provide for alternatives to jail or prison for persons with a substance use disorder shall be required to ensure all persons under their care are assessed for substance use disorders using standard diagnostic criteria by a licensed physician who actively treats patients with substance use disorders. The court or other diversion program shall make available the MAT services covered under this section, consistent with a treatment plan developed by the physician, and shall not impose any limitations on the type of medication or other treatment prescribed or the dose or duration of MAT recommended by the physician.**

**8. Requirements under this section shall not be subject to a covered person's prior success or failure of the services provided.**

**191.1167. Any contract provision, written policy, or written procedure in violation of sections 191.1164 to 191.1168 shall be deemed to be unenforceable and shall be null and void.**

**191.1168. If any provision of sections 191.1164 to 191.1168 or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of sections 191.1164 to 191.1168 which may be given effect without the invalid provision or application, and to that end the provisions of sections 191.1164 to 191.1168 are severable.**

192.007. 1. The director of the department of health and senior services shall be appointed by the governor by and with the advice and consent of the senate. The director shall serve at the pleasure of the governor and the director's salary shall not exceed appropriations made for that purpose.

2. The director shall be a person of recognized character, integrity and executive ability, **[**~~shall be a graduate of an institution of higher education approved by recognized accrediting agencies, and shall have had the administrative experience necessary to enable him to successfully perform the duties of his office. He shall have experience in public health management and agency operation and management~~**] and shall have, at a minimum, the following qualifications:**

**(1) A medical doctor or a doctor of osteopathy degree; or**

**(2) A Ph.D. in a health-related field, which may include nursing, public health, health policy, environmental health, community health, or health education or a master's degree in public health or an equivalent academic degree from an institution of higher education approved by recognized accrediting agencies.**

192.667. 1. All health care providers shall at least annually provide to the department charge data as required by the department. All hospitals shall at least annually provide patient abstract data and financial data as required by the department. Hospitals as defined in section 197.020 shall report patient abstract data for outpatients and inpatients. Ambulatory surgical centers and abortion facilities as defined in section 197.200 shall provide patient abstract data to the department. The department shall specify by rule the types of information which shall be submitted and the method of submission.

2. The department shall collect data on the incidence of health care-associated infections from hospitals, ambulatory surgical centers, abortion facilities, and other facilities as necessary to generate the reports required by this section. Hospitals, ambulatory surgical centers, abortion facilities, and other facilities shall provide such data in compliance with this section. **In order to streamline government and to eliminate duplicative reporting requirements, if the Centers for Medicare and Medicaid Services, or its successor entity, requires hospitals to submit health care-associated infection data, then hospitals and the department shall not be required to comply with the health care-associated infection data reporting requirements of subsections 2 to 17 of this section applicable to hospitals; except that, the department shall post a link on its website to publicly reported data by hospitals on the Centers for Medicare and Medicaid Services' Hospital Compare website, or its successor.**

3. The department shall promulgate rules specifying the standards and procedures for the collection, analysis, risk adjustment, and reporting of the incidence of health care-associated infections and the types of infections and procedures to be monitored pursuant to subsection 13 of this section. In promulgating such rules, the department shall:

(1) Use methodologies and systems for data collection established by the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor; and

(2) Consider the findings and recommendations of the infection control advisory panel established pursuant to section 197.165.

4. By January 1, 2017, the infection control advisory panel created by section 197.165 shall make recommendations to the department regarding the Centers for Medicare and Medicaid Services' health care-associated infection data collection, analysis, and public reporting requirements for hospitals, ambulatory surgical centers, and other facilities in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, in lieu of all or part of the data collection, analysis, and public reporting requirements of this section. The advisory panel recommendations shall address which hospitals shall be required as a condition of licensure to use the National Healthcare Safety Network for data collection; the use of the National Healthcare Safety Network for risk adjustment and analysis of hospital submitted data; and the use of the Centers for Medicare and Medicaid Services' Hospital

Compare website, or its successor, for public reporting of the incidence of health care-associated infection metrics. The advisory panel shall consider the following factors in developing its recommendation:

(1) Whether the public is afforded the same or greater access to facility-specific infection control indicators and metrics;

(2) Whether the data provided to the public is subject to the same or greater accuracy of risk adjustment;

(3) Whether the public is provided with the same or greater specificity of reporting of infections by type of facility infections and procedures;

(4) Whether the data is subject to the same or greater level of confidentiality of the identity of an individual patient;

(5) Whether the National Healthcare Safety Network, or its successor, has the capacity to receive, analyze, and report the required data for all facilities;

(6) Whether the cost to implement the National Healthcare Safety Network infection data collection and reporting system is the same or less.

