SECOND REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 1790,

HOUSE BILL NO. 1805,

AND

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 1546

94TH GENERAL ASSEMBLY

Reported from the Committee on Health and Mental Health, May 1, 2008, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

4329S.05C

AN ACT

To repeal sections 190.100, 190.176, 190.200, 190.241, 190.243, 190.245, 192.667, 197.150, and 354.535, RSMo, and to enact in lieu thereof ten new sections relating to health care services, with a penalty provision.

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

Section A. Sections 190.100, 190.176, 190.200, 190.241, 190.243, 190.245, 192.667, 197.150, and 354.535, RSMo, are repealed and ten new sections enacted in lieu thereof, to be known as sections 190.100, 190.176, 190.200, 190.241, 190.243, 190.245, 192.667, 197.150, 354.535, and 376.387, to read as follows:

190.100. As used in sections 190.001 to 190.245, the following words and terms mean:

(1) "Advanced life support (ALS)", an advanced level of care as provided to the adult and pediatric patient such as defined by national curricula, and any modifications to that curricula specified in rules adopted by the department pursuant to sections 190.001 to 190.245;

(2) "Ambulance", any privately or publicly owned vehicle or craft that is specially designed, constructed or modified, staffed or equipped for, and is intended or used, maintained or operated for the transportation of persons who

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

are sick, injured, wounded or otherwise incapacitated or helpless, or who require the presence of medical equipment being used on such individuals, but the term does not include any motor vehicle specially designed, constructed or converted for the regular transportation of persons who are disabled, handicapped, normally using a wheelchair, or otherwise not acutely ill, or emergency vehicles used within airports;

(3) "Ambulance service", a person or entity that provides emergency or nonemergency ambulance transportation and services, or both, in compliance with sections 190.001 to 190.245, and the rules promulgated by the department pursuant to sections 190.001 to 190.245;

(4) "Ambulance service area", a specific geographic area in which an ambulance service has been authorized to operate;

(5) "Basic life support (BLS)", a basic level of care, as provided to the adult and pediatric patient as defined by national curricula, and any modifications to that curricula specified in rules adopted by the department pursuant to sections 190.001 to 190.245;

(6) "Council", the state advisory council on emergency medical services;

(7) "Department", the department of health and senior services, state of Missouri;

(8) "Director", the director of the department of health and senior services or the director's duly authorized representative;

(9) "Dispatch agency", any person or organization that receives requests for emergency medical services from the public, by telephone or other means, and is responsible for dispatching emergency medical services;

(10) "Emergency", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that the absence of immediate medical care could result in:

(a) Placing the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain;

(11) "Emergency medical dispatcher", a person who receives emergency calls from the public and has successfully completed an emergency medical dispatcher course, meeting or exceeding the national curriculum of the United

States Department of Transportation and any modifications to such curricula specified by the department through rules adopted pursuant to sections 190.001 to 190.245;

(12) "Emergency medical response agency", any person that regularly provides a level of care that includes first response, basic life support or advanced life support, exclusive of patient transportation;

(13) "Emergency medical services for children (EMS-C) system", the arrangement of personnel, facilities and equipment for effective and coordinated delivery of pediatric emergency medical services required in prevention and management of incidents which occur as a result of a medical emergency or of an injury event, natural disaster or similar situation;

(14) "Emergency medical services (EMS) system", the arrangement of personnel, facilities and equipment for the effective and coordinated delivery of emergency medical services required in prevention and management of incidents occurring as a result of an illness, injury, natural disaster or similar situation;

(15) "Emergency medical technician", a person licensed in emergency medical care in accordance with standards prescribed by sections 190.001 to 190.245, and by rules adopted by the department pursuant to sections 190.001 to 190.245;

(16) "Emergency medical technician-basic" or "EMT-B", a person who has successfully completed a course of instruction in basic life support as prescribed by the department and is licensed by the department in accordance with standards prescribed by sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245;

(17) "Emergency medical technician-intermediate" or "EMT-I", a person who has successfully completed a course of instruction in certain aspects of advanced life support care as prescribed by the department and is licensed by the department in accordance with sections 190.001 to 190.245 and rules and regulations adopted by the department pursuant to sections 190.001 to 190.245;

(18) "Emergency medical technician-paramedic" or "EMT-P", a person who has successfully completed a course of instruction in advanced life support care as prescribed by the department and is licensed by the department in accordance with sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245;

