SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE NO. 2 FOR

HOUSE BILL NO. 1793

97TH GENERAL ASSEMBLY

5244L.06C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.010, 208.166, 208.325, 334.035, 335.036, and 354.535, RSMo, and to enact in lieu thereof fifteen new sections relating to the provision of health care, with a penalty provision.

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

Section A. Sections 208.010, 208.166, 208.325, 334.035, 335.036, and 354.535, RSMo, are repealed and fifteen new sections enacted in lieu thereof, to be known as sections 191.875, 208.010, 208.166, 208.187, 208.325, 334.035, 334.036, 334.037, 335.036, 335.038, 335.375, 335.380, 354.535, 376.387, and 1, to read as follows:

191.875. 1. On or after July 1, 2015, any patient or consumer of health care services, or any MO HealthNet recipient or the division on behalf of a MO HealthNet recipient under section 208.187, who makes a request for an estimate of the cost of health care services from a health care provider shall be provided such estimate no later than five business days after receiving such request, except when the requested information is posted on the department's website under subsections 7 to 11 of this section. The provisions of this subsection shall not apply to emergency health care services.

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

(1) "Ambulatory surgical center", any ambulatory surgical center as defined in section 197.200;

(2) "CPT code", the Current Procedure Terminology code;

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

(4) "DRG", diagnosis related group;

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.

(5) "Estimate of cost", an estimate based on the information entered and assumptions about typical utilization and costs for health care services. Such estimate of cost shall include the following:

(a) The amount that will be charged to a patient for the health services if all charges are paid in full without a public or private third party paying for any portion of the charges;

(b) The average negotiated settlement on the amount that will be charged to a patient required to be provided in paragraph (a) of this subdivision;

(c) The amount of any MO HealthNet reimbursement for the health care services, including claims and pro rata supplemental payments, if known;

(d) The amount of any Medicare reimbursement for the medical services, if known; and

(e) The amount of any insurance co-payments for the health benefit plan of the patient, if known;

(6) "Health care provider", any hospital, ambulatory surgical center, physician, dentist, clinical psychologist, pharmacist, optometrist, podiatrist, registered nurse, physician assistant, chiropractor, physical therapist, nurse anesthetist, long-term care facility, or other licensed health care facility or professional providing health care services in this state;

(7) "Health carrier", an entity as such term is defined under section 376.1350;

(8) "Public or private third party", a state government, the federal government, employer, health carrier, third-party administrator, or managed care organization.

3. Health care providers and the department shall include with any estimate of cost the following: "Your estimated cost is based on the information entered and assumptions about typical utilization and costs. The actual amount billed to you may be different from the estimate of cost provided to you. Many factors affect the actual bill you will receive, and this estimate of cost does not account for all of them. Additionally, the estimate of cost is not a guarantee of insurance coverage or payment of benefits by a public or private third party. You will be billed at the provider's charge for any service provided to you that is not a covered benefit under your plan or by a public or private third party. Please check with your insurance company or public or private third party to receive an estimate of the amount you will owe under your plan or if you need help understanding your benefits for the service chosen.".

4. Each health care provider shall also make available the percentage or amount of any discounts for cash payment of any charges incurred by a posting on the provider's website and by making it available at the provider's location.

5. Nothing in this section shall be construed as violating any provider contract provisions with a health carrier that prohibit disclosure of the provider's fee schedule with a health carrier to third parties.

6. The department may promulgate rules to implement the provisions of subsections 1 to 5 of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

7. A hospital may provide the information specified in subsections 7 to 11 of this section to the department. A hospital which does so shall not be required to provide such information under subsection 1 of this section.

8. The department shall make available to the public on its internet website the most current price information it receives from hospitals under subsections 9 and 10 of this section. The department shall provide such information in a manner that is easily understood by the public and meets the following minimum requirements:

(1) Information for each participating hospital shall be listed separately and hospitals shall be listed in groups by category as determined by the department by rule;

(2) Information for each hospital outpatient department shall be listed separately.

9. Any data disclosed to the department by a hospital under subsections 10 and 11 of this section shall be the sole property of the hospital that submitted the data. Any data or product derived from the data disclosed under subsections 7 to 11 of this section, including a consolidation or analysis of the data, shall be the sole property of the state. The department shall not allow proprietary information it receives or discloses under subsections 7 to 11 of this section to be used by any person or entity for commercial purposes.

10. Beginning with the quarter ending June 30, 2015, and quarterly thereafter, each participating hospital shall provide to the department, in the manner and format determined by the department, the following information about the one hundred most frequently reported admissions by DRG for inpatients as established by the department:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges;

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection;

(3) The amount of Medicaid reimbursement for each DRG, including claims and pro rata supplemental payments;

(4) The amount of Medicare reimbursement for each DRG.

A hospital shall not report or be required to report the information required by this subsection for any of the one hundred most frequently reported admissions where the reporting of such information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

11. Beginning with the quarter ending June 30, 2015, and quarterly thereafter, each participating hospital shall provide to the department, in a manner and format determined by the department, information on the total costs for the fifty most common outpatient surgical procedures by CPT code and the fifty most common imaging procedures by CPT code performed in hospital outpatient settings. Participating hospitals shall report this information in the same manner as required by subsection 10 of this section; provided that, hospitals shall not report or be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of HIPAA or other federal law.

12. The department shall promulgate rules to implement subsections 7 to 11 of this section, which shall include all of the following:

(1) The one hundred most frequently reported DRGs for inpatients for which participating hospitals will provide the data set out in subsection 10 of this section;

(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the department's internet website;

(3) In accordance with subsection 11 of this section, the list of the fifty most common outpatient surgical procedures by CPT code and the fifty most common imaging procedures by CPT code performed in a hospital outpatient setting.

Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to

disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

208.010. 1. In determining the eligibility of a claimant for public assistance pursuant to this law, it shall be the duty of the family support division to consider and take into account all facts and circumstances surrounding the claimant, including his or her living conditions, earning capacity, income and resources, from whatever source received, and if from all the facts and circumstances the claimant is not found to be in need, assistance shall be denied. In determining the need of a claimant, the costs of providing medical treatment which may be furnished pursuant to sections 208.151 to 208.158 shall be disregarded. The amount of benefits, when added to all other income, resources, support, and maintenance shall provide such persons with reasonable subsistence compatible with decency and health in accordance with the standards developed by the family support division; provided, when a husband and wife are living together, the combined income and resources of both shall be considered in determining the eligibility of either or both. "Living together" for the purpose of this chapter is defined as including a husband and wife separated for the purpose of obtaining medical care or nursing home care, except that the income of a husband or wife separated for such purpose shall be considered in determining the eligibility of his or her spouse, only to the extent that such income exceeds the amount necessary to meet the needs (as defined by rule or regulation of the division) of such husband or wife living separately. In determining the need of a claimant in federally aided programs there shall be disregarded such amounts per month of earned income in making such determination as shall be required for federal participation by the provisions of the federal Social Security Act (42 U.S.C.A. 301, et seq.), or any amendments thereto. When federal law or regulations require the exemption of other income or resources, the family support division may provide by rule or regulation the amount of income or resources to be disregarded.