5. After considering the recommendations of the infection control advisory panel, and provided that the requirements of subsection 13 of this section can be met, the department shall implement guidelines from the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor. It shall be a condition of licensure for hospitals that meet the minimum public reporting requirements of the National Healthcare Safety Network and the Centers for Medicare and Medicaid Services to participate in the National Healthcare Safety Network, or its successor. Such hospitals shall permit the National Healthcare Safety Network, or its successor, to disclose facility-specific infection data to the department as required under this section, and as necessary to provide the public reports required by the department. It shall be a condition of licensure for any ambulatory surgical center or abortion facility which does not voluntarily participate in the National Healthcare Safety Network, or its successor, to submit facility-specific data to the department as required under this section, and as necessary to provide the public reports required by the department.

6. The department shall not require the resubmission of data which has been submitted to the department of health and senior services or the department of social services under any other provision of law. The department of health and senior services shall accept data submitted by associations or related organizations on behalf of health care providers by entering into binding agreements negotiated with such associations or related organizations to obtain data required pursuant to section 192.665 and this section. A health care provider shall submit the required information to the department of health and senior services:

(1) If the provider does not submit the required data through such associations or related organizations;

(2) If no binding agreement has been reached within ninety days of August 28, 1992, between the department of health and senior services and such associations or related organizations; or

(3) If a binding agreement has expired for more than ninety days.

7. Information obtained by the department under the provisions of section 192.665 and this section shall not be public information. Reports and studies prepared by the department based upon such information shall be public information and may identify individual health care providers. The department of health and senior services may authorize the use of the data by other research organizations pursuant to the provisions of section 192.067. The department shall not use or release any information provided under section 192.665 and this section which would enable any person to determine any health care provider's negotiated discounts with specific preferred provider organizations or other managed care organizations. The department shall not release data in a form which could be used to identify a patient. Any violation of this subsection is a class A misdemeanor.

8. The department shall undertake a reasonable number of studies and publish information, including at least an annual consumer guide, in collaboration with health care providers, business coalitions and consumers based upon the information obtained pursuant to the provisions of section 192.665 and this section. The department shall allow all health care providers and associations and related organizations who have submitted data which will be used in any publication to review and comment on the publication prior to its publication or release for general use. The publication shall be made available to the public for a reasonable charge.

9. Any health care provider which continually and substantially, as these terms are defined by rule, fails to comply with the provisions of this section shall not be allowed to participate in any program administered by the state or to receive any moneys from the state.

10. A hospital, as defined in section 197.020, aggrieved by the department's determination of ineligibility for state moneys pursuant to subsection 9 of this section may appeal as provided in section 197.071. An ambulatory surgical center or abortion facility as defined in section 197.200 aggrieved by the department's determination of ineligibility for state moneys pursuant to subsection 9 of this section may appeal as provided in section 197.221.

11. The department of health may promulgate rules providing for collection of data and publication of the incidence of health care-associated infections for other types of health facilities determined to be sources of infections; except that, physicians' offices shall be exempt from reporting and disclosure of such infections.

12. By January 1, 2017, the advisory panel shall recommend and the department shall adopt in regulation with an effective date of no later than January 1, 2018, the requirements for the reporting of the following types of infections as specified in this subsection:

(1) Infections associated with a minimum of four surgical procedures for hospitals and a minimum of two surgical procedures for ambulatory surgical centers that meet the following criteria:

(a) Are usually associated with an elective surgical procedure. An "elective surgical procedure" is a planned, nonemergency surgical procedure that may be either medically required such as a hip replacement or optional such as breast augmentation;

(b) Demonstrate a high priority aspect such as affecting a large number of patients, having a substantial impact for a smaller population, or being associated with substantial cost, morbidity, or mortality; or

(c) Are infections for which reports are collected by the National Healthcare Safety Network or its successor;

(2) Central line-related bloodstream infections;

(3) Health care-associated infections specified for reporting by hospitals, ambulatory surgical centers, and other health care facilities by the rules of the Centers for Medicare and Medicaid Services to the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor; and

(4) Other categories of infections that may be established by rule by the department.

The department, in consultation with the advisory panel, shall be authorized to collect and report data on subsets of each type of infection described in this subsection.

13. In consultation with the infection control advisory panel established pursuant to section 197.165, the department shall develop and disseminate to the public reports based on data compiled for a period of twelve months. Such reports shall be updated quarterly and shall show for each hospital, ambulatory surgical center, abortion facility, and other facility metrics on risk-adjusted health care-associated infections under this section.

