SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE NO. 2 FOR

HOUSE BILL NOS. 1933, 1375, 1662, 1816, 1940, 1971, 2240, 2313, 2423 & 2435

94TH GENERAL ASSEMBLY

Reported from the Special Committee on Healthcare Transformation April 21, 2008 with recommendation that House Committee Substitute No. 2 for House Bill Nos. 1933, 1375, 1662, 1816, 1940, 1971, 2240, 2313, 2423 & 2435 Do Pass. Referred to the Committee on Rules pursuant to Rule 25(21)(f).

D. ADAM CRUMBLISS, Chief Clerk

4824L.04C

AN ACT

To repeal sections 197.285, 208.152, 208.227, 208.955, 345.033, 346.020, and 376.383, RSMo, and to enact in lieu thereof fifteen new sections relating to health care, with penalty provisions.

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

Section A. Sections 197.285, 208.152, 208.227, 208.955, 345.033, 346.020, and 376.383, RSMo, are repealed and fifteen new sections enacted in lieu thereof, to be known as sections 197.285, 197.525, 197.625, 208.148, 208.152, 208.227, 208.955, 287.055, 345.033, 346.020, 376.383, 1, 2, 3, and 4, to read as follows:

197.285. 1. **No supervisor or individual with authority to hire, fire, or discipline in a hospital or ambulatory surgical center shall:**

(1) Retaliate or otherwise take any adverse action against an employee based on his or her protected activity; or

(2) In any manner attempt to dissuade, prevent, or interfere with an employee who wishes to engage in protected activity.

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

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.

(1) "Adverse action", any retaliatory action by a supervisor or individual with authority to hire, fire, or discipline that would dissuade a reasonable person from making or supporting protected activity under this section. Adverse actions include but are not limited to refusal to hire, termination, discrimination or disparate treatment, imposition of any discipline or penalty, or any action that adversely affects an employee's pay or benefits. Adverse actions also include threats to take any adverse actions against an employee who engages in protected activity;

(2) "Department", the department of health and senior services;

(3) "Protected activity":

(a) The reporting or disclosure of any information related to:

a. Alleged facilities mismanagement, fraudulent activity, or billing errors, or unethical, immoral, or illegal business practices; or

b. Alleged violations of federal or state laws or regulations regarding patient care, patient safety, or facility safety; or

c. Alleged violations of professional standards of conduct or accepted standards of quality patient care; or

d. The ability of employees to perform their assigned duties consistent with professional standards of conduct or accepted standards of quality patient care;

(b) Includes, but is not limited to:

a. The filing of any complaint or grievance, or the participation in any investigation or proceeding conducted by a hospital, ambulatory surgical center, or any government entity;

b. The refusal to participate in an activity that would result in a violation of any federal or state laws or regulations, professional standards of conduct, or accepted standards of quality patient care; and

(c) Whether an action is considered protected activity entitled to protection under this section shall not depend on whether any investigation by the hospital, ambulatory surgical center, or any governmental authority results in a finding that the hospital or ambulatory surgical center committed any violation of law, regulation, professional standard of conduct, or accepted standards of quality patient care. An employee's actions shall be deemed protected activity if the employee's commission of such activity was reasonable and in good faith.

3. Hospitals and ambulatory surgical centers shall **additionally take the following actions:**

(1) Establish and implement a written policy adopted by each hospital and ambulatory surgical center relating to the protections for employees who **[**disclose information pursuant to**]**

engage in protected activity as defined in subsection 2 of this section. This policy shall include a time frame for completion of investigations related to complaints, not to exceed thirty days, and a method for notifying the complainant of the disposition of the investigation. This policy shall be submitted to the department of health and senior services to verify implementation**[**. At a minimum, such policy shall include the following provisions:

(1) No supervisor or individual with authority to hire or fire in a hospital or ambulatory surgical center shall prohibit employees from disclosing information pursuant to subsection 2 of this section;

(2) No supervisor or individual with authority to hire or fire in a hospital or ambulatory surgical center shall use or threaten to use his or her supervisory authority to knowingly discriminate against, dismiss, penalize or in any way retaliate against or harass an employee because the employee in good faith reported or disclosed any information pursuant to subsection 2 of this section, or in any way attempt to dissuade, prevent or interfere with an employee who wishes to report or disclose such information**]**;

[(3)**] (2)** Establish a program to identify a compliance officer who is a designated person responsible for administering the reporting and investigation process and an alternate person should the primary designee be implicated in the report**[**.

2. This section shall apply to information disclosed or reported in good faith by an employee concerning:

(1) Alleged facility mismanagement or fraudulent activity;

(2) Alleged violations of applicable federal or state laws or administrative rules concerning patient care, patient safety or facility safety; or

(3) The ability of employees to successfully perform their assigned duties.**] ;**

(3) Permit employees making a report who wish to remain anonymous to do so, and shall include safeguards to protect the confidentiality of the employee making the report, the confidentiality of patients, and the integrity of data, information, and medical records. If the employee elects to remain anonymous, such employee is permitted to designate another individual or entity to receive the results of the investigation of the complaint.