2. Benefits shall not be payable to any claimant who:

(1) Has or whose spouse with whom he or she is living has, prior to July 1, 1989, given away or sold a resource within the time and in the manner specified in this subdivision. In determining the resources of an individual, unless prohibited by federal statutes or regulations, there shall be included (but subject to the exclusions pursuant to subdivisions (4) and (5) of this subsection, and subsection 5 of this section) any resource or interest therein owned by such individual or spouse within the twenty-four months preceding the initial investigation, or at any time during which benefits are being drawn, if such individual or spouse gave away or sold such resource or interest within such period of time at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits, including but not limited to benefits based on December, 1973, eligibility requirements, as follows:

(a) Any transaction described in this subdivision shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance pursuant to this chapter unless such individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose;

(b) The resource shall be considered in determining eligibility from the date of the transfer for the number of months the uncompensated value of the disposed of resource is divisible by the average monthly grant paid or average Medicaid payment in the state at the time of the investigation to an individual or on his or her behalf under the program for which benefits are claimed, provided that:

a. When the uncompensated value is twelve thousand dollars or less, the resource shall not be used in determining eligibility for more than twenty-four months; or

b. When the uncompensated value exceeds twelve thousand dollars, the resource shall not be used in determining eligibility for more than sixty months;

(2) The provisions of subdivision (1) of this subsection shall not apply to a transfer, other than a transfer to claimant's spouse, made prior to March 26, 1981, when the claimant furnishes convincing evidence that the uncompensated value of the disposed of resource or any part thereof is no longer possessed or owned by the person to whom the resource was transferred;

(3) Has received, or whose spouse with whom he or she is living has received, benefits to which he or she was not entitled through misrepresentation or nondisclosure of material facts or failure to report any change in status or correct information with respect to property or income as required by section 208.210. A claimant ineligible pursuant to this subsection shall be ineligible for such period of time from the date of discovery as the family support division may deem proper; or in the case of overpayment of benefits, future benefits may be decreased, suspended or entirely withdrawn for such period of time as the division may deem proper;

(4) Owns or possesses resources in the sum of **[**one**]** **two** thousand dollars or more; provided, however, that if such person is married and living with spouse, he or she, or they, individually or jointly, may own resources not to exceed **[**two**]** **four** thousand dollars; and provided further, that in the case of a temporary assistance for needy families claimant, the provision of this subsection shall not apply;

(5) Prior to October 1, 1989, owns or possesses property of any kind or character, excluding amounts placed in an irrevocable prearranged funeral or burial contract under chapter 436, or has an interest in property, of which he or she is the record or beneficial owner, the value of such property, as determined by the family support division, less encumbrances of record, exceeds twenty-nine thousand dollars, or if married and actually living together with husband or wife, if the value of his or her property, or the value of his or her interest in property, together with that of such husband and wife, exceeds such amount;

(6) In the case of temporary assistance for needy families, if the parent, stepparent, and child or children in the home owns or possesses property of any kind or character, or has an interest in property for which he or she is a record or beneficial owner, the value of such property, as determined by the family support division and as allowed by federal law or regulation, less encumbrances of record, exceeds **[**one**]** **two** thousand dollars, excluding the home occupied by the claimant, amounts placed in an irrevocable prearranged funeral or burial contract under chapter 436, one automobile which shall not exceed a value set forth by federal law or regulation and for a period not to exceed six months, such other real property which the family is making a good-faith effort to sell, if the family agrees in writing with the family support division to sell such property and from the net proceeds of the sale repay the amount of assistance received during such period. If the property has not been sold within six months, or if eligibility terminates for any other reason, the entire amount of assistance paid during such period shall be a debt due the state;

(7) Is an inmate of a public institution, except as a patient in a public medical institution.

3. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the income and resources of a relative or other person living in the home shall be taken into account to the extent the income, resources, support and maintenance are allowed by federal law or regulation to be considered.

4. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the value of burial lots or any amounts placed in an irrevocable prearranged funeral or burial contract under chapter 436 shall not be taken into account or considered an asset of the burial lot owner or the beneficiary of an irrevocable prearranged funeral or funeral contract. For purposes of this section, "burial lots" means any burial space as defined in section 214.270 and any memorial, monument, marker, tombstone or letter marking a burial space. If the beneficiary, as defined in chapter 436, of an irrevocable prearranged funeral or burial contract receives any public assistance benefits pursuant to this chapter and if the purchaser of such contract or his or her successors in interest transfer, amend, or take any other such actions regarding the contract so that any person will be entitled to a refund, such refund shall be paid to the state of Missouri with any amount in excess of the public assistance benefits provided under this chapter to be refunded by the state of Missouri to the purchaser or his or her successors. In determining eligibility and the amount of benefits to be granted under federally aided programs, the value of any life insurance policy where a seller or provider is made the beneficiary or where the life insurance policy is assigned to a seller or provider, either being in consideration for an irrevocable prearranged funeral contract under chapter 436, shall not be taken into account or considered an asset of the beneficiary of the irrevocable prearranged funeral contract. In addition, the value of any funds, up to nine thousand nine hundred ninety-nine

dollars, placed into an irrevocable personal funeral trust account, where the trustee of the irrevocable personal funeral trust account is a state or federally chartered financial institution authorized to exercise trust powers in the state of Missouri, shall not be taken into account or considered an asset of the person whose funds are so deposited if such funds are restricted to be used only for the burial, funeral, preparation of the body, or other final disposition of the person whose funds were deposited into said personal funeral trust account. No person or entity shall charge more than ten percent of the total amount deposited into a personal funeral trust in order to create or set up said personal funeral trust, and any fees charged for the maintenance of such a personal funeral trust shall not exceed three percent of the trust assets annually. Trustees may commingle funds from two or more such personal funeral trust accounts so long as accurate books and records are kept as to the value, deposits, and disbursements of each individual depositor's funds and trustees are to use the prudent investor standard as to the investment of any funds placed into a personal funeral trust. If the person whose funds are deposited into the personal funeral trust account receives any public assistance benefits pursuant to this chapter and any funds in the personal funeral trust account are, for any reason, not spent on the burial, funeral, preparation of the body, or other final disposition of the person whose funds were deposited into the trust account, such funds shall be paid to the state of Missouri with any amount in excess of the public assistance benefits provided under this chapter to be refunded by the state of Missouri to the person who received public assistance benefits or his or her successors. No contract with any cemetery, funeral establishment, or any provider or seller shall be required in regards to funds placed into a personal funeral trust account as set out in this subsection.

5. In determining the total property owned pursuant to subdivision (5) of subsection 2 of this section, or resources, of any person claiming or for whom public assistance is claimed, there shall be disregarded any life insurance policy, or prearranged funeral or burial contract, or any two or more policies or contracts, or any combination of policies and contracts, which provides for the payment of one thousand five hundred dollars or less upon the death of any of the following:

(1) A claimant or person for whom benefits are claimed; or

(2) The spouse of a claimant or person for whom benefits are claimed with whom he or she is living.

If the value of such policies exceeds one thousand five hundred dollars, then the total value of such policies may be considered in determining resources; except that, in the case of temporary assistance for needy families, there shall be disregarded any prearranged funeral or burial

contract, or any two or more contracts, which provides for the payment of one thousand five hundred dollars or less per family member.