14. The types of infections under subsection 12 of this section to be publicly reported shall be determined by the department by rule and shall be consistent with the infections tracked by the National Healthcare Safety Network, or its successor.

15. Reports published pursuant to subsection 13 of this section shall be published and readily accessible on the department's internet website. The reports shall be distributed at least annually to the governor and members of the general assembly. The department shall make such reports available to the public for a period of at least two years.

16. The Hospital Industry Data Institute shall publish a report of Missouri hospitals', ambulatory surgical centers', and abortion facilities' compliance with standardized quality of care

measures established by the federal Centers for Medicare and Medicaid Services for prevention of infections related to surgical procedures. If the Hospital Industry Data Institute fails to do so by July 31, 2008, and annually thereafter, the department shall be authorized to collect information from the Centers for Medicare and Medicaid Services or from hospitals, ambulatory surgical centers, and abortion facilities and publish such information in accordance with this section.

17. The data collected or published pursuant to this section shall be available to the department for purposes of licensing hospitals, ambulatory surgical centers, and abortion facilities pursuant to chapter 197.

18. The department shall promulgate rules to implement the provisions of section 192.131 and sections 197.150 to 197.160. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

19. No later than August 28, 2017, each hospital, excluding mental health facilities as defined in section 632.005, and each ambulatory surgical center and abortion facility as defined in section 197.200, shall in consultation with its medical staff establish an antimicrobial stewardship program for evaluating the judicious use of antimicrobials, especially antibiotics that are the last line of defense against resistant infections. The hospital's stewardship program and the results of the program shall be monitored and evaluated by hospital quality improvement departments and shall be available upon inspection to the department. At a minimum, the antimicrobial stewardship program shall be designed to evaluate that hospitalized patients receive, in accordance with accepted medical standards of practice, the appropriate antimicrobial, at the appropriate dose, at the appropriate time, and for the appropriate duration.

20. Hospitals described in subsection 19 of this section shall meet the National Healthcare Safety Network requirements for reporting antimicrobial usage or resistance by using the Centers for Disease Control and Prevention's Antimicrobial Use and Resistance (AUR) Module when **[**~~regulations concerning Stage 3 of the Medicare and Medicaid Electronic Health Records Incentive Programs promulgated by the Centers for Medicare and Medicaid Services that enable the electronic interface for such reporting are effective~~**] conditions of participation promulgated by the Centers for Medicare and Medicaid Services requiring the electronic reporting of antibiotic use or antibiotic resistance by hospitals become effective**. When such

antimicrobial usage or resistance reporting takes effect, hospitals shall authorize the National Healthcare Safety Network, or its successor, to disclose to the department facility-specific information reported to the AUR Module. Facility-specific data on antibiotic usage and resistance collected under this subsection shall not be disclosed to the public, but the department may release case-specific information to other facilities, physicians, and the public if the department determines on a case-by-case basis that the release of such information is necessary to protect persons in a public health emergency. **Nothing in this section shall prohibit a hospital from voluntarily reporting antibiotic use or antibiotic resistance data through the National Healthcare Safety Network, or its successor, prior to the effective date of the conditions of participation that require the reporting.**

21. The department shall make a report to the general assembly beginning January 1, 2018, and on every January first thereafter on the incidence, type, and distribution of antimicrobial-resistant infections identified in the state and within regions of the state.

195.080. 1. Except as otherwise provided in this chapter and chapter 579, this chapter and chapter 579 shall not apply to the following cases: prescribing, administering, dispensing or selling at retail of liniments, ointments, and other preparations that are susceptible of external use only and that contain controlled substances in such combinations of drugs as to prevent the drugs from being readily extracted from such liniments, ointments, or preparations, except that this chapter and chapter 579 shall apply to all liniments, ointments, and other preparations that contain coca leaves in any quantity or combination.

2. Unless otherwise provided in sections 334.037, 334.104, and 334.747, a practitioner, other than a veterinarian, shall not issue an initial prescription for more than a seven-day supply of any opioid controlled substance upon the initial consultation and treatment of a patient for acute pain. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription in compliance with the general provisions of this chapter and chapter 579. Prior to issuing an initial prescription for an opioid controlled substance, a practitioner shall consult with the patient regarding the quantity of the opioid and the patient's option to fill the prescription in a lesser quantity and shall inform the patient of the risks associated with the opioid prescribed. If, in the professional medical judgment of the practitioner, more than a seven-day supply is required to treat the patient's acute pain, the practitioner may issue a prescription for the quantity needed to treat the patient; provided, that the practitioner shall document in the patient's medical record the condition triggering the necessity for more than a seven-day supply and that a nonopioid alternative was not appropriate to address the patient's condition. The provisions of this subsection shall not apply to prescriptions for opioid controlled substances for a patient who is currently undergoing treatment for cancer **or sickle cell disease**, is receiving hospice care from a hospice certified under chapter

197 or palliative care, is a resident of a long-term care facility licensed under chapter 198, or is receiving treatment for substance abuse or opioid dependence.