(19) "Emergency services", health care items and services furnished or required to screen and stabilize an emergency which may include, but shall not

be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider or by an ambulance service or emergency medical response agency;

(20) "First responder", a person who has successfully completed an emergency first response course meeting or exceeding the national curriculum of the United States Department of Transportation and any modifications to such curricula specified by the department through rules adopted pursuant to sections 190.001 to 190.245 and who provides emergency medical care through employment by or in association with an emergency medical response agency;

(21) "Health care facility", a hospital, nursing home, physician's office or other fixed location at which medical and health care services are performed;

(22) "Hospital", an establishment as defined in the hospital licensing law, subsection 2 of section 197.020, RSMo, or a hospital operated by the state;

(23) "Medical control", supervision provided by or under the direction of physicians to providers by written or verbal communications;

(24) "Medical direction", medical guidance and supervision provided by a physician to an emergency services provider or emergency medical services system;

(25) "Medical director", a physician licensed pursuant to chapter 334, RSMo, designated by the ambulance service or emergency medical response agency and who meets criteria specified by the department by rules pursuant to sections 190.001 to 190.245;

(26) "Memorandum of understanding", an agreement between an emergency medical response agency or dispatch agency and an ambulance service or services within whose territory the agency operates, in order to coordinate emergency medical services;

(27) "Patient", an individual who is sick, injured, wounded, diseased, or otherwise incapacitated or helpless, or dead, excluding deceased individuals being transported from or between private or public institutions, homes or cemeteries, and individuals declared dead prior to the time an ambulance is called for assistance;

(28) "Person", as used in these definitions and elsewhere in sections 190.001 to 190.245, any individual, firm, partnership, copartnership, joint venture, association, cooperative organization, corporation, municipal or private, and whether organized for profit or not, state, county, political subdivision, state department, commission, board, bureau or fraternal organization, estate, public

trust, business or common law trust, receiver, assignee for the benefit of creditors, trustee or trustee in bankruptcy, or any other service user or provider;

(29) "Physician", a person licensed as a physician pursuant to chapter 334, RSMo;

(30) "Political subdivision", any municipality, city, county, city not within a county, ambulance district or fire protection district located in this state which provides or has authority to provide ambulance service;

(31) "Professional organization", any organized group or association with an ongoing interest regarding emergency medical services. Such groups and associations could include those representing volunteers, labor, management, firefighters, EMT-B's, nurses, EMT-P's, physicians, communications specialists and instructors. Organizations could also represent the interests of ground ambulance services, air ambulance services, fire service organizations, law enforcement, hospitals, trauma centers, communication centers, pediatric services, labor unions and poison control services;

(32) "Proof of financial responsibility", proof of ability to respond to damages for liability, on account of accidents occurring subsequent to the effective date of such proof, arising out of the ownership, maintenance or use of a motor vehicle in the financial amount set in rules promulgated by the department, but in no event less than the statutory minimum required for motor vehicles. Proof of financial responsibility shall be used as proof of self-insurance;

(33) "Protocol", a predetermined, written medical care guideline, which may include standing orders;

(34) "Regional EMS advisory committee", a committee formed within an emergency medical services (EMS) region to advise ambulance services, the state advisory council on EMS and the department;

(35) "Specialty care transportation", the transportation of a patient requiring the services of an emergency medical technician-paramedic who has received additional training beyond the training prescribed by the department. Specialty care transportation services shall be defined in writing in the appropriate local protocols for ground and air ambulance services and approved by the local physician medical director. The protocols shall be maintained by the local ambulance service and shall define the additional training required of the emergency medical technician-paramedic;

(36) "Stabilize", with respect to an emergency, the provision of such medical treatment as may be necessary to attempt to assure within reasonable

medical probability that no material deterioration of an individual's medical condition is likely to result from or occur during ambulance transportation unless the likely benefits of such transportation outweigh the risks;

(37) "State advisory council on emergency medical services", a committee formed to advise the department on policy affecting emergency medical service throughout the state;

(38) "State EMS medical directors advisory committee", a subcommittee of the state advisory council on emergency medical services formed to advise the state advisory council on emergency medical services and the department on medical issues;

(39) "STEMI" or "ST-elevation myocardial infarction", a type of heart attack in which impaired blood flow to the patient's heart muscle is evidenced by ST-segment elevation in electrocardiogram analysis, and as further defined in rules promulgated by the department under sections 190.001 to 190.250;

(40) "STEMI center", a hospital that is currently designated as such by the department to care for patients with ST-segment elevation myocardial infarctions;