6. Beginning September 30, 1989, when determining the eligibility of institutionalized spouses, as defined in 42 U.S.C. Section 1396r-5, for medical assistance benefits as provided for in section 208.151 and 42 U.S.C. Sections 1396a, et seq., the family support division shall comply with the provisions of the federal statutes and regulations. As necessary, the division shall by rule or regulation implement the federal law and regulations which shall include but not be limited to the establishment of income and resource standards and limitations. The division shall require:

(1) That at the beginning of a period of continuous institutionalization that is expected to last for thirty days or more, the institutionalized spouse, or the community spouse, may request an assessment by the family support division of total countable resources owned by either or both spouses;

(2) That the assessed resources of the institutionalized spouse and the community spouse may be allocated so that each receives an equal share;

(3) That upon an initial eligibility determination, if the community spouse's share does not equal at least twelve thousand dollars, the institutionalized spouse may transfer to the community spouse a resource allowance to increase the community spouse's share to twelve thousand dollars;

(4) That in the determination of initial eligibility of the institutionalized spouse, no resources attributed to the community spouse shall be used in determining the eligibility of the institutionalized spouse, except to the extent that the resources attributed to the community spouse do exceed the community spouse's resource allowance as defined in 42 U.S.C. Section 1396r-5;

(5) That beginning in January, 1990, the amount specified in subdivision (3) of this subsection shall be increased by the percentage increase in the Consumer Price Index for All Urban Consumers between September, 1988, and the September before the calendar year involved; and

(6) That beginning the month after initial eligibility for the institutionalized spouse is determined, the resources of the community spouse shall not be considered available to the institutionalized spouse during that continuous period of institutionalization.

7. Beginning July 1, 1989, institutionalized individuals shall be ineligible for the periods required and for the reasons specified in 42 U.S.C. Section 1396p.

8. The hearings required by 42 U.S.C. Section 1396r-5 shall be conducted pursuant to the provisions of section 208.080.

9. Beginning October 1, 1989, when determining eligibility for assistance pursuant to this chapter there shall be disregarded unless otherwise provided by federal or state statutes the home of the applicant or recipient when the home is providing shelter to the applicant or recipient, or his or her spouse or dependent child. The family support division shall establish by rule or regulation in conformance with applicable federal statutes and regulations a definition of the home and when the home shall be considered a resource that shall be considered in determining eligibility.

10. Reimbursement for services provided by an enrolled Medicaid provider to a recipient who is duly entitled to Title XIX Medicaid and Title XVIII Medicare Part B, Supplementary Medical Insurance (SMI) shall include payment in full of deductible and coinsurance amounts as determined due pursuant to the applicable provisions of federal regulations pertaining to Title XVIII Medicare Part B, except for hospital outpatient services or the applicable Title XIX cost sharing.

11. A "community spouse" is defined as being the noninstitutionalized spouse.

12. An institutionalized spouse applying for Medicaid and having a spouse living in the community shall be required, to the maximum extent permitted by law, to divert income to such community spouse to raise the community spouse's income to the level of the minimum monthly needs allowance, as described in 42 U.S.C. Section 1396r-5. Such diversion of income shall occur before the community spouse is allowed to retain assets in excess of the community spouse protected amount described in 42 U.S.C. Section 1396r-5.

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

(1) "Department", the Missouri department of social services;

(2) "Prepaid capitated", a mode of payment by which the department periodically reimburse a contracted health provider plan or primary care physician sponsor for delivering health care services for the duration of a contract to a maximum specified number of members based on a fixed rate per member, notwithstanding:

(a) The actual number of members who receive care from the provider; or

(b) The amount of health care services provided to any members;

(3) "Primary care case-management", a mode of payment by which the department reimburses a contracted primary care physician sponsor on a fee-for-service schedule plus a monthly fee to manage each recipient's case;

(4) "Primary care physician sponsor", a physician licensed pursuant to chapter 334 who is a family practitioner, general practitioner, pediatrician, general internist or an obstetrician or gynecologist;

(5) "Specialty physician services arrangement", an arrangement where the department may restrict recipients of specialty services to designated providers of such services, even in the absence of a primary care case-management system.

2. The department or its designated division shall maximize the use of prepaid health plans, where appropriate, and other alternative service delivery and reimbursement methodologies, including, but not limited to, individual primary care physician sponsors or specialty physician services arrangements, designed to facilitate the cost-effective purchase of comprehensive health care.

3. In order to provide comprehensive health care, the department or its designated division shall have authority to:

(1) Purchase medical services for recipients of public assistance from prepaid health plans, health maintenance organizations, health insuring organizations, preferred provider organizations, individual practice associations, local health units, community health centers, or primary care physician sponsors;

(2) Reimburse those health care plans or primary care physicians' sponsors who enter into direct contract with the department on a prepaid capitated or primary care case-management basis on the following conditions:

(a) That the department or its designated division shall ensure, whenever possible and consistent with quality of care and cost factors, that publicly supported neighborhood and community-supported health clinics shall be utilized as providers;

(b) That the department or its designated division shall ensure reasonable access to medical services in geographic areas where managed or coordinated care programs are initiated; and

(c) That the department shall ensure full freedom of choice for prescription drugs at any Medicaid participating pharmacy;

(3) Limit providers of medical assistance benefits to those who demonstrate efficient and economic service delivery for the level of service they deliver, and provided that such limitation shall not limit recipients from reasonable access to such levels of service;

(4) Provide recipients of public assistance with alternative services as provided for in state law, subject to appropriation by the general assembly;

(5) Designate providers of medical assistance benefits to assure specifically defined medical assistance benefits at a reduced cost to the state, to assure reasonable access to all levels of health services and to assure maximization of federal financial participation in the delivery of health related services to Missouri citizens; provided, all qualified providers that deliver such specifically defined services shall be afforded an opportunity to compete to meet reasonable state criteria and to be so designated;

(6) Upon mutual agreement with any entity of local government, to elect to use local government funds as the matching share for Title XIX payments, as allowed by federal law or regulation;

(7) To elect not to offset local government contributions from the allowable costs under the Title XIX program, unless prohibited by federal law and regulation.

4. Nothing in this section shall be construed to authorize the department or its designated division to limit the recipient's freedom of selection among health care plans or primary care physician sponsors, as authorized in this section, who have entered into contract with the department or its designated division to provide a comprehensive range of health care services on a prepaid capitated or primary care case-management basis, except in those instances of overutilization of Medicaid services by the recipient.

5. The provisions of this section shall expire upon the statewide implementation of the MO HealthNet benefits delivery system established under section 208.187.

208.187. 1. This section shall be known and may be cited as the "MO HealthNet Patient-centered Care Act of 2014".

2. Beginning July 1, 2015, or upon termination of any current contracted health plans in the pilot project areas and subject to receipt of any necessary state plan amendments or waivers from the federal Department of Health and Human Services under subsection 4 of this section, the MO HealthNet division shall establish the "MO HealthNet Patient-centered Care Pilot Project", which transfers current MO HealthNet recipients in the pilot project areas to an approved health plan arrangement as defined in this section wherein recipients may purchase health services through individual health savings accounts and implements an electronic benefit transfer (EBT) payment system for participating recipients.