3. A pharmacist or pharmacy shall not be subject to disciplinary action or other civil or criminal liability for dispensing or refusing to dispense medication in good faith pursuant to an otherwise valid prescription that exceeds the prescribing limits established by subsection 2 of this section.

4. Unless otherwise provided in this section, the quantity of Schedule II controlled substances prescribed or dispensed at any one time shall be limited to a thirty-day supply. The quantity of Schedule III, IV or V controlled substances prescribed or dispensed at any one time shall be limited to a ninety-day supply and shall be prescribed and dispensed in compliance with the general provisions of this chapter and chapter 579. The supply limitations provided in this subsection may be increased up to three months if the physician describes on the prescription form or indicates via telephone, fax, or electronic communication to the pharmacy to be entered on or attached to the prescription form the medical reason for requiring the larger supply. The supply limitations provided in this subsection shall not apply if:

(1) The prescription is issued by a practitioner located in another state according to and in compliance with the applicable laws of that state and the United States and dispensed to a patient located in another state; or

(2) The prescription is dispensed directly to a member of the United States Armed Forces serving outside the United States.

5. The partial filling of a prescription for a Schedule II substance is permissible as defined by regulation by the department of health and senior services.

**197.108. 1. The department of health and senior services shall not assign an individual to inspect or survey a hospital, for any purpose, if the inspector or surveyor was an employee of such hospital or another hospital within its organization or a competing hospital within fifty miles of the hospital to be inspected or surveyed in the preceding two years.**

**2. For any inspection or survey of a hospital, regardless of the purpose, the department shall require every newly hired inspector or surveyor at the time of hiring or any currently employed inspector or surveyor as of August 28, 2019, to disclose:**

**(1) The name of every hospital in which he or she has been employed in the last ten years and the approximate length of service and the job title at the hospital; and**

**(2) The name of any member of his or her immediate family who has been employed in the last ten years or is currently employed at a hospital and the approximate length of service and the job title at the hospital.**

**The disclosures under this subsection shall be made to the department whenever the event giving rise to disclosure first occurs.**

**3. For purposes of this section, the phrase "immediate family member" shall mean a husband, wife, natural or adoptive parent, child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, or grandchild.**

**4. The information provided under subsection 2 of this section shall be considered a public record under the provisions of section 610.010.**

**5. Any person may notify the department if facts exist that would lead a reasonable person to conclude that any inspector or surveyor has any personal or business affiliation that would result in a conflict of interest in conducting an inspection or survey for a hospital. Upon receiving such notice, the department, when assigning an inspector or surveyor to inspect or survey a hospital, for any purpose, shall take steps to verify the information and, if the department has reason to believe that such information is correct, the department shall not assign the inspector or surveyor to the hospital or any hospital within its organization so as to avoid an appearance of prejudice or favor to the hospital or bias on the part of the inspector or surveyor.**

198.082. 1. Each **certified** nursing assistant hired to work in a skilled nursing or intermediate care facility after January 1, 1980, shall have successfully completed a nursing assistant training program approved by the department or shall enroll in and begin the first available approved training program which is scheduled to commence within ninety days of the date of the **certified** nursing assistant's employment and which shall be completed within four months of employment. Training programs shall be offered at any facility licensed **[**~~or approved~~**]** by the department of health and senior services**; any skilled nursing or intermediate care unit in a Missouri veterans home, as defined in section 42.002; or any hospital, as defined in section 197.020. Training programs shall be [**~~which is most~~**]** reasonably accessible to the enrollees in each class. The program may be established by **[**~~the~~**] a** skilled nursing or intermediate care facility, **unit, or hospital;** by a professional organization**[**~~,~~**] ;** or by the department, and training shall be given by the personnel of the facility, **unit, or hospital;** by a professional organization**[**~~,~~**] ;** by the department**[**~~,~~**] ;** by any community college**;** or by the vocational education department of any high school.

2. As used in this section the term "**certified** nursing assistant" means an employee**[**~~,~~**]** **who has completed the training required under subsection 1 of this section, who has passed the certification exam, and [**~~including a nurse's aide or an orderly,~~**]** who is assigned by a skilled nursing or intermediate care facility**, unit, or hospital** to provide or assist in the provision of

direct resident health care services under the supervision of a nurse licensed under the nursing practice law, chapter 335.