(41) "STEMI care", includes education and prevention emergency transport, triage, and acute care and rehabilitative services for STEMI that requires immediate medical or surgical intervention or treatment;

(42) "Stroke", a condition of impaired blood flow to a patient's brain as defined by the department;

(43) "Stroke care", includes emergency transport, triage, and acute intervention and other acute care services for stroke that potentially require immediate medical or surgical intervention or treatment, and may include education, primary prevention, acute intervention, acute and subacute management, prevention of complications, secondary stroke prevention, and rehabilitative services;

(44) "Stroke center", a hospital that is currently designated as such by the department;

[(39)**] (45)** "Trauma", an injury to human tissues and organs resulting from the transfer of energy from the environment;

[(40)**] (46)** "Trauma care" includes injury prevention, triage, acute care and rehabilitative services for major single system or multisystem injuries that potentially require immediate medical or surgical intervention or treatment;

[(41)**]** **(47)** "Trauma center", a hospital that is currently designated as such by the department.

190.176. 1. The department shall develop and administer a uniform data collection system on all ambulance runs and injured patients, pursuant to rules promulgated by the department for the purpose of injury etiology, patient care outcome, injury **and disease** prevention and research purposes. The department shall not require disclosure by hospitals of data elements pursuant to this section unless those data elements are required by a federal agency or were submitted to the department as of January 1, 1998, pursuant to:

(1) Departmental regulation of trauma centers; or

(2) The Missouri head and spinal cord injury registry established by sections 192.735 to 192.745, RSMo; or

(3) Abstracts of inpatient hospital data; or

(4) If such data elements are requested by a lawful subpoena or subpoena duces tecum.

2. All information and documents in any civil action, otherwise discoverable, may be obtained from any person or entity providing information pursuant to the provisions of sections 190.001 to 190.245.

190.200. **1.** The department of health and senior services in cooperation with local and regional EMS systems and agencies may provide public and professional information and education programs related to emergency medical services systems including trauma**, STEMI, and stroke** systems and emergency medical care and treatment. The department of health and senior services may also provide public information and education programs for informing residents of and visitors to the state of the availability and proper use of emergency medical services, of the value and nature of programs to involve citizens in the administering of prehospital emergency care, including cardiopulmonary resuscitation, and of the availability of training programs in emergency care for members of the general public.

2. The department shall, for STEMI care and stroke care respectively:

(1) Compile and assess peer-reviewed and evidence-based clinical research and guidelines that provide or support recommended treatment standards;

(2) Assess the capacity of the emergency medical services system and hospitals to deliver recommended treatments in a timely fashion;

(3) Use the research, guidelines, and assessment to promulgate rules establishing protocols for transporting STEMI patients to a STEMI center or stroke patients to a stroke center. Such transport protocols shall direct patients to STEMI centers and stroke centers under section 190.243 based on the centers' capacities to deliver recommended acute care treatments within time limits suggested by clinical research;

(4) Define regions within the state for purposes of coordinating the delivery of STEMI care and stroke care, respectively;

(5) Promote the development of regional or community-based plans for transporting STEMI or stroke patients via ground or air ambulance to STEMI centers or stroke centers, respectively, in accordance with section 190.243; and

(6) Establish procedures for the submission of community-based or regional plans for department approval.

3. A community-based or regional plan shall be submitted to the department for approval. Such plan shall be based on the clinical research and guidelines and assessment of capacity described in subsection 1 of this section and shall include a mechanism for evaluating its effect on medical outcomes. Upon approval of a plan, the department shall waive the requirements of rules promulgated under sections 190.100 to 190.245 that are inconsistent with the community-based or regional plan. A community-based or regional plan shall be developed by or in consultation with the representatives of hospitals, physicians, and emergency medical services providers in the community or region.

190.241. 1. The department shall designate a hospital as an adult, pediatric or adult and pediatric trauma center when a hospital, upon proper application submitted by the hospital and site review, has been found by the department to meet the applicable level of trauma center criteria for designation in accordance with rules adopted by the department **as prescribed by section 190.185**.

2. **The department shall designate a hospital as a STEMI or stroke center when such hospital, upon proper application and site review, has been found by the department to meet the applicable level of STEMI or stroke center criteria for designation in accordance with**

rules adopted by the department as prescribed by section 190.185. In developing STEMI center and stroke center designation criteria, the department shall use, as it deems practicable, appropriate peer-reviewed or evidence-based research on such topics including, but not limited to, the most recent guidelines of the American College of Cardiology and American Heart Association for STEMI centers, the Joint Commission's Primary Stroke Center Certification program criteria for stroke centers, or Primary and Comprehensive Stroke Center Recommendations as published by the American Stroke Association.