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

(1) "Approved health plan arrangement", a MO HealthNet benefit arrangement, approved by the division and funded in accordance with this section, which is composed of individual health savings accounts from which a recipient purchases a high deductible health insurance plan and services from qualified providers selected by the recipients through direct pay to the provider, or other cost-effective health care products providing benefits and payment for services approved by the division. The following providers shall be considered qualified providers by the division:

(a) An osteopathic (D.O.) or allopathic (M.D.) physician licensed in this state; or

(b) A physician assistant, advanced practice registered nurse, certified registered nurse anesthetist, or assistant physician licensed in this state working under a collaborative practice arrangement with a physician licensed in this state;

(c) A health care provider licensed in this state to whom the patient is referred by a physician licensed in ths state as described in this section; or

(d) A dentist for eligible dental services under section 208.152.

Such arrangement shall include a requirement that all costs for health care services described in this subdivision and incurred by a policyholder shall be considered a qualified medical expense for purposes of the deductible and any maximum out-of-pocket medical expense limits under a high-deductible health plan;

(2) "Division", the MO HealthNet division within the department of social services;

(3) "Health information exchange" or "HIE", the electronic movement of health-related information among organizations in accordance with nationally recognized standards, with the goal of facilitating access to and retrieval of clinical data to provide safer, timelier, efficient, effective, equitable, patient-centered care;

(4) "HIPAA", the federal Health Insurance Portability and Accountability Act;

(5) "MO HealthNet", the medical assistance program on behalf of needy persons, Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301, et seq. and administered by the department of social services.

4. The MO HealthNet division shall seek any necessary state plan amendments and waivers from the federal Department of Health and Human Services necessary to implement the provisions of this section. If such necessary amendments or waivers are not granted by the federal Department of Health and Human Services, the division shall not be required to implement the provisions of this section.

5. (1) The MO HealthNet division shall establish a minimum of three, but not more than six, pilot project areas in this state which shall include at least ten percent of the total MO HealthNet recipient population, excluding the aged, blind, and disabled population, in the first two years of the pilot project. In the third year of the pilot project, the division may increase the total number of pilot project areas to not more than ten and shall increase the number of participants to at least twenty percent of the total MO HealthNet recipient population, excluding the aged, blind, and disabled population. If the pilot project is automatically implemented on a statewide basis in accordance with subsection 16 of this section, the provisions of this section shall apply to every MO HealthNet recipient, excluding the aged, blind, and disabled population. To ensure an accurate sampling of MO HealthNet recipients, the demographics of the pilot project population shall reflect, to the extent practicable within the geographic area served by the system described in subsection 6 of this section, the current percentages of recipients in the MO HealthNet program population regarding age, gender, socioeconomic status, healthy versus chronically ill

populations, urban versus rural populations, and other relevant demographics as determined by the division. Nothing in this subsection shall be construed as requiring the division to obtain the exact and precise demographics of the current MO HealthNet recipient population in the pilot project or to include or exclude recipients based solely on the pilot project demographic requirements contained in this subsection.

(2) The division shall compile and include a summary of the demographic information for the pilot project and the current MO HealthNet program in the reports required under subsection 13 of this section.

6. (1) The pilot project shall be supported by a health management and population analytics system that tracks and monitors health outcomes in traditionally challenging populations, such as mothers at risk for premature births, frequent utilizers of emergency departments, and those suffering from chronic pain conditions. The system shall implement clinically based predictive models and interventions to improve the care coordination for the targeted populations within the pilot area.

(2) The MO HealthNet division shall contract for a system that shall:

(a) Support an interoperable data anyalytics platform for analyzing clinical data for defined populations, such as mothers at risk of premature birth, frequent utilizers of emergency departments, and those suffering from chronic pain conditions. The system shall be able to leverage cloud-based technology and be hosted remotely by the vendor of the application services system with interoperability capabilities to connect with disparate systems;

(b) Have the ability to interoperate using accepted industry standards, collect and aggregate data from disparate systems, and include but not be limited to clinical data, electronic medical records, claims and eligibility databases, state-managed registries and health information exchanges;

(c) Provide a member portal to beneficiaries to view and manage their personal health information, wellness plans, and overall health, and a HIPAA-compliant provider portal that allows providers with access to patient information;

(d) Allow for real-time patient queries and present clinical information to providers for the purpose of avoiding duplicate tests and improving care coordination;

(e) Have the ability to create condition specific registries for managing populations and provide predictive modeling or alerting functionality which alerts providers of at-risk patients and is able to communicate between various systems to provide electronic medical record (EMR) workflow integration or similar tools to communicate with a health care provider's workflow; and

(f) Operate on a statewide, regional, or community-wide basis.

(3) The coverage area of the system shall comprise the pilot project area and any MO HealthNet recipient participating in the pilot project shall reside in the designated pilot project area.

(4) All MO HealthNet providers providing services to MO HealthNet recipients in the designated pilot project area shall be required to participate in the system described in this subsection for their MO HealthNet recipient patients.

(5) All firearms-related data fields contained in any system shall be redacted or otherwise made inaccessible to system users for all MO HealthNet participants in the pilot project.

7. Under the pilot project, the division shall:

(1) Require recipients to receive benefits and services through an approved health plan arrangement;

(2) Require the use of electronic benefit transfer (EBT) cards issued to participating recipients to pay for MO HealthNet services;

(3) Require recipients to receive an annual examination within six months of enrollment;

(4) Provide educational opportunities for recipients relating to budgeting, planning, and appropriate use of health care options;

(5) Provide assistance and education to recipients and providers which encourages:

(a) Recipients to seek an estimate of cost for health care service under section 191.875 prior to receipt of health care services and providers to provide such estimate of cost prior to receipt of health care services; and

(b) Providers to work with recipients to assist them in making the best and most cost-effective choices available based on the recipient's medical needs.

The division is authorized to request an estimate of cost on the recipient's behalf under section 191.875 and assist recipients, in collaboration with their providers, in making good health care choices and the best use of their health savings account moneys based on the recipient's approved health plan arrangement;

(6) Provide incentives for recipients to seek health care services as needed, while retaining a portion of any savings achieved from efficient use of their EBT cards;

(7) Provide moneys to recipients for health savings accounts, payment of health insurance premiums, and other health-related costs to recipients;

(8) Provide reimbursement of any willing providers licensed in this state and eligible to provide services under the terms of the pilot project at a rate of one hundred percent of the Medicare reimbursement rate for the same or similar services provided; and

(9) Provide demographic and cost-efficiency information to determine feasibility of statewide implementation of the EBT payment system; and

(10) Allow recipients to designate a third party to act on behalf of the participating recipient in case of incapacity, incompetence, or other physical or mental condition as determined by rule of the division which necessitates a designee to act on behalf of the participating recipient. If no designee is selected by a participating recipient, the division shall act on behalf of the participating recipient.

8. (1) Under the pilot project, the government assistance amount necessary to fund the pilot project shall be determined annually based on a survey of the commercial health market in this state and establishing the average cost of an approved health plan arrangement which is composed of direct primary care services and a high-deductible insurance plan. Such average cost shall be the government assistance amount which shall be deposited in the MO HealthNet health savings account trust fund under subsection 10 of this section.

(2) Transfer savings is an amount equal to the current cost of MO HealthNet benefits for all MO HealthNet enrollees in the pilot project areas minus the government assistance amount as determined in subdivision (1) of this subsection multiplied by the number of enrollees in the pilot project.