**3.** This section shall not apply to any person otherwise **regulated or** licensed to perform health care services under the laws of this state. It shall not apply to volunteers or to members of religious or fraternal orders which operate and administer the facility, if such volunteers or members work without compensation.

**[**~~3.~~**]** **4.** The training program **[**~~after January 1, 1989, shall consist of at least the following:~~

~~(1) A training program consisting~~**] requirements shall be defined in regulation by the department and shall require [**~~of~~**]** at least seventy-five classroom hours of training **[**~~on basic nursing skills, clinical practice, resident safety and rights, the social and psychological problems of residents, and the methods of handling and caring for mentally confused residents such as those with Alzheimer's disease and related disorders,~~]** and one hundred hours supervised and on-the-job training. **On-the-job training sites shall include supervised practical training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse.** The **[**~~one hundred hours~~**] training** shall be completed within four months of employment and may consist of normal employment as nurse assistants **or hospital nursing support staff** under the supervision of a licensed nurse**[**~~; and~~

~~(2) Continuing in-service training to assure continuing competency in existing and new nursing skills. All nursing assistants trained prior to January 1, 1989, shall attend, by August 31, 1989, an entire special retraining program established by rule or regulation of the department which shall contain information on methods of handling mentally confused residents and which may be offered on premises by the employing facility~~**]**.

**[**~~4.~~**] 5. Certified nursing [**~~Nursing~~**]** assistants who have not successfully completed the nursing assistant training program prior to employment may begin duties as a **certified** nursing assistant **[**~~only after completing an initial twelve hours of basic orientation approved by the department~~**]** and may provide direct resident care only if under the **[**~~general~~**] direct** supervision of a licensed nurse prior to completion of the seventy-five classroom hours of the training program.

**6. The competency evaluation shall be performed in a facility, as defined in 42 CFR 483.5, or laboratory setting comparable to the setting in which the individual shall function as a certified nursing assistant.**

**7. Persons completing the training requirements of unlicensed assistive personnel under 19 CSR 30-20.125, or its successor regulation, and who have completed the competency evaluation shall be allowed to take the certified nursing assistant examination**

**and be deemed to have fulfilled the classroom and clinical standards for designation as a certified nursing assistant.**

**8. The department of health and senior services may offer additional training programs and certifications to students who are already certified as nursing assistants according to regulations promulgated by the department and curriculum approved by the board.**

208.909. 1. Consumers receiving personal care assistance services shall be responsible for:

(1) Supervising their personal care attendant;

(2) Verifying wages to be paid to the personal care attendant;

(3) Preparing and submitting time sheets, signed by both the consumer and personal care attendant, to the vendor on a biweekly basis;

(4) Promptly notifying the department within ten days of any changes in circumstances affecting the personal care assistance services plan or in the consumer's place of residence;

(5) Reporting any problems resulting from the quality of services rendered by the personal care attendant to the vendor. If the consumer is unable to resolve any problems resulting from the quality of service rendered by the personal care attendant with the vendor, the consumer shall report the situation to the department; **[**~~and~~**]**

(6) Providing the vendor with all necessary information to complete required paperwork for establishing the employer identification number**; and**

**(7) Allowing the vendor to comply with its quality assurance and supervision process, which shall include, but not be limited to, biannual face-to-face home visits and monthly case management activities**.

2. Participating vendors shall be responsible for:

(1) Collecting time sheets or reviewing reports of delivered services and certifying the accuracy thereof;

(2) The Medicaid reimbursement process, including the filing of claims and reporting data to the department as required by rule;

(3) Transmitting the individual payment directly to the personal care attendant on behalf of the consumer;

(4) Monitoring the performance of the personal care assistance services plan. **Such monitoring shall occur during the biannual face-to-face home visits under section 208.918. The vendor shall document whether the attendant was present and if services are being provided to the consumer as set forth in the plan of care. If the attendant was not present or not providing services, the vendor shall notify the department and the department may suspend services to the consumer.**

3. No state or federal financial assistance shall be authorized or expended to pay for services provided to a consumer under sections 208.900 to 208.927, if the primary benefit of the services is to the household unit, or is a household task that the members of the consumer's household may reasonably be expected to share or do for one another when they live in the same household, unless such service is above and beyond typical activities household members may reasonably provide for another household member without a disability.

4. No state or federal financial assistance shall be authorized or expended to pay for personal care assistance services provided by a personal care attendant who has not undergone the background screening process under section 192.2495. If the personal care attendant has a disqualifying finding under section 192.2495, no state or federal assistance shall be made, unless a good cause waiver is first obtained from the department in accordance with section 192.2495.