All information disclosed, collected and maintained pursuant to this subsection and pursuant to the written policy requirements of this section shall be accessible to the department of health and senior services at all times and shall be reviewed by the department of health and senior services at least annually. Complainants shall be notified of the department of health and senior services' access to such information and of the complainant's right to notify the department of health and senior services of any information concerning alleged violations of applicable federal or state laws or administrative rules concerning patient care, patient safety or facility safety.

3. Prior to any disclosure to individuals or agencies other than the department of health and senior services, employees wishing to make a disclosure pursuant to the provisions of this section shall first report to the individual or individuals designated by the hospital or ambulatory surgical center pursuant to subsection 1 of this section.

4. If the compliance officer, compliance committee or management official discovers credible evidence of misconduct from any source and, after a reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil or administrative law, then the hospital or ambulatory surgical center shall report the existence of misconduct to the appropriate governmental authority within a reasonable period, but not more than seven days after determining that there is credible evidence of a violation.

5. Reports made to the department of health and senior services shall be subject to the provisions of section 197.477, provided that the restrictions of section 197.477 shall not be construed to limit the employee's ability to subpoena from the original source the information reported to the department pursuant to this section.

6. Each written policy shall allow employees making a report who wish to remain anonymous to do so, and shall include safeguards to protect the confidentiality of the employee making the report, the confidentiality of patients and the integrity of data, information and medical records.

7. Each hospital and ambulatory surgical center shall, within forty-eight hours of the receipt of a report, notify the employee that his or her report has been received and is being reviewed.

197.525. 1. This section shall be known and may be cited as the "Health Care Whistleblower Protection Act".

2. No employer shall take any retaliatory action against an employee because the employee does any of the following:

(1) Discloses or threatens to disclose to a supervisor or to a public body an activity, policy, or practice of the employer of another employer with whom there is a business relationship that the employee reasonably believes is in violation of a law or a rule adopted thereunder, or in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care;

(2) Provides information to or testifies before any public body conducting an investigation, hearing, or inquiry into any violation of law or rule adopted thereunder by the employer or another employer with whom there is a business relationship, or in the case of an employee who is a licensed or certified health care professional, provides information to or testifies before any public body conducting an investigation, hearing, or inquiry into the quality of patient care; or

(3) Objects to or refuses to participate in any activity, policy, or practice which the employee reasonably believes:

(a) Is in violation of a law or rule adopted thereunder, or if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;

(b) Is fraudulent or criminal; or

(c) Is incompatible with a clear mandate of public policy concerning the public health, safety, or welfare or protection of the environment.

3. Upon violation of any of the provisions of this section, an aggrieved employee or former employee may, within one year, institute a civil action in a court of competent jurisdiction. Upon the application of any party, a jury shall be directed to try the validity of any claim under this section specified in the suit. All remedies available in common law tort actions shall be available to prevailing plaintiffs. Such remedies shall be in addition to any legal or equitable relief provided by this section or any other state law. The court may also order:

(1) An injunction to restrain continued violation of this section;

(2) The reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position;

(3) The reinstatement of full fringe benefits and seniority rights;

(4) The compensation for lost wages, benefits, and other remuneration;

(5) The payment by the employer of reasonable costs and attorney's fees;

(6) Punitive damages; or

(7) An assessment of a civil fine of not more than one thousand dollars for the first violation of this section and not more than five thousand dollars for each subsequent violation, which shall be distributed to the schools of this state in the same manner that proceeds of all penalties, forfeitures, and fines collected for any breach of the penal laws of the state are distributed.

4. A court may also order that reasonable attorney's fees and court costs be awarded to an employer if the court determines that an action brought by an employee under this section was without basis in law or in fact; except that, an employee shall not be assessed attorney's fees under this section if, after exercising reasonable and diligent efforts after filing a suit, the employee files a voluntary dismissal concerning the employer within a reasonable time after determining that the employer would not be found to be liable for damages.

5. An employer shall conspicuously display notices of its employees' protections and obligations under this section, and use other appropriate means to keep its employees so

informed. Each notice posted under this section shall include the name of the person or persons the employer has designated to receive written notification.

6. Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any federal or state law or regulation, or under any collective bargaining agreement or employment contract; except that, the institution of an action in accordance with this section shall be deemed a waiver of the rights and remedies available under any other contract, collective bargaining agreement, state law or regulation thereunder, or under the common law.

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

(1) "Lift team", hospital employees specially trained to conduct patient lifts, transfers, and repositioning using lifting equipment when appropriate;

(2) "Musculoskeletal disorders", conditions that involve the nerves, tendons, muscles, and supporting structures of the body;

(3) "Safe patient handling", the use of engineering controls, lifting and transfer aids, or assistive devices, by lift teams or other staff instead of manual lifting, to perform the acts of lifting, transferring, and repositioning health care patients and residents.

2. By January 1, 2009, each hospital shall establish a safe patient handling committee either by creating a new committee or assigning the functions of a safe patient handling committee to an existing committee. The purpose of the committee is to design and recommend the process for implementing a safe patient handling program. At least half of the members of the safe patient handling committee shall be frontline nonmanagerial employees who provide direct care to patients unless doing so would adversely affect patient care.