3. The department of health and senior services shall, not less than once every five years, conduct an on-site review of every trauma**, STEMI, and stroke** center through appropriate department personnel or a qualified contractor. **On-site reviews shall be coordinated for the different types of centers to the extent practicable with hospital licensure inspections conducted under chapter 197, RSMo.** No person shall be a qualified contractor for purposes of this subsection who has a substantial conflict of interest in the operation of any trauma**, STEMI, or stroke** center under review. The department may deny, place on probation, suspend or revoke **[**a trauma center**]** **such** designation in any case in which it has reasonable cause to believe that there has been a substantial failure to comply with the provisions of this chapter or any rules or regulations promulgated pursuant to this chapter. If the department of health and senior services has reasonable cause to believe that a hospital is not in compliance with such provisions or regulations, it may conduct additional announced or unannounced site reviews of the hospital to verify compliance. If a trauma**, STEMI, or stroke** center fails two consecutive on-site reviews because of substantial noncompliance with standards prescribed by sections 190.001 to 190.245 or rules adopted by the department pursuant to sections 190.001 to 190.245, its trauma center designation shall be revoked.

[3.**]** **4.** The department of health and senior services may establish appropriate fees to offset the costs of trauma**, STEMI, and stroke** center reviews.

[4.**]** **5.** No hospital shall hold itself out to the public as **[**an adult, pediatric or adult and pediatric trauma center**] a STEMI center, stroke center, adult trauma center, pediatric trauma center, or an adult and pediatric trauma center** unless it is designated as such by the department of

health and senior services.

[5.**]** **6.** Any person aggrieved by an action of the department of health and senior services affecting the trauma**, STEMI, or stroke** center designation pursuant to this chapter, including the revocation, the suspension, or the granting of, refusal to grant, or failure to renew a designation, may seek a determination thereon by the administrative hearing commission **[**pursuant to the provisions of chapter 536**] under chapter 621**, RSMo. It shall not be a condition to such determination that the person aggrieved seek a reconsideration, a rehearing, or exhaust any other procedure within the department.

190.243. 1. Severely injured patients shall be transported to a trauma center. **Patients who suffer a STEMI, as defined in section 190.100, shall be transported to a STEMI center. Patients who suffer a stroke, as defined in section 190.100, shall be transported to a stroke center.**

2. A physician or registered nurse authorized by a physician who has established verbal communication with ambulance personnel shall instruct the ambulance personnel to transport a severely **ill or** injured patient to the closest hospital or designated trauma**, STEMI, or stroke** center, as determined according to estimated transport time whether by ground ambulance or air ambulance, in accordance with transport protocol approved by the medical director and the department of health and senior services, even when the hospital is located outside of the ambulance service's primary service area. When initial transport from the scene of **illness or** injury to a trauma**, STEMI, or stroke** center would be prolonged, the **STEMI, stroke, or** severely injured patient may be transported to the nearest appropriate facility for stabilization prior to transport to a trauma**, STEMI, or stroke** center.

[2.**]** **3.** Transport of the **STEMI, stroke, or** severely injured patient shall be governed by principles of timely and medically appropriate care; consideration of reimbursement mechanisms shall not supersede those principles.

[3.**]** **4.** Patients who **[**are not severely injured**] do not meet the criteria for direct transport to a trauma, STEMI, or stroke center** shall be transported to and cared for at the hospital of their choice so long as such ambulance service is not in violation of local protocols.

190.245. The department shall require hospitals, as defined by chapter 197, RSMo, designated as trauma**, STEMI, or stroke** centers to provide for a peer review system, approved by the department, for trauma**, STEMI, and stroke** cases **[**pursuant to the provisions of**], respective to their**

designations, under section 537.035, RSMo. For purposes of sections 190.241 to 190.245, the department of health and senior services shall have the same powers and authority of a health care licensing board pursuant to subsection 6 of section 537.035, RSMo. Failure of a hospital to provide all medical records necessary for the department to implement provisions of sections 190.241 to 190.245 shall result in the revocation of the hospital's designation as a trauma**, STEMI, or stroke** center. Any medical records obtained by the department or peer review committees shall be used only for purposes of implementing the provisions of sections 190.241 to 190.245 and the names of hospitals, physicians and patients shall not be released by the department or members of review committees.