5. (1) All vendors shall, by July 1, 2015, have, maintain, and use a telephone tracking system for the purpose of reporting and verifying the delivery of consumer-directed services as authorized by the department of health and senior services or its designee. **[**~~Use of such a system prior to July 1, 2015, shall be voluntary.~~**]** The telephone tracking system shall be used to process payroll for employees and for submitting claims for reimbursement to the MO HealthNet division. At a minimum, the telephone tracking system shall:

(a) Record the exact date services are delivered;

(b) Record the exact time the services begin and exact time the services end;

(c) Verify the telephone number from which the services are registered;

(d) Verify that the number from which the call is placed is a telephone number unique to the client;

(e) Require a personal identification number unique to each personal care attendant;

(f) Be capable of producing reports of services delivered, tasks performed, client identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service; and

(g) Be capable of producing reimbursement requests for consumer approval that assures accuracy and compliance with program expectations for both the consumer and vendor.

(2) **[**~~The department of health and senior services, in collaboration with other appropriate agencies, including centers for independent living, shall establish telephone tracking system pilot projects, implemented in two regions of the state, with one in an urban area and one in a rural area. Each pilot project shall meet the requirements of this section and section 208.918. The department of health and senior services shall, by December 31, 2013, submit a report to the governor and general assembly detailing the outcomes of these pilot projects. The report shall take into consideration the impact of a telephone tracking system on the quality of the services delivered to the consumer and the principles of self-directed care.~~

~~(3)~~**]** As new technology becomes available, the department may allow use of a more advanced tracking system, provided that such system is at least as capable of meeting the requirements of this subsection.

**[**~~(4)~~**]** **(3)** The department of health and senior services shall promulgate by rule the minimum necessary criteria of the telephone tracking system. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2010, shall be invalid and void.

**[**~~6. In the event that a consensus between centers for independent living and representatives from the executive branch cannot be reached, the telephony report issued to the general assembly and governor shall include a minority report which shall detail those elements of substantial dissent from the main report.~~

~~7. No interested party, including a center for independent living, shall be required to contract with any particular vendor or provider of telephony services nor bear the full cost of the pilot program.~~**]**

208.918. 1. In order to qualify for an agreement with the department, the vendor shall have a philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical disabilities, and shall demonstrate the ability to provide, directly or through contract, the following services:

(1) Orientation of consumers concerning the responsibilities of being an employer**[**~~,~~**]** **and** supervision of personal care attendants including the preparation and verification of time sheets**. Such orientation shall include notifying customers that falsification of attendant visit verification records shall be considered fraud and shall be reported to the department. Such orientation shall take place in the presence of the personal care attendant, to the fullest extent possible**;

(2) Training for consumers about the recruitment and training of personal care attendants;

(3) Maintenance of a list of persons eligible to be a personal care attendant;

(4) Processing of inquiries and problems received from consumers and personal care attendants;

(5) Ensuring the personal care attendants are registered with the family care safety registry as provided in sections 210.900 to **[**~~210.937~~**]** **210.936**; and

(6) The capacity to provide fiscal conduit services through a telephone tracking system by the date required under section 208.909.

2. In order to maintain its agreement with the department, a vendor shall comply with the provisions of subsection 1 of this section and shall:

(1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports and **an** annual **financial statement** audit **[**~~submitted to the department~~**] performed by a certified public accountant if the vendor's annual gross revenue is one hundred thousand dollars or more or, if the vendor's annual gross revenue is less than one hundred thousand dollars, an annual financial statement audit or annual financial statement review performed by a certified public accountant. Such reports, audits, and reviews shall be completed and made available upon request to the department**; **[**~~and~~**]**

(2) Demonstrate a positive impact on consumer outcomes regarding the provision of personal care assistance services as evidenced on accurate quarterly and annual service reports submitted to the department;

(3) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records**:**

**(a) The department of health and senior services shall promulgate by rule a consumer-directed services division provider certification manager course**; and

**(b) The vendor shall perform with the consumer at least biannual face-to-face home visits to provide ongoing monitoring of the provision of services in the plan of care and assess the quality of care being delivered. The biannual face-to-face home visits do not preclude the vendor's responsibility from its ongoing diligence of case management activity oversight; and**

(4) Comply with all provisions of sections 208.900 to 208.927, and the regulations promulgated thereunder.