3. By July 1, 2009, each hospital shall establish a safe patient handling program. As part of the program, each hospital shall:

(1) Implement a safe patient handling policy for all shifts and units of the hospital. Implementation of the safe patient handling policy may be phased-in with the acquisition of equipment under subsection 4 of this section;

(2) Conduct a patient handling hazard assessment. Such assessment shall be considered such variables as patient-handling tasks, types of nursing units, patient populations, and the physical environment of patient care areas;

(3) Develop a process to identify the appropriate use of the safe patient handling policy based on the patient's physical and medical condition and the availability of lifting equipment or lift teams. The policy shall include a means to address circumstances under which it would be medically contraindicated to use lifting or transfer aids or assistive devices for particular patients;

(4) Conduct an annual performance evaluation of the program to determine its effectiveness, with the results of the evaluation reported to the safe patient handling committee. The evaluation shall determine the extent to which implementation of the program has resulted in a reduction in musculoskeletal disorder caused by patient handling, and include recommendations to increase the program's effectiveness; and

(5) When developing architectural plans for constructing or remodeling a hospital or a unit of a hospital in which patient handling and movement occurs, consider the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate such equipment at a later date.

4. By January 1, 2012, each hospital shall complete, at a minimum, acquisition of their choice of:

(1) One readily available lift per acute care unit on the same floor unless the safe patient handling committee determines a lift is unnecessary in the unit;

(2) One lift for every ten acute care available patient beds; or

(3) Equipment for use by lift teams.

Hospitals shall train staff on policies, equipment, and devices at least annually.

5. Nothing in this section shall preclude lift team members from performing other duties as assigned during their shift.

6. Each hospital shall develop procedures for hospital employees to refuse to perform or be involved in patient handling or movement that the hospital employee believes in good faith will expose a patient or hospital employee to an unacceptable risk of injury. A hospital employee who in good faith follows the procedure developed by the hospital in accordance with this subsection shall not be the subject of disciplinary action by the hospital for the refusal to perform or be involved in patient handling or movement.

208.148. 1. As used in this section, "MO HealthNet" means the program described in section 208.001.

2. Subject to appropriation, under the MO HealthNet program, any physician who is a provider in the program and meets the requirements of this section shall receive enhanced reimbursement for the specified services provided. In order to qualify for the enhanced reimbursement, the physician provider shall:

(1) Become the health care home for a MO HealthNet patient;

(2) Complete a patient history and consultation, including but not limited to a review of systems, a list of problems, and the initiation of coordination of care for the MO HealthNet patient; and

(3) File a treatment plan for the MO HealthNet patient. Such plan may be filed electronically.

3. If a physician provider meets the requirements of subsection 2 of this section, the physician provider shall be reimbursed under the program at the following rates for all services provided by the physician with the American Medical Association Current Procedural Terminology (CPT) codes 99201 to 99205 for new patients and CPT codes 99211 to 99215 for established patients:

(1) For new patients, one hundred percent of the Medicare reimbursement rate for such services; and

(2) For established patients, one hundred percent of the Medicare reimbursement rate for such services.

4. (1) For purposes of this section, the MO HealthNet division, any third-party administrator, or any other entity that contracts with the division for health care services shall not change any diagnostic or current procedural terminology code submitted by the health care provider for health care services without the express written permission of the health care provider and without the examination of the patient record.

(2) Every contract between the division or any agent of the division and a health care provider shall specifically set forth the codes, including code modifiers, for which the division shall provide compensation, remuneration, or reimbursement, and the amount of compensation, remuneration, or reimbursement for each such code. The code and code modifier shall refer to the most recent American Medical Association code book and other recognized codes as adopted and used in the Medicare and Medicaid programs of the state and federal government.

5. The MO HealthNet division may promulgate rules for implementation of this section. 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, 2008, shall be invalid and void.

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as defined in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for

the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

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

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

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

the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

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

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

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

(10) Home health care services;

(11) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term;

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

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

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

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

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

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

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

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules.

With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

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

(17) Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, RSMo, and regulations promulgated thereunder;

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

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

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

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

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

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

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

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

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

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

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

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

(24) (a) Subject to appropriations, home nursing visits for newborn infants. Such nursing services shall consist of home visits by registered nurses designed to prevent infant mortality, child abuse and neglect for at-risk infants by providing health care, health education, and positive parenting skills, and shall be capable of providing follow-up care as needed until the infant's second birthday. For purposes of this subdivision, "at risk" may include infants born medically fragile, chemically dependent, or deemed by the treating physician as displaying failure to thrive or born to a chemically dependent mother, a teenage mother, a mentally or physically challenged mother, or into a family where there has been a history of prior premature births, abuse or neglect, or domestic violence.