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, RSMo, shall report patient abstract data for outpatients and inpatients. Within one year of August 28, 1992, ambulatory surgical centers as defined in section 197.200, RSMo, 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 required nosocomial infection incidence rates from hospitals, ambulatory surgical centers, and other facilities as necessary to generate the reports required by this section. Hospitals, ambulatory surgical centers, and other facilities shall provide such data in compliance with this section.

3. No later than July 1, 2005, the department shall promulgate rules specifying the standards and procedures for the collection, analysis, risk adjustment, and reporting of nosocomial infection incidence rates and the types of infections and procedures to be monitored pursuant to subsection 12 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 National **[**Nosocomial Infection Surveillance System**] 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, RSMo.

4. The infection control advisory panel created by section 197.165, RSMo, shall make a recommendation to the department regarding the appropriateness of implementing all or part of the nosocomial infection data collection, analysis, and public reporting requirements of this act by authorizing hospitals, ambulatory surgical centers, and other facilities to participate in the federal Centers for Disease Control and Prevention's National **[**Nosocomial Infection Surveillance System**]** **Healthcare Safety Network**, or its successor. 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 rates than would be provided under subsections 2, 3, and 6 to 12 of this section;

(2) Whether the data provided to the public are subject to the same or greater accuracy of risk adjustment than would be provided under subsections 2, 3, and 6 to 12 of this section;

(3) Whether the public is provided with the same or greater specificity of reporting of infections by type of facility infections and procedures than would be provided under subsections 2, 3, and 6 to 12 of this section;

(4) Whether the data are subject to the same or greater level of confidentiality of the identity of an individual patient than would be provided under subsections 2, 3, and 6 to 12 of this section;

(5) Whether the National **[**Nosocomial Infection Surveillance System**]** **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 nosocomial infection data collection and reporting system is the same or less than under subsections 2, 3, and 6 to 12 of this section.

5. Based on the affirmative recommendation of the infection control advisory panel, and provided that the requirements of subsection 12 of this section can be met, the department may or may not implement the federal Centers for Disease Control and Prevention **[**Nosocomial Infection Surveillance System**]** **National Healthcare Safety Network**, or its successor, as an alternative means of complying with the requirements of subsections 2, 3, and 6 to 12 of this section. If the department chooses to implement the use of the federal Centers for Disease Control Prevention **[**Nosocomial Infection Surveillance System**]** **National Healthcare Safety Network**, or its successor, as an

alternative means of complying with the requirements of subsections 2, 3, and 6 to 12 of this section, it shall be a condition of licensure for hospitals and ambulatory surgical centers which opt to participate in the federal program to permit the federal program to disclose facility-specific data to the department as necessary to provide the public reports required by the department. Any hospital or ambulatory surgical center which does not voluntarily participate in the National **[**Nosocomial Infection Surveillance System**]** **Healthcare Safety Network**, or its successor, shall be required to abide by all of the requirements of subsections 2, 3, and 6 to 12 of this section.

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 report to review and comment on the report prior to its publication or release for general use. The department shall include any comments of a health care provider, at the option of the provider, and associations and related organizations in the publication if the department does not change the publication based upon those comments. The report 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, RSMo, 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, RSMo. An ambulatory surgical center as defined in section 197.200, RSMo, 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, RSMo.

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

12. In consultation with the infection control advisory panel established pursuant to section 197.165, RSMo, 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, and other facility a risk-adjusted nosocomial infection incidence rate for the following types of infection:

(1) Class I surgical site infections;

(2) Ventilator-associated pneumonia**; provided that, upon the recommendation of the infection control advisory panel one or more**

other quality indicators designed to better measure the risk of acquiring ventilator-associated pneumonia can be substituted for a risk-adjusted nosocomial infection incidence rate;

(3) Central line-related bloodstream infections;

(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 the event the provisions of this act are implemented by requiring hospitals, ambulatory surgical centers, and other facilities to participate in the federal Centers for Disease Control and Prevention National **[**Nosocomial Infection Surveillance System**] Healthcare Safety Network**, or its successor, the types of infections to be publicly reported shall be determined by the department by rule and shall be consistent with the infections tracked by the National Nosocomial Infection Surveillance System, or its successor.

14. Reports published pursuant to subsection 12 of this section shall be published on the department's Internet web site. The initial report shall be issued by the department not later than December 31, 2006. The reports shall be distributed at least annually to the governor and members of the general assembly.