**3. No state or federal funds shall be authorized or expended if the person providing the personal care is the same as the person conducting the biannual face-to-face home visits.**

208.924. A consumer's personal care assistance services may be discontinued under circumstances such as the following:

(1) The department learns of circumstances that require closure of a consumer's case, including one or more of the following: death, admission into a long-term care facility, no longer needing service, or inability of the consumer to consumer-direct personal care assistance service;

(2) The consumer has falsified records**; provided false information of his or her condition, functional capacity, or level of care needs;** or committed fraud;

(3) The consumer is noncompliant with the plan of care. Noncompliance requires persistent actions by the consumer which negate the services provided in the plan of care;

(4) The consumer or member of the consumer's household threatens or abuses the personal care attendant or vendor to the point where their welfare is in jeopardy and corrective action has failed;

(5) The maintenance needs of a consumer are unable to continue to be met because the plan of care hours exceed availability; and

(6) The personal care attendant is not providing services as set forth in the personal care assistance services plan and attempts to remedy the situation have been unsuccessful.

**208.935. Subject to appropriations, the department of health and senior services shall develop, or contract with a state agency or third party to develop, an interactive assessment tool, which may include mobile as well as centralized functionality, for utilization when implementing the assessment and authorization process for MO HealthNet home and community-based services authorized by the division of senior and disability services.**

**217.930. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than canceled or terminated, for a person who is an offender in a correctional center if:**

**(a) The department of social services is notified of the person's entry into the correctional center;**

**(b) On the date of entry, the person was enrolled in the MO HealthNet program; and**

**(c) The person is eligible for MO HealthNet except for institutional status.**

**(2) A suspension under this subsection shall end on the date the person is no longer an offender in a correctional center.**

**(3) Upon release from incarceration, such person shall continue to be eligible for receipt of MO HealthNet benefits until such time as the person is otherwise determined to no longer be eligible for the program.**

**2. The department of corrections shall notify the department of social services:**

**(1) Within twenty days after receiving information that a person receiving benefits under MO HealthNet is or will be an offender in a correctional center; and**

**(2) Within forty-five days prior to the release of a person who is qualified for suspension under subsection 1 of this section.**

**221.125. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than canceled or terminated, for a person who is an offender in a county jail, a city jail, or a private jail if:**

**(a) The department of social services is notified of the person's entry into the jail;**

**(b) On the date of entry, the person was enrolled in the MO HealthNet program; and**

**(c) The person is eligible for MO HealthNet except for institutional status.**

**(2) A suspension under this subsection shall end on the date the person is no longer an offender in a jail.**

**(3) Upon release from incarceration, such person shall continue to be eligible for receipt of MO HealthNet benefits until such time as the person is otherwise determined to no longer be eligible for the program.**

**2. City, county, and private jails shall notify the department of social services within ten days after receiving information that a person receiving medical assistance under MO HealthNet is or will be an offender in the jail.**

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

2. As used in this section, "telehealth" shall have the same meaning as such term is defined in section 191.1145.

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

(2) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid and void.

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

**[**~~5. Under section 23.253 of the Missouri sunset act:~~

~~(1) The provisions of the new program authorized under this section shall automatically sunset six years after August 28, 2013, unless reauthorized by an act of the general assembly; and~~

~~(2) If such program is reauthorized, the program authorized under this section shall automatically sunset twelve years after the effective date of the reauthorization of this section; and~~

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

344.030. 1. An applicant for an initial license shall file a completed application with the board on a form provided by the board, accompanied by an application fee as provided by rule payable to the department of health and senior services. Information provided in the application shall be attested by signature to be true and correct to the best of the applicant's knowledge and belief.

2. No initial license shall be issued to a person as a nursing home administrator unless:

(1) The applicant provides the board satisfactory proof that the applicant is of good moral character and a high school graduate or equivalent; **and**

(2) The applicant provides the board satisfactory proof that the applicant has had a minimum of three years' experience in health care administration**,** or two years of postsecondary education in health care administration**, or has an associate degree or higher from an accredited academic institution,** or has satisfactorily completed a course of instruction and training prescribed by the board, which includes instruction in the needs properly to be served by nursing homes, the protection of the interests of residents therein, and the elements of good nursing home administration, or has presented evidence satisfactory to the board of sufficient education, training, or experience in the foregoing fields to administer, supervise and manage a nursing home; and

(3) The applicant passes the examinations administered by the board. If an applicant fails to make a passing grade on either of the examinations such applicant may make application for reexamination on a form furnished by the board and may be retested. If an applicant fails either of the examinations a third time, the applicant shall be required to complete a course of instruction prescribed and approved by the board. After completion of the board-prescribed course of instruction, the applicant may reapply for examination. With regard to the national examination required for licensure, no examination scores from other states shall be recognized by the board after the applicant has failed his or her third attempt at the national examination. There shall be a separate, nonrefundable fee for each examination. The board shall set the amount of the fee for examination by rules and regulations promulgated pursuant to section 536.021. The fee shall be set at a level to produce revenue which shall not substantially exceed the cost and expense of administering the examination.