(b) Such services shall be developed as a three-year pilot project in a county with a charter form of government and with more than six hundred thousand but fewer than seven hundred thousand inhabitants, in a county of the first classification with more than eighty-five thousand but fewer than eighty-seven thousand inhabitants, and in a county of the first classification with more than two hundred forty thousand three hundred but fewer than two hundred forty thousand four hundred inhabitants, with no more than five hundred thousand dollars to be expended in each county.

(c) The division shall request appropriate waivers or state plan amendments from the Secretary of the federal Department of Health and Human Services to carry out the requirements of this section;

(25) Medically necessary home telemonitoring services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines, consistent with national standards shall be used to verify medical needs. The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental

reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

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

(1) Dental services;

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

(3) Optometric services as defined in section 336.010, RSMo;

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

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

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536, 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, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, RSMo, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the Missouri MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

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

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a and federal regulations promulgated thereunder.

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

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

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

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

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

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

208.227. **1.** Fee for service eligible policies for prescribing psychotropic medications shall not include any new limits to initial access requirements, except dose optimization or new drug combinations consisting of one or more existing drug entities or preference algorithms for SSRI antidepressants, for persons with mental illness diagnosis, or other illnesses for which treatment with psychotropic medications are indicated and the drug has been approved by the federal Food and Drug Administration for at least one indication and is a recognized treatment

in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature and deemed medically appropriate for a diagnosis. No restrictions to access shall be imposed that preclude availability of any individual atypical antipsychotic monotherapy for the treatment of schizophrenia, bipolar disorder, or psychosis associated with severe depression.

2. The provisions of this section shall apply to any additional geographic areas of the state or populations covered and designated after the effective date of this section to receive MO HealthNet benefits through a care plan other than fee for service.

208.955. 1. There is hereby established in the department of social services the "MO HealthNet Oversight Committee", which shall be appointed by January 1, 2008, and shall consist of **[**eighteen**] twenty-three** members as follows:

(1) Two members of the house of representatives, one from each party, appointed by the speaker of the house of representatives and the minority floor leader of the house of representatives;

(2) Two members of the Senate, one from each party, appointed by the president pro tem of the senate and the minority floor leader of the senate;

(3) One consumer representative **with no affiliation with any of the professional organizations listed in subdivisions (1) to (15) of this subsection**;

(4) Two primary care physicians, licensed under chapter 334, RSMo, recommended by **[**any Missouri organization or association that represents a significant number of physicians licensed in this state, who care for participants, not from the same geographic area**] the Missouri Academy of Family Physicians, the Missouri State Medical Association, or the Missouri Association of Osteopathic Physicians and Surgeons**;

(5) Two physicians, licensed under chapter 334, RSMo, who care for participants but who are not primary care physicians and are not from the same geographic area, recommended by **[**any Missouri organization or association that represents a significant number of physicians licensed in this state**] the Missouri State Medical Association or the Missouri Association of Osteopathic Physicians and Surgeons**;

(6) **One podiatrist, licensed under chapter 330, RSMo, who cares for participants. The podiatrist shall be recommended by the Missouri Podiatric Medical Association;**

(7) One nurse, licensed under chapter 335, RSMo, who cares for participants. The nurse shall be recommended by the Missouri Nurses Association;

(8) One representative of the state hospital association;

[(7)**] (9)** One nonphysician **and nonnurse licensed** health care professional who cares for participants, recommended by the **[**director of the department of insurance, financial institutions and professional registration**] appropriate health care organization or association representing such licensed health care professionals**;

[(8)**] (10)** One dentist, who cares for participants. The dentist shall be recommended by **[**any Missouri organization or association that represents a significant number of dentists licensed in this state**] the Missouri Dental Association**;

[(9)**] (11)** Two patient advocates **which have no affiliation with any provider or provider organization**;

(12) Two licensed mental health professionals, one of whom shall be from a rural area, recommended by an appropriate health care organization or association representing such licensed mental health care professional;

[(10)**] (13)** One **[**public member; and**] representative of federally qualified health centers;**

[(11)**] (14) One representative of rural health clinics; and**

(15) The directors of the department of social services, the department of mental health, the department of health and senior services, or the respective directors' designees, who shall serve as ex-officio members of the committee.

2. The members of the oversight committee, other than the members from the general assembly and ex-officio members, shall be appointed by the governor with the advice and consent of the senate. A chair of the oversight committee shall be selected by the members of the oversight committee. Of the members first appointed to the oversight committee by the governor, eight members shall serve a term of two years, seven members shall serve a term of one year, and thereafter, members shall serve a term of two years. Members shall continue to serve until their successor is duly appointed and qualified. Any vacancy on the oversight committee shall be filled in the same manner as the original appointment. Members shall serve on the oversight committee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of social services for that purpose. The department of social services shall provide technical, actuarial, and administrative support services as required by the oversight committee. The oversight committee shall:

(1) Meet on at least four occasions annually, including at least four before the end of December of the first year the committee is established. Meetings can be held by telephone or video conference at the discretion of the committee;

(2) Review the participant and provider satisfaction reports and the reports of health outcomes, social and behavioral outcomes, use of evidence-based medicine and best practices as required of the health improvement plans and the department of social services under section 208.950;

(3) Review the results from other states of the relative success or failure of various models of health delivery attempted;