(3) A portion of the transfer savings described in subdivision (2) of this subsection shall be deposited in the MO HealthNet health savings account trust fund created under subsection 10 of this section in an amount not to exceed the amount necessary to pay the lesser of gap insurance or the average deductible under a high-deductible health insurance plan component of an approved health plan arrangement described in this section until an individual's health savings account balance is determined actuarially sufficient to cover the deductible of such high-deductible health insurance plan without moneys from the trust fund.

(4) In addition to the amounts deposited under subdivision (3) of this subsection, the division shall seek additional moneys from any sources which may be available for funding gap insurance and deductibles described in subdivision (3) of this subsection, including but not limited to moneys available through public or private health foundations and organizations, other nonprofit entities, and any federal or other governmental funding programs. The division shall also seek technical assistance from foundations and other nongovernmental resources to search and apply for available grant and funding opportunities.

9. For the purpose of maximizing available coverage choices for recipients, the division shall approve any health plan arrangement that meets all of the following requirements:

(1) Any insurance plan component is offered by a health insurer issuer as described in 42 U.S.C. Section 18021(a)(1)(C);

(2) The arrangement offers access to quality health care by providing coverage under a package of benefits that is at least equal to coverage required for a catastrophic plan under 42 U.S.C. Section 18022(e); except that, the age restriction for such catastrophic plan shall not apply. When making its determination under this section, the division shall consider the availability of all of the following in the benefits package:

(a) Benefits under a high-deductible health insurance option;

(b) Direct primary care services option;

(c) Fee-for-service option; and

(d) Any combination of the options described in paragraphs (a) to (c) of this subdivision.

10. (1) (a) There is hereby created in the state treasury the "MO HealthNet Health Savings Account Trust Fund", which shall consist of moneys deposited in accordance with this section and other moneys received from any source for deposit into the fund. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and, upon appropriation, money in the fund shall be used solely for the pilot project established under this section.

(b) Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund.

(c) The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

(2) Moneys in this fund shall be used to pay for approved health plan arrangement costs and to credit recipient EBT cards under subsection 11 of this section. Each recipient shall have credited to the recipient's health savings account the amount necessary to pay for any high deductible plan premiums, one-half of the recipient's deductible amount under the recipient's high deductible plan, and direct primary care costs. If a recipient spends one-half of the recipient's total deductible amount prior to the end of the plan year, the recipient's health savings account may be credited with the remaining one-half of such recipient's deductible amount.

11. (1) Pilot project recipients shall receive a prepaid EBT card to pay for MO HealthNet services received through an approved health plan arrangement, including but not limited to payment of deductible amounts. The division shall determine the amount credited to such EBT card from the recipient's health savings account for each recipient on a risk adjusted basis and in accordance with subdivision (2) of subsection 10 of this section.

(2) Providers in the MO HealthNet pilot project shall be required to swipe a recipient's EBT card for every visit or service received, regardless of the balance on the recipient's EBT card. Subject to any federal and state laws, the division shall maintain a record of every visit or service received by a recipient, regardless of whether payment was obtained from a recipient's EBT card. Participating recipients shall be required to permit, and if required sign a waiver for, disclosure of the information required in this subsection to the division. Nothing in this subsection shall be construed as requiring the division to maintain specific medical records of recipients. The disclosure required under this section shall be limited to name of the provider, date, and general nature of the visit or service.

(3) Any remaining balance on a recipient's EBT card at the end of the benefit year shall be apportioned as follows:

(a) To the recipient:

a. For a recipient who does not receive the mandatory health services under subdivision (3) of subsection 7 of this section, no apportionment to the recipient of the remaining amount and the remaining balance shall revert to the division in accordance with subdivision (4) of this subsection;

b. For a recipient who receives the mandatory annual examination under subdivision (3) of subsection 7 of this section, the recipient shall receive any remaining EBT card balance not to exceed twenty-five percent of the total amount credited to the EBT card at the beginning of the benefit year;

c. Any remaining balance apportioned to a recipient shall only be carried over to the following benefit year or credited as a benefit under another public assistance program for which the recipient is eligible, including but not limited to temporary assistance for needy families (TANF), women, infants and children (WIC), early periodic screening diagnosis and treatment (EPSDT), supplemental nutrition assistance program (SNAP), supplemental security income (SSI), child care subsidies, and other public assistance programs as determined by the division.

(4) Any balance not apportioned to the recipient under subdivision (3) of this subsection shall revert to the division. Any reverted amounts which, in the aggregate, total twenty-five percent or less of the total amounts credited on all EBT cards under the pilot

project shall be deposited in the MO HealthNet health savings account trust fund created in subsection 10 of this section. The division shall reassess the amount of MO HealthNet moneys allocated for the pilot project based on the amounts reverting to the division under this subsection.

12. If a state medical assistance program, including but not limited to the pilot project established under this section, is amended to provide that recipients of such program are transferred and enrolled in a health care delivery system that include a health savings account component and moneys saved from such transfer is deposited into the MO HealthNet health savings account trust fund, the division shall expend the amount of money deposited into the fund for the benefit of such recipients to pay any deductibles under high-deductible health insurance plan components of an approved health plan arrangement as triggered by the health care services needed by the recipients. The division shall continue to pay the deductibles for such recipients until such time as each recipient's individual health savings account balance is determined by the division to be actuarially sufficient to cover his or her deductibles.

13. The division shall prepare and submit the following reports to the governor and general assembly:

(1) Beginning with the first calendar quarter of the pilot project, a report detailing the number of participants, amount of government assistance, transfer savings, grant moneys, and all other moneys allocated to the pilot project, provider participation, any information relating to recipient usage, and any data analysis under subsection 6 of this section. Such reports shall be submitted until termination of the pilot project;

(2) Beginning September 1, 2016, and no later than September first of each subsequent year, an annual report specifically detailing the demographics, provider participation, recipient participation, costs of the pilot project, any data analysis under subsection 6 of this section, and recommendations of the division regarding the feasibility of statewide implementation. Such report shall also include any additional information the division deems relevant.

14. Except as authorized under the MO HealthNet program, the disclosure of any information provided to or obtained by a provider, business, or vendor under the pilot project within the MO HealthNet program as established in this section is prohibited. Such provider, business, or vendor shall not use or sell such information and shall not divulge the information without a court order. Violation of this subsection is a class A misdemeanor.

15. The MO HealthNet division shall promulgate rules necessary to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section

536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

16. Beginning July 1, 2017, unless the provisions of this section are repealed by an act of the general assembly, the pilot project described in this section shall automatically be implemented on a statewide basis for all MO HealthNet recipients who are eligible to receive MO HealthNet benefits under this section in accordance with federal law and state plan amendments and waivers.

208.325. 1. Beginning October 1, 1994, the department of social services shall enroll AFDC recipients in the self-sufficiency program established by this section. The department may target AFDC households which meet at least one of the following criteria:

(1) Received AFDC benefits in at least eighteen out of the last thirty-six months; or

(2) Are parents under twenty-four years of age without a high school diploma or a high school equivalency certificate and have a limited work history; or

(3) Whose youngest child is sixteen years of age, or older; or

(4) Are currently eligible to receive benefits pursuant to section 208.041, an assistance program for unemployed married parents.