3. Nothing in **[**~~sections 344.010 to 344.108~~**]** **this chapter**, or the rules or regulations thereunder shall be construed to require an applicant for a license as a nursing home administrator, who is employed by an institution listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., to administer institutions certified by such commission for the care and treatment of the sick in accordance with the creed or tenets of a recognized church or religious denomination, to demonstrate proficiency in any techniques or to meet any educational qualifications or standards not in accord with the remedial care and treatment provided in such institutions. The applicant's license shall be endorsed to confine the applicant's practice to such institutions.

4. The board may issue a temporary emergency license for a period not to exceed **[**~~ninety~~**] one hundred twenty** days to a person **[**~~twenty-one~~**] eighteen** years of age or over, of good moral character and a high school graduate or equivalent to serve as an acting nursing home administrator, provided such person is replacing a licensed nursing home administrator who has died, has been removed or has vacated the nursing home administrator's position. No temporary emergency license may be issued to a person who has had a nursing home administrator's license denied, suspended or revoked. **[**~~A temporary emergency license may be renewed for one additional ninety-day period upon a showing that the person seeking the renewal of a temporary emergency license meets the qualifications for licensure and has filed an application for a regular license, accompanied by the application fee, and the applicant has taken the examination or examinations but the results have not been received by the board. No temporary emergency license may be renewed more than one time.~~**]**

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

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

(2) "Facility", the same meaning given to such term in section 376.1350;

(3) "Health care professional", the same meaning given to such term in section 376.1350;

(4) "Health carrier", the same meaning given to such term in section 376.1350;

(5) "Unanticipated out-of-network care", health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged.

2. (1) Health care professionals **[**~~may~~**] shall** send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier within one hundred eighty days of the delivery of the unanticipated out-of-network care on a U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, or electronically using the 837 HIPAA format, or its successor.

(2) Within forty-five processing days, as defined in section 376.383, of receiving the health care professional's claim, the health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated out-of-network care based on the health care professional's services. If the health care professional participates in one or more of the carrier's commercial networks, the offer of reimbursement for unanticipated out-of-network care shall be the amount from the network which has the highest reimbursement.

(3) If the health care professional declines the health carrier's initial offer of reimbursement, the health carrier and health care professional shall have sixty days from the date of the initial offer of reimbursement to negotiate in good faith to attempt to determine the reimbursement for the unanticipated out-of-network care.

(4) If the health carrier and health care professional do not agree to a reimbursement amount by the end of the sixty-day negotiation period, the dispute shall be resolved through an arbitration process as specified in subsection 4 of this section.

(5) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within one hundred twenty days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the final offer by each party. A claim for unanticipated out-of-network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with subdivisions (3) to (5) of this subsection.

(6) No health care professional who sends a claim to a health carrier under subsection 2 of this section shall send a bill to the patient for any difference between the reimbursement rate as determined under this subsection and the health care professional's billed charge.

3. (1) When unanticipated out-of-network care is provided, the health care professional who sends a claim to a health carrier under subsection 2 of this section may bill a patient for no more than the cost-sharing requirements described under this section.

(2) Cost-sharing requirements shall be based on the reimbursement amount as determined under subsection 2 of this section.

(3) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within forty-five processing days of receiving a claim from the health care professional for services provided.

(4) The in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for the unanticipated out-of-network care.

4. The director shall ensure access to an external arbitration process when a health care professional and health carrier cannot agree to a reimbursement under subdivision (3) of subsection 2 of this section. In order to ensure access, when notified of a parties' intent to arbitrate, the director shall randomly select an arbitrator for each case from the department's approved list of arbitrators or entities that provide binding arbitration. The director shall specify the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared equally between and will be directly billed to the health care professional and health carrier. These costs will include, but are not limited to, reasonable time necessary for the arbitrator to review materials in preparation for the arbitration, travel expenses and reasonable time following the arbitration for drafting of the final decision.

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall be binding on all parties. The arbitrator shall provide a copy of the final decision to the director. The initial request for arbitration, all correspondence and documents received by the department and the final arbitration decision shall be considered a closed record under section 374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of section 536.010.

6. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare-allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

7. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, or experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

8. The enrollee shall not be required to participate in the arbitration process. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section.

9. **[**~~This section shall take effect on January 1, 2019.~~

~~10.~~**]** The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to procedural requirements for arbitration. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void.

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