(4) Review the results of studies comparing health plans conducted under section 208.950;

(5) Review the data from health risk assessments collected and reported under section 208.950;

(6) Review the results of the public process input collected under section 208.950;

(7) Advise and approve proposed design and implementation proposals for new health improvement plans submitted by the department, as well as make recommendations and suggest modifications when necessary;

(8) Determine how best to analyze and present the data reviewed under section 208.950 so that the health outcomes, participant and provider satisfaction, results from other states, health plan comparisons, financial impact of the various health improvement plans and models of care, study of provider access, and results of public input can be used by consumers, health care providers, and public officials;

(9) Present significant findings of the analysis required in subdivision (8) of this subsection in a report to the general assembly and governor, at least annually, beginning January 1, 2009;

(10) Review the budget forecast issued by the legislative budget office, and the report required under subsection (22) of subsection 1 of section 208.151, and after study:

(a) Consider ways to maximize the federal drawdown of funds;

(b) Study the demographics of the state and of the MO HealthNet population, and how those demographics are changing;

(c) Consider what steps are needed to prepare for the increasing numbers of participants as a result of the baby boom following World War II;

(11) Conduct a study to determine whether an office of inspector general shall be established. Such office would be responsible for oversight, auditing, investigation, and performance review to provide increased accountability, integrity, and oversight of state medical assistance programs, to assist in improving agency and program operations, and to deter and identify fraud, abuse, and illegal acts. The committee shall review the experience of all states that have created a similar office to determine the impact of creating a similar office in this state; **[**and**]**

(12) **Approve all health insurance plans for the insure Missouri plan established under sections 376.1300 to 376.1345, RSMo; and**

(13) Perform other tasks as necessary, including but not limited to making recommendations to the division concerning the promulgation of rules and emergency rules so that quality of care, provider availability, and participant satisfaction can be assured.

3. By July 1, 2011, the oversight committee shall issue findings to the general assembly on the success and failure of health improvement plans and shall recommend whether or not any health improvement plans should be discontinued.

4. The oversight committee shall designate a subcommittee devoted to advising the department on the development of a comprehensive entry point system for long-term care that shall:

(1) Offer Missourians an array of choices including community-based, in-home, residential and institutional services;

(2) Provide information and assistance about the array of long-term care services to Missourians;

(3) Create a delivery system that is easy to understand and access through multiple points, which shall include but shall not be limited to providers of services;

(4) Create a delivery system that is efficient, reduces duplication, and streamlines access to multiple funding sources and programs;

(5) Strengthen the long-term care quality assurance and quality improvement system;

(6) Establish a long-term care system that seeks to achieve timely access to and payment for care, foster quality and excellence in service delivery, and promote innovative and cost-effective strategies; and

(7) Study one-stop shopping for seniors as established in section 208.612.

5. The subcommittee shall include the following members:

(1) The lieutenant governor or his or her designee, who shall serve as the subcommittee chair;

(2) One member from a Missouri area agency on aging, designated by the governor;

(3) One member representing the in-home care profession, designated by the governor;

(4) One member representing residential care facilities, predominantly serving MO HealthNet participants, designated by the governor;

(5) One member representing assisted living facilities or continuing care retirement communities, predominantly serving MO HealthNet participants, designated by the governor;

(6) One member representing skilled nursing facilities, predominantly serving MO HealthNet participants, designated by the governor;

(7) One member from the office of the state ombudsman for long-term care facility residents, designated by the governor;

(8) One member representing Missouri centers for independent living, designated by the governor;

(9) One consumer representative with expertise in services for seniors or the disabled, designated by the governor;

(10) One member with expertise in Alzheimer's disease or related dementia;

(11) One member from a county developmental disability board, designated by the governor;

(12) One member representing the hospice care profession, designated by the governor;

(13) One member representing the home health care profession, designated by the governor;

(14) One member representing the adult day care profession, designated by the governor;

(15) One member gerontologist, designated by the governor;

(16) Two members representing the aged, blind, and disabled population, not of the same geographic area or demographic group designated by the governor;

(17) The directors of the departments of social services, mental health, and health and senior services, or their designees; and

(18) One member of the house of representatives and one member of the senate serving on the oversight committee, designated by the oversight committee chair.

Members shall serve on the subcommittee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of health and senior services for that purpose. The department of health and senior services shall provide technical and administrative support services as required by the committee.

6. By October 1, 2008, the comprehensive entry point system subcommittee shall submit its report to the governor and general assembly containing recommendations for the implementation of the comprehensive entry point system, offering suggested legislative or administrative proposals deemed necessary by the subcommittee to minimize conflict of interests for successful implementation of the system. Such report shall contain, but not be limited to, recommendations for implementation of the following consistent with the provisions of section 208.950:

(1) A complete statewide universal information and assistance system that is integrated into the web-based electronic patient health record that can be accessible by phone, in-person, via MO HealthNet providers and via the Internet that connects consumers to services or providers and is used to establish consumers' needs for services. Through the system, consumers shall be able to independently choose from a full range of home, community-based, and facility-based health and social services as well as access appropriate services to meet individual needs and preferences from the provider of the consumer's choice;

(2) A mechanism for developing a plan of service or care via the web-based electronic patient health record to authorize appropriate services;

(3) A preadmission screening mechanism for MO HealthNet participants for nursing home care;

(4) A case management or care coordination system to be available as needed; and

(5) An electronic system or database to coordinate and monitor the services provided which are integrated into the web-based electronic patient health record.