2. The department shall, subject to appropriation, enroll in self-sufficiency pacts by July 1, 1996, the following AFDC households:

(1) Not fewer than fifteen percent of AFDC households who are required to participate in the FUTURES program under sections 208.405 and 208.410, and who are currently participating in the FUTURES program;

(2) Not fewer than five percent of AFDC households who are required to participate in the FUTURES program under sections 208.405 and 208.410, but who are currently not participating in the FUTURES program; and

(3) By October 1, 1997, not fewer than twenty-five percent of aid to families with dependent children recipients, excluding recipients who meet the following criteria and are exempt from mandatory participation in the family self-sufficiency program:

(a) Disabled individuals who meet the criteria for coverage under the federal Americans with Disabilities Act, P.L. 101-336, and are assessed as lacking the capacity to engage in full-time or part-time subsidized employment;

(b) Parents who are exclusively responsible for the full-time care of disabled children; and

(c) Other families excluded from mandatory participation in FUTURES by federal guidelines.

3. Upon enrollment in the family self-sufficiency program, a household shall receive an initial assessment of the family's educational, child care, employment, medical and other supportive needs. There shall also be assessment of the recipient's skills, education and work experience and a review of other relevant circumstances. Each assessment shall be completed in consultation with the recipient and, if appropriate, each child whose needs are being assessed.

4. Family assessments shall be used to complete a family self-sufficiency pact in negotiation with the family. The family self-sufficiency pact shall identify a specific point in time, no longer than twenty-four months after the family enrolls in the self-sufficiency pact, when the family's primary self-sufficiency pact shall conclude. The self-sufficiency pact is subject to reassessment and may be extended for up to an additional twenty-four months, but the maximum term of any self-sufficiency pact shall not exceed a total of forty-eight months. Family self-sufficiency pacts should be completed and entered into within three months of the initial assessment.

5. The division of family services shall complete family self-sufficiency pact assessments and/or may contract with other agencies for this purpose, subject to appropriation.

6. Family self-sufficiency assessments shall be used to develop a family self-sufficiency pact after a meeting. The meeting participants shall include:

(1) A representative of the division of family services, who may be a case manager or other specially designated, trained and qualified person authorized to negotiate the family self-sufficiency pact and follow-up with the family and responsible state agencies to ensure that the self-sufficiency pact is reviewed at least annually and, if necessary, revised as further assessments, experience, circumstances and resources require;

(2) The recipient and, if appropriate, another family member, assessment personnel or an individual interested in the family's welfare.

7. The family self-sufficiency pact shall:

(1) Be in writing and establish mutual state and family member obligations as part of a plan containing goals, objectives and timelines tailored to the needs of the family and leading to self-sufficiency;

(2) Identify available support services such as subsidized child care, medical services and transportation benefits during a transition period, to help ensure that the family will be less likely to return to public assistance.

8. The family self-sufficiency pact shall include a parent and child development plan to develop the skills and knowledge of adults in their role as parents to their children and partners of their spouses. Such plan shall include school participation records. The department of social services shall, in cooperation with the department of health and senior services, the department of mental health, and the "Parents as Teachers" program in the department of elementary and secondary education, develop or make available existing programs to be presented to persons enrolled in a family self-sufficiency pact.

9. A family enrolled in a family self-sufficiency pact may own or possess property as described in subdivision (6) of subsection 2 of section 208.010 with a value of five thousand dollars instead of the **[**one**]** **two** thousand dollars as set forth in subdivision (6) of subsection 2 of section 208.010.

10. A family receiving AFDC may own one automobile, which shall not be subject to property value limitations provided in section 208.010.

11. Subject to appropriations and necessary waivers, the department of social services may disregard from one-half to two-thirds of a recipient's gross earned income for job-related and other expenses necessary for a family to make the transition to self-sufficiency.

12. A recipient may request a review by the director of the division of family services, or his designee, of the family self-sufficiency pact or any of its provisions that the recipient objects to because it is inappropriate. After receiving an informal review, a recipient who is still aggrieved may appeal the results of that review under the procedures in section 208.080.

13. The term of the family self-sufficiency pact may only be extended due to circumstances creating barriers to self-sufficiency and the family self-sufficiency pact may be updated and adjusted to identify and address the removal of these barriers to self-sufficiency.

14. Where the capacity of services does not meet the demand for the services, limited services may be substituted and the pact completion date extended until the necessary services become available for the participant. The pact shall be modified appropriately if the services are not delivered as a result of waiting lists or other delays.

15. The division of family services shall establish a training program for self-sufficiency pact case managers which shall include but not be limited to:

(1) Knowledge of public and private programs available to assist recipients to achieve self-sufficiency;

(2) Skills in facilitating recipient access to public and private programs; and

(3) Skills in motivating and in observing, listening and communicating.

16. The division of family services shall ensure that families enrolled in the family self-sufficiency program make full use of the federal earned income tax credit.

17. Failure to comply with any of the provisions of a self-sufficiency pact developed pursuant to this section shall result in a recalculation of the AFDC cash grant for the household without considering the needs of the caretaker recipient.

18. If a suspension of caretaker benefits is imposed, the recipient shall have the right to a review by the director of the division of family services or his designee.

19. After completing the family self-sufficiency program, should a recipient who has previously received thirty-six months of aid to families with dependent children benefits again become eligible for aid to families with dependent children benefits, the cash grant amount shall be calculated without considering the needs of caretaker recipients. The limitations of this subsection shall not apply to any applicant who starts a self-sufficiency pact on or before July 1, 1997, or to any applicant who has become disabled or is receiving or has received unemployment benefits since completion of a self-sufficiency program.

20. There shall be conducted a comprehensive evaluation of the family self-sufficiency program contained in the provisions of this act and the job opportunities and basic skills training program ("JOBS" or "FUTURES") as authorized by the provisions of sections 208.400 to 208.425. The evaluation shall be conducted by a competitively chosen independent and impartial contractor selected by the commissioner of the office of administration. The evaluation shall be based on specific, measurable data relating to those who participate successfully and unsuccessfully in these programs and a control group, factors which contributed to such success or failures, the structure of such programs and other areas. The evaluation shall include recommendations on whether such programs should be continued and suggested improvements in such programs. The first such evaluation shall be completed and reported to the governor and the general assembly by September 1, 1997. Future evaluations shall be completed every three years thereafter. In addition, in 1997, and every three years thereafter, the oversight division of the committee on legislative research shall complete an evaluation on general relief, child care and development block grants and social services block grants.

21. The director of the department of social services may promulgate rules and regulations, pursuant to section 660.017, and chapter 536 governing the use of family self-sufficiency pacts in this program and in other programs, including programs for noncustodial parents of children receiving assistance.

22. The director of the department of social services shall apply to the United States Secretary of Health and Human Services for all waivers of requirements under federal law necessary to implement the provisions of this section with full federal participation. The provisions of this section shall be implemented, subject to appropriation, as waivers necessary to ensure continued federal participation are received.

334.035. **Except as otherwise provided in section 334.036,** every applicant for a permanent license as a physician and surgeon shall provide the board with satisfactory evidence of having successfully completed such postgraduate training in hospitals or medical or osteopathic colleges as the board may prescribe by rule.