15. The Hospital Industry Data Institute shall publish a report of Missouri hospitals' and ambulatory surgical centers' 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 and ambulatory surgical centers and publish such information in accordance with subsection 14 of this section.

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

17. The department shall promulgate rules to implement the provisions of section 192.131 and sections 197.150 to 197.160, RSMo. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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.

197.150. **1.** The department shall require that each hospital, ambulatory surgical center, and other facility have in place procedures for monitoring and enforcing compliance with infection control regulations and standards. Such procedures shall be coordinated with administrative staff, personnel staff, and the quality improvement program. Such procedures shall include, at a minimum, requirements for the facility's infection control program to conduct surveillance of personnel with a portion of the surveillance to be done in such manner that employees and medical staff are observed without their knowledge of such observation, provided that this unobserved surveillance requirement shall not be considered to be grounds for licensure enforcement action by the department until the department establishes clear and verifiable criteria for determining compliance. Such surveillance also may include monitoring of the rate of use of hand hygiene products.

2. Beginning January 1, 2009, the department shall require every hospital licensed in this state to establish a methicillin-resistant staphylococcus aureus (MRSA) control program. The program shall be developed by the hospital's administrative staff, medical staff, and quality improvement program, and shall:

(1) Establish procedures to isolate identified MRSA-colonized and MRSA-infected patients or use alternative methods to reduce the risk of MRSA transmission when private rooms are not available;

(2) Establish procedures, protocols, and education for staff known to be MRSA-colonized or MRSA-infected;

(3) Establish an infection-control intervention protocol that includes at a minimum the following elements:

(a) Infection control precautions, based on nationally recognized standards, for general surveillance of infected or colonized patients;

(b) Intervention protocols based on evidence-based standards;

(c) Physical plant operations related to infection control and environmental cleaning;

(d) Strict hand washing hygiene protocols and the use of contact barriers;

(e) Appropriate use of antimicrobial agents; and

(f) Mandatory educational programs for personnel.

354.535. 1. If a pharmacy, operated by or contracted with by a health maintenance organization, is closed or is unable to provide health care services to an enrollee in an emergency, a pharmacist may take an assignment of such enrollee's right to reimbursement, if the policy or contract provides for such reimbursement, for those goods or services provided to an enrollee of a health maintenance organization. No health maintenance organization shall refuse to pay the pharmacist any payment due the enrollee under the terms of the policy or contract.

2. No health maintenance organization, conducting business in the state of Missouri, shall contract with a pharmacy, pharmacy distributor or wholesale drug distributor, nonresident or otherwise, unless such pharmacy or distributor has been granted a permit or license from the Missouri board of pharmacy to operate in this state.

3. Every health maintenance organization shall apply the same coinsurance, co-payment and deductible factors to all drug prescriptions filled by a pharmacy provider who participates in the health maintenance organization's network if the provider meets the contract's explicit product cost determination. If any such contract is rejected by any pharmacy provider, the health maintenance organization may offer other contracts necessary to comply with any network adequacy provisions of this act. However, nothing in this section shall be construed to prohibit the health maintenance organization from applying different coinsurance, co-payment and deductible factors between generic and brand name drugs.

4. **If the co-payment applied by a health maintenance organization exceeds the usual and customary retail price of the prescription drug, enrollees shall only be required to pay the usual and customary retail price of the prescription drug.**

5. Health maintenance organizations shall not set a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription, unless such limit is applied uniformly to all pharmacy providers in the health

maintenance organization's network.

[5.**]** **6.** Health maintenance organizations shall not insist or mandate any physician or other licensed health care practitioner to change an enrollee's maintenance drug unless the provider and enrollee agree to such change. For the purposes of this provision, a maintenance drug shall mean a drug prescribed by a practitioner who is licensed to prescribe drugs, used to treat a medical condition for a period greater than thirty days. Violations of this provision shall be subject to the penalties provided in section 354.444. Notwithstanding other provisions of law to the contrary, health maintenance organizations that change an enrollee's maintenance drug without the consent of the provider and enrollee shall be liable for any damages resulting from such change. Nothing in this subsection, however, shall apply to the dispensing of generically equivalent products for prescribed brand name maintenance drugs as set forth in section 338.056, RSMo.

376.387. If the co-payment for prescription drugs applied by a health insurer exceeds the usual and customary retail price of the prescription drug, enrollees shall only be required to pay the usual and customary retail price of the prescription drug.

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