7. Starting July 1, 2009, and for three years thereafter, the subcommittee shall provide to the governor, lieutenant governor and the general assembly a yearly report that provides an update on progress made by the subcommittee toward implementing the comprehensive entry point system.

8. The provisions of section 23.253, RSMo, shall not apply to sections 208.950 to 208.955.

287.055. 1. By January 1, 2010, the division of workers' compensation shall develop rules to provide a reduced workers' compensation premium for hospitals that implement a safe patient handing program in accordance with section 197.625, RSMo. The rules shall include any requirements for obtaining the reduced premium that shall be met by hospitals.

2. The division shall complete an evaluation of the results of the reduced premium, including changes in claim frequency and costs, and shall report to the appropriate committees of the general assembly by December 1, 2013, and 2015.

3. 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, 2008, shall be invalid and void.

345.033. 1. Any person licensed under sections 345.010 to 345.080 who dispenses products associated with professional practice to clients for remuneration shall deliver to each person supplied with a product a completed purchase agreement which shall include the terms of the sale clearly stated using ordinary English language and terminology which is easily understood by the purchaser. If a product which is not new is sold, the purchase agreement and the container thereof shall be clearly marked as "used", "recased", or "reconditioned", whichever is applicable, with terms of guarantee, if any.

2. Any audiologist licensed under sections 345.010 to 345.080 who dispenses hearing instruments shall include in the purchase agreement for a hearing instrument the following:

(1) The licensee's signature, business address, and license number;

(2) The specifications of the hearing instrument dispensed including make, model, and serial number;

(3) The exact amount of any down payment **and total amount charged for the hearing instrument**;

(4) The length of any trial period provided;

(5) The amount of any charges or service fees connected with any trial period;

(6) A description of the right of the purchaser to return the hearing instrument or written notification that no such right exists;

(7) The name of the manufacturer of the component parts and the assembler or reassembler of the hearing instrument when the product sold is remanufactured or assembled by someone other than the manufacturer of the component parts.

3. Any audiologist licensed under sections 345.010 to 345.080 who dispenses hearing instruments shall, at the time of the initial examination for fitting and sale of a hearing instrument, provide information to each prospective purchaser about:

(1) Magnetic coupling options, also known as "telecoil", "t coil", or "t switch technology", and other coupling technologies available in hearing instruments that provide benefits such as increased access to telephones and assistive listening devices;

(2) Proper use of magnetic coupling or other coupling technologies provided by the hearing instrument purchased; and

(3) The telecommunications equipment distribution program established under section 209.253, RSMo.

4. Information satisfying the requirements of subdivisions (1) and (3) of subsection 3 of this section shall be made available in print and alternative formats by the administrator of the telecommunications equipment distribution program.

346.020. 1. Any person who engages in the practice of fitting hearing instruments shall deliver to each person supplied with a hearing instrument a completed purchase agreement which shall include the licensee's signature, business address and the licensee's license number, together with specifications as to the make, model and serial number of the hearing instrument furnished. The terms of the sale shall be clearly stated in the purchase agreement using ordinary English language and terminology which is easily understood by the purchaser. The purchase agreement shall include, at a minimum: the exact amount of any down payment **and total amount charged for the hearing instrument**, the length of any trial period provided, the amount of any charges or service fees connected with any trial period and any right of the purchaser to return the hearing instrument. If no right exists to return the hearing instrument, the seller shall specify such in writing in the agreement. If a hearing instrument which is not new is sold, the purchase

agreement and the container thereof shall be clearly marked as "used", "recased" or "reconditioned", whichever is applicable, with terms of guarantee, if any.

2. If a hearing instrument is remanufactured or assembled by someone other than the manufacturer of the component parts, the purchase agreement shall contain the name of the manufacturer of the component parts and the assembler or reassembler of such hearing instrument.

3. Any person who engaged in the practice of fitting hearing instruments shall, at the time of the initial examination for fitting and sale of a hearing instrument, make available information to each prospective purchaser about:

(1) Magnetic coupling options, also known as "telecoil", "t coil", or "t switch technology", and other coupling technologies available in hearing instruments that provide benefits such as increased access to telephones and assistive listening devices;

(2) Proper use of magnetic coupling or other coupling technologies provided by the hearing instrument purchased; and

(3) The telecommunications equipment distribution program established under section 209.253, RSMo.

4. Information satisfying the requirements of subdivisions (1) and (3) of subsection 3 of this section shall be made available in print and alternative formats by the administrator of the telecommunications equipment distribution program.