334.036. 1. For purposes of this section, the following terms shall mean:

(1) "Assistant physician", any medical school graduate who:

(a) Is a resident and citizen of the United States or is a legal resident alien;

(b) Has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination or the equivalent of such steps of any other board-approved medical licensing examination within the two-year period immediately preceding application for licensure as an assistant physician, but in no event more than three years after graduation from a medical college or osteopathic medical college; and

(c) Has not completed an approved postgraduate residency and has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such step of any other board-approved medical licensing examination within the immediately preceding two-year period, unless when such two-year anniversary occurs he or she was serving as a resident physician in an accredited residency in the United States and continued to do so within thirty days prior to application for licensure as an assistant physician;

(d) Has proficiency in the English language;

(2) "Assistant physician collaborative practice arrangement", an agreement between a physician and an assistant physician which meets the requirements of this section and section 334.037;

(3) "Medical school graduate", any person who has graduated from a medical college or osteopathic medical college described in section 334.031.

2. (1) An assistant physician collaborative practice arrangement shall limit the assistant physician to providing only primary care services and only in medically underserved rural or urban areas of this state or in any pilot project areas established in which assistant physicians may practice.

(2) For a physician-assistant physician team working in a rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended:

(a) An assistant physician shall be considered a physician assistant for purposes of regulations of the Centers for Medicare and Medicaid Services (CMS); and

(b) No supervision requirements in addition to the minimum federal law shall be required.

3. (1) For purposes of this section, the licensure of assistant physicians shall take place within processes established by rules of the state board of registration for the healing arts. The board of healing arts is authorized to establish rules under chapter 536 establishing licensure and renewal procedures, supervision, collaborative practice arrangements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensure may be denied or the licensure of an assistant physician may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule.

(2) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

4. An assistant physician shall clearly identify himself or herself as an assistant physician and shall be permitted to use the terms "doctor", "Dr." or "doc". No assistant physician shall practice or attempt to practice without an assistant physician collaborative practice arrangement, except as otherwise provided in this section and in an emergency situation.

5. The collaborating physician is responsible at all times for the oversight of the activities of, and accepts responsibility for, primary care services rendered by the assistant physician.

6. The provisions of section 334.037 shall apply to all assistant physician collaborative practice arrangements. To be eligible to practice as an assistant physician, a licensed assistant physician shall enter into an assistant physician collaborative practice arrangement within six months of his or her initial licensure and shall not have more than a six-month time period between collaborative practice arrangements during his or her licensure period. Any renewal of licensure under this section shall include verification of actual practice under a collaborative practice arrangement in accordance with this subsection during the immediately preceding licensure period.

334.037. 1. A physician may enter into collaborative practice arrangements with assistant physicians. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health

care services. Collaborative practice arrangements, which shall be in writing, may delegate to an assistant physician the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the assistant physician and is consistent with that assistant physician's skill, training, and competence and the skill and training of the collaborating physician.

2. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the assistant physician;

(2) A list of all other offices or locations besides those listed in subdivision (1) of this subsection where the collaborating physician authorized the assistant physician to prescribe;

(3) A requirement that there shall be posted at every office where the assistant physician is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by an assistant physician and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the assistant physician;

(5) The manner of collaboration between the collaborating physician and the assistant physician, including how the collaborating physician and the assistant physician shall:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity, except the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar year for rural health clinics as defined by P.L. 95-210, as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. Such exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics where the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics where the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician shall maintain documentation related to such requirement and present it to the state board of registration for the healing arts when requested; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(6) A description of the assistant physician's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the assistant physician to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(7) A list of all other written practice agreements of the collaborating physician and the assistant physician;

(8) The duration of the written practice agreement between the collaborating physician and the assistant physician;

(9) A description of the time and manner of the collaborating physician's review of the assistant physician's delivery of health care services. The description shall include provisions that the assistant physician shall submit a minimum of ten percent of the charts documenting the assistant physician's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days; and

(10) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the assistant physician prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (9) of this subsection.

3. The state board of registration for the healing arts under section 334.125 shall promulgate rules regulating the use of collaborative practice arrangements for assistant physicians. Such rules shall specify:

(1) Geographic areas to be covered;

(2) The methods of treatment that may be covered by collaborative practice arrangements;

(3) In conjunction with deans of medical schools and primary care residency program directors in the state, the development and implementation of educational methods and programs undertaken during the collaborative practice service which shall facilitate the advancement of the assistant physician's medical knowledge and capabilities, and which may lead to credit toward a future residency program for programs that deem such documented educational achievements acceptable; and

(4) The requirements for review of services provided under collaborative practice arrangements, including delegating authority to prescribe controlled substances.

Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section shall be subject to the approval of the state

board of pharmacy. Any rules relating to dispensing or distribution of controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the department of health and senior services and the state board of pharmacy. The state board of registration for the healing arts shall promulgate rules applicable to assistant physicians which shall be consistent with guidelines for federally funded clinics. The rulemaking authority granted in this subsection shall not extend to collaborative practice arrangements of hospital employees providing inpatient care within hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

4. The state board of registration for the healing arts shall not deny, revoke, suspend or otherwise take disciplinary action against a collaborating physician for health care services delegated to an assistant physician provided the provisions of this section and the rules promulgated thereunder are satisfied.

5. Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice agreement, including collaborative practice agreements delegating the authority to prescribe controlled substances, and also report to the board the name of each assistant physician with whom the physician has entered into such agreement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such agreements to ensure that agreements are carried out for compliance under this chapter.

6. A collaborating physician shall not enter into a collaborative practice arrangement with more than three full-time equivalent assistant physicians. Such limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

7. The collaborating physician shall determine and document the completion of at least a one-month period of time during which the assistant physician shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. Such limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

8. No agreement made under this section shall supersede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital as defined in

section 197.020 if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

9. No contract or other agreement shall require a physician to act as a collaborating physician for an assistant physician against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular assistant physician. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any assistant physician, but such requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff.

10. No contract or other agreement shall require any assistant physician to serve as a collaborating assistant physician for any collaborating physician against the assistant physician's will. An assistant physician shall have the right to refuse to collaborate, without penalty, with a particular physician.

11. All collaborating physicians and assistant physicians in collaborative practice arrangements shall wear identification badges while acting within the scope of their collaborative practice arrangement. The identification badges shall prominently display the licensure status of such collaborating physicians and assistant physicians.

335.036. 1. The board shall:

(1) Elect for a one-year term a president and a secretary, who shall also be treasurer, and the board may appoint, employ and fix the compensation of a legal counsel and such board personnel as defined in subdivision (4) of subsection **[**10**]** **11** of section 324.001 as are necessary to administer the provisions of sections 335.011 to 335.096;

(2) Adopt and revise such rules and regulations as may be necessary to enable it to carry into effect the provisions of sections 335.011 to 335.096;

(3) Prescribe minimum standards for educational programs preparing persons for licensure pursuant to the provisions of sections 335.011 to 335.096;

(4) Provide for surveys of such programs every five years and in addition at such times as it may deem necessary;

(5) Designate as "approved" such programs as meet the requirements of sections 335.011 to 335.096 and the rules and regulations enacted pursuant to such sections; and the board shall annually publish a list of such programs;

(6) Deny or withdraw approval from educational programs for failure to meet prescribed minimum standards;

(7) Examine, license, and cause to be renewed the licenses of duly qualified applicants;

(8) Cause the prosecution of all persons violating provisions of sections 335.011 to 335.096, and may incur such necessary expenses therefor;

(9) Keep a record of all the proceedings; and make an annual report to the governor and to the director of the department of insurance, financial institutions and professional registration;

(10) Establish an impaired nurse program**;**

(11) Enter into a contractual agreement with the "Missouri Nurses Foundation Center for Advancing Health", a nonprofit organization established for the purpose of creating a comprehensive nurse workforce center to assess and improve the nursing workforce and its distribution. This center may enter into a contractual agreement with a public institution of higher education for the purpose of collecting and analyzing workforce data from its licensees for future workforce planning.