376.383. 1. For purposes of this section and section 376.384, the following terms shall mean:

(1) "Claimant", any individual, corporation, association, partnership or other legal entity asserting a right to payment arising out of a contract or a contingency or loss covered under a health benefit plan as defined in section 376.1350;

(2) "Deny" or "denial", when the health carrier refuses to reimburse all or part of the claim;

(3) "Health carrier", health carrier as defined in section 376.1350, except that health carrier shall not include a workers' compensation carrier providing benefits to an employee pursuant to chapter 287, RSMo;

(4) "Health care provider", health care provider as defined in section 376.1350;

(5) "Health care services", health care services as defined in section 376.1350;

(6) "Processing days", number of days the health carrier has the claim in its possession. Processing days shall not include days in which the health carrier is waiting for a response to a request for additional information;

(7) "Request for additional information", when the health carrier requests information from the claimant to determine if all or part of the claim will be reimbursed;

(8) "Suspends the claim", giving notice to the claimant specifying the reason the claim is not yet paid, including but not limited to grounds as listed in the contract between the claimant and the health carrier; and

(9) "Third-party contractor", a third party contracted with the health carrier to receive or process claims for reimbursement of health care services.

2. Within ten working days after receipt of a claim by a health carrier or a third-party contractor, a health carrier shall:

(1) Send an acknowledgment of the date of receipt; or

(2) Send notice of the status of the claim that includes a request for additional information **that specifies the information requested and from whom it is requested, such as the claimant, the patient, or another health care provider**.

If a health carrier pays the claim, subdivisions (1) and (2) shall not apply.

3. Within fifteen days after receipt of additional information by a health carrier or a third-party contractor, a health carrier shall pay the claim or any undisputed part of the claim in accordance with this section or send a notice of receipt and status of the claim:

(1) That denies all or part of the claim and specifies each reason for denial; or

(2) That makes a final request for additional information.

4. Within fifteen days after the day on which the health carrier or a third-party contractor receives the additional requested information in response to a final request for information, it shall pay the claim or any undisputed part of the claim or deny or suspend the claim.

5. If the health carrier has not paid the claimant on or before the forty-fifth day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month. The interest shall be calculated based upon the unpaid balance of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest. A health carrier may combine interest payments and make payment once the aggregate amount reaches five dollars.

6. If a health carrier fails to pay, deny or suspend the claim within forty processing days, and has received, on or after the fortieth day, notice from the health care provider that such claim has not been paid, denied or suspended, the health carrier shall, in addition to monthly interest due, pay to the claimant per day an amount of fifty percent of the claim but not to exceed twenty dollars for failure to pay all or part of a claim or interest due thereon or deny or suspend as required by this section. Such penalty shall not accrue for more than thirty days unless the claimant provides a second written or electronic notice on or after the thirty days to the health carrier that the claim remains unpaid and that penalties are claimed to be due pursuant to this

section. Penalties shall cease if the health carrier pays, denies or suspends the claim. Said penalty shall also cease to accrue on the day after a petition is filed in a court of competent jurisdiction to recover payment of said claim. Upon a finding by a court of competent jurisdiction that the health carrier failed to pay a claim, interest or penalty without reasonable cause, the court shall enter judgment for reasonable attorney fees for services necessary for recovery. Upon a finding that a provider filed suit without reasonable grounds to recover a claim, the court shall award the health carrier reasonable attorney fees necessary to the defense.

7. The department of insurance**, financial institutions and professional registration** shall monitor suspensions and determine whether the health carrier acted reasonably.

8. If a health carrier or third-party contractor has reasonable grounds to believe that a fraudulent claim is being made, the health carrier or third-party contractor shall notify the department of insurance of the fraudulent claim pursuant to sections 375.991 to 375.994, RSMo.

9. Denial of a claim shall be communicated to the claimant and shall include the specific reason why the claim was denied. **If a denied claim does not include a specific reason for the denial, the claim shall not be considered denied under this section and section 376.384.**

10. Requests for additional information shall specify what additional information is necessary to process the claim for payment. Information requested shall be reasonable and pertain to the health carrier's determination of liability. The health carrier shall acknowledge receipt of the requested additional information to the claimant within five working days or pay the claim.

Section 1. 1. As used in sections 1 to 3 of this act, the following words and phrases shall mean:

(1) "Generic equivalent", another drug with the same chemical compound as the originally prescribed medication;

(2) "Health carrier", the same meaning as such term is defined in section 376.1350, RSMo; except when such health care services are provided, delivered, arranged for, paid for, or reimbursed by the department of social services or the department of mental health;

(3) "Pharmacy benefit manager" or "PBM", a person or entity other than a pharmacy or pharmacist acting as an administrator in connection with pharmacy benefits;

(4) "Therapeutic alternative", another drug within the same drug class as the originally prescribed medication; and

(5) "Switch communication", a communication from a health insurance carrier or PBM to a patient or the patient's physician that recommends a patient's medication be switched by the original prescribing health care professional to a different medication than the medication originally prescribed by the prescribing health care professional.

2. (1) Any time a patient's medication is recommended to be switched to a medication other than that originally prescribed by the prescribing health care professional, a switch communication shall be sent to:

(a) The patient providing information about why the switch is proposed and the patient's rights for refusing the recommended change in treatment; and

(b) The plan sponsor informing such sponsor of the cost, shown in currency form, of the recommended medication and the cost, shown in currency form, of the originally prescribed medication.

(2) A switch communication shall not be required for generic equivalent medication switches, unless the cost to the patient or plan sponsor is greater than the medication originally prescribed and dispensed.

(3) A switch communication shall be required for therapeutic alternative medication switches.

3. Such switch communication shall:

(1) Clearly identify the originally prescribed medication and the medication to which it has been proposed that the patient should be switched;

(2) Explain any financial incentives that may be provided to, or have been offered to, the prescribing health care professional by the health carrier or PBM that could result in the switch to the different drug. In particular, cash or in-kind compensation payable to prescribers or their professional practices for switching patients from their currently prescribed medication to a different medication shall be disclosed to the patient as well as incentives that may be provided through general health care professional compensation programs used by the health carrier or PBM;

(3) Explain any financial incentive that a health carrier or PBM may have to encourage the switch to a different drug;

(4) Advise the patient of his or her rights to discuss the proposed change in treatment before such a switch takes place, including a discussion with the patient's prescribing health care professional, the filing of a grievance with the health carrier to prevent the switch if such a switch is based on a financial incentive and the filing of a grievance with the department of insurance, financial institutions and professional registration; and

(5) Explain any cost sharing changes for which the patient is responsible.

4. Switch communications to health care providers shall disclose financial incentives or benefits that may be received by the health carrier or PBM.

5. Switch communications to health care providers shall direct the prescriber to advise the patient that is subjected to a switch by the prescriber of any financial incentives

received by the prescriber or other inducements from the health carrier or PBM that may influence the decision to switch.

6. A copy of any switch communication sent to a patient shall also be sent to the prescribing health care professional.

7. Health insurance payers, including employers, shall be notified of medication switches among plan participants. Such notification shall include any financial incentive the health carrier or PBM may be utilizing to encourage or induce the switch. Information contained in the notification shall be in the aggregate and must not contain any personally identifiable information.

8. The department of insurance, financial institutions and professional registration shall create one form for health carriers and pharmacy benefit managers to use in switch communications to patients, prescribing health care professionals, and health insurance payers including employers.

9. The department shall promulgate rules governing switch communications.

10. Such rules shall include, but not be limited to the following:

(1) Procedures for verifying the accuracy of any switch communications from health benefit plans and pharmacy benefit managers to ensure that such switch communications are truthful, accurate, and not misleading based on cost to the patient and plan sponsor, the product package labeling, medical compendia recognized by the MO HealthNet program for the drug utilization review program, and peer-reviewed medical literature, with appropriate references provided;

(2) A requirement that all switch communications bear a prominent legend on the first page that states: "This is not a product safety notice. This is a promotional announcement from your health care insurer or pharmacy benefit manager about one of your current prescribed medications.";

(3) A requirement that, if the switch communication contains information regarding a potential therapeutic substitution, such communication shall explain that medications in the same therapeutic class are associated with different risks and benefits and may work differently in different patients.

11. 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, 2008, shall be invalid and void.

Section 2. 1. Issuing or delivering or causing to be issued or delivered a switch communication that has not been approved and is not in compliance with the requirements of section 1 of this act, is punishable by a fine not to exceed twenty-five thousand dollars.

2. Providing a misrepresentation or false statement in a switch communication under section 1 of this act, is punishable by a fine not to exceed twenty-five thousand dollars.

3. Any other material violation of section 1 of this act, is punishable by a fine not to exceed twenty-five thousand dollars.

Section 3. 1. When medications for the treatment of any medical condition are restricted for use by a health carrier or PBM by a step therapy or fail first protocol, a prescriber may override such restriction if:

(1) The preferred treatment by the health carrier or the PBM has been ineffective in the treatment of the covered person's disease or medical condition; or

(2) Based on sound clinical evidence and medical and scientific evidence:

(a) The preferred treatment is expected to be ineffective based on the known relevant physical or mental characteristics of the covered person and known characteristics of the drug regimen, and is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

(b) The preferred treatment has caused or based on sound clinical evidence and medical and scientific evidence is likely to cause an adverse reaction or other harm to the covered person.

2. The duration of any step therapy or fail first protocol shall not be longer than a period of fourteen days when such treatment is deemed clinically ineffective by the prescribing physician.

3. For medications with no generic equivalent and for which the prescribing physician in their clinical judgment feels that no appropriate therapeutic alternative is available a health carrier or PBM shall provide access to United States Food and Drug Administration (FDA) labeled medications without restriction to treat such medical conditions for which an FDA labeled medication is available.

4. Nothing in this section shall require coverage for a condition specifically excluded by the policy which is not otherwise covered by law.

Section 4. 1. Each hospital may apply to the Missouri health and educational facilities authority for low cost loans to acquire their choice of patient handling equipment.

2. The department of health and senior services may promulgate rules to implement the provisions of this section. 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, 2008, shall be invalid and void.

✓