2. The board shall set the amount of the fees which this chapter authorizes and requires by rules and regulations. The fees shall be set at a level to produce revenue which shall not substantially exceed the cost and expense of administering this chapter.

3. All fees received by the board pursuant to the provisions of sections 335.011 to 335.096 shall be deposited in the state treasury and be placed to the credit of the state board of nursing fund. All administrative costs and expenses of the board shall be paid from appropriations made for those purposes. The board is authorized to provide funding for the nursing education incentive program established in sections 335.200 to 335.203.

4. The provisions of section 33.080 to the contrary notwithstanding, money in this fund shall not be transferred and placed to the credit of general revenue until the amount in the fund at the end of the biennium exceeds two times the amount of the appropriation from the board's funds for the preceding fiscal year or, if the board requires by rule, permit renewal less frequently than yearly, then three times the appropriation from the board's funds for the preceding fiscal year. The amount, if any, in the fund which shall lapse is that amount in the fund which exceeds the appropriate multiple of the appropriations from the board's funds for the preceding fiscal year.

5. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this chapter shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. All rulemaking authority delegated prior to August 28, 1999, is of no force and effect and repealed. Nothing in this section shall be interpreted to repeal or affect the validity of any rule filed or adopted prior to August 28, 1999, if it fully complied with all applicable provisions of law. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and

annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 1999, shall be invalid and void.

335.038. 1. Notwithstanding the provisions of subsection 3 of section 324.001, the board of nursing may release identifying data to the contractor to facilitate data analysis of the healthcare workforce including geographic, demographic, and practice or professional characteristics of licensees.

2. The contractor must maintain the confidentiality of information it receives from the board under this chapter and shall only release information in an aggregate form that cannot be used to identify the individual.

3. The board may expend appropriated funds necessary for operational expenses of the program formed under this section and may promulgate rules subject to the provisions of this section and chapter 536 to effectuate and implement nursing workforce data collection and analysis formed under this section.

335.375. There is hereby established the "Nursing Workforce Center Fund". All fees collected under section 335.380, general revenue moneys appropriated to the nursing workforce center fund, voluntary contributions to support or match nursing workforce data collection and analysis, grants, and funds received from the federal government shall be deposited in the state treasury and be placed to the credit of the nursing workforce center fund. The fund shall be managed by the state board of nursing and all administrative costs and expenses incurred as a result of the effectuation of sections 335.038 and 335.380 shall be paid from the fund.

335.380. The board in addition to any other duties it may have regarding licensure of nurses shall collect at the time of licensure or licensure renewal, a surcharge from each person licensed or relicensed under this chapter in the amount of five dollars per year for registered professional nurses and licensed practical nurses. These funds shall be deposited in the nursing workforce center fund created under section 335.375. All expenditures authorized by sections 335.038, 335.375, and this section shall be paid from funds appropriated by the general assembly from the nursing workforce center fund. The provisions of section 33.080 to the contrary notwithstanding, money in this fund shall not be transferred and placed to the credit of the general revenue fund.

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, the pharmacy shall inform the enrollee that the usual and customary price of the prescription drug is lower than the co-payment for such drug through the enrollee's plan. The enrollee may opt to pay the usual and customary price of the prescription drug instead of submitting the claim for payment through the enrollee's plan.**

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.

376.387. If the co-payment for prescription drugs applied by a health carrier or health benefit plan, as defined in section 376.1350, exceeds the usual and customary retail price of the prescription drug, the pharmacy shall inform the enrollee that the usual and

customary price of the prescription drug is lower than the co-payment for such drug through the enrollee's health carrier or health benefit plan. The enrollee may opt to pay the usual and customary price of the prescription drug instead of submitting the claim for payment through the enrollee's health carrier or health benefit plan.

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

(1) "Assistant physician", a person licensed to practice under section 334.036 in a collaborative practice arrangement under section 334.037;

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

(3) "Medically underserved area":

(a) An area in this state with a medically underserved population;

(b) An area in this state designated by the United States secretary of health and human services as an area with a shortage of personal health services;

(c) A population group designated by the United States secretary of health and human services as having a shortage of personal health services;

(d) An area designated under state or federal law as a medically underserved community; or

(e) An area that the department considers to be medically underserved based on relevant demographic, geographic, and environmental factors;

(4) "Primary care", physician services in family practice, general practice, internal medicine, pediatrics, obstetrics, or gynecology;

(5) "Start-up money", a payment made by a county or municipality in this state which includes a medically underserved area for reasonable costs incurred for the establishment of a medical clinic, ancillary facilities for diagnosing and treating patients, and payment of physicians, assistant physicians, and any support staff.

2. (1) The department of health and senior services shall establish and administer a program under this section to increase the number of medical clinics in medically underserved areas. A county or municipality in this state which includes a medically underserved area may establish a medical clinic in the medically underserved area by contributing start-up money for the medical clinic and having such contribution matched wholly or partly by grant moneys from the medical clinics in medically underserved areas fund established in subsection 3 of this section. The department shall seek all available moneys from any source whatsoever, including but not limited to moneys from the Missouri Foundation for Health, to assist in funding the program.

(2) A participating county or municipality which includes a medically underserved area may provide start-up money for a medical clinic over a two-year period. The department shall not provide more than one hundred thousand dollars to such county or

municipality in a fiscal year unless the department makes a specific finding of need in the medically underserved area.

(3) The department shall establish priorities so that the counties or municipalities which include the neediest medically underserved areas eligible for assistance under this section are assured the receipt of a grant.

3. (1) There is hereby created in the state treasury the "Medical Clinics in Medically Underserved Areas Fund", which shall consist of any state moneys appropriated, gifts, grants, donations, or any other contribution from any source for such purpose. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and, upon appropriation, money in the fund shall be used solely for the administration of this section.

(2) Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund.

(3) The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

4. To be eligible to receive a matching grant from the department, a county or municipality which includes a medically underserved area shall:

(1) Apply for the matching grant; and

(2) Provide evidence satisfactory to the department that it has entered into an agreement or combination of agreements with a collaborating physician or physicians for the collaborating physician or physicians and assistant physician or assistant physicians in accordance with a collaborative practice agreement under section 334.037 to provide primary care in the medically underserved area for at least two years.

5. The department shall promulgate rules necessary for the implementation of this section, including rules addressing:

(1) Eligibility criteria for a medically underserved area;

(2) A requirement that a medical clinic utilize an assistant physician in a collaborative practice arrangement under section 334.037;

(3) Minimum and maximum county or municipality contributions to the start-up money for a medical clinic to be matched with grant moneys from the state;

(4) Conditions under which grant moneys shall be repaid by a county or municipality for failure to comply with the requirements for receipt of such grant moneys;

(5) Procedures for disbursement of grant moneys by the department;

(6) The form and manner in which a county or municipality shall make its contribution to the start-up money; and

(7) Requirements for the county or municipality to retain interest in any property, equipment, or durable goods for seven years, including but not limited to the criteria for a county or municipality to be excused from such retention requirement.

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