CCS HCS SS#2 SB 754 -- HEALTH CARE

This bill changes the laws regarding health care.

STATE LEGAL EXPENSE FUND (Section 105.711, RSMo)

Currently, for the purposes of the State Legal Expense Fund a "free health clinic" means a nonprofit community health center exempt from federal taxation that provides primary care and preventative services to people without health insurance without charge. The bill changes the term "free health clinic" to "community health clinic" and removes the without charge requirement. The bill excludes specified federally funded community health centers and rural health clinics from the organizations that are eligible to receive payment of a claim from the fund.

MENINGOCOCCAL VACCINE (Section 174.335)

Currently, an institution of higher education must require all students residing in on-campus housing to sign a written waiver stating that the institution has provided the student or, if the student is a minor, his or her guardian or parent with detailed written information on the risks associated with meningococcal disease and the availability and effectiveness of the meningococcal vaccine. The bill repeals that requirement and requires all students residing in on-campus housing to have received the meningococcal vaccine unless a signed statement of medical or religious exemption is on file with the institution's administration. A medical exemption requires a signed certification by a physician licensed to practice in Missouri indicating that the immunization would seriously endanger the student's health or life or the student has documentation of the disease or laboratory evidence of immunity to the disease. A student must be exempted from the requirement if he or she objects in writing to the institution's administration that immunization violates his or her religious beliefs.

UMBILICAL CORD BLOOD COLLECTION (Section 191.761)

Beginning July 1, 2015, the Department of Health and Senior Services must provide a courier service to transport collected, donated umbilical cord blood samples to a nonprofit umbilical cord blood bank located in St. Louis City in existence as of the effective date of the bill. The collection sites must only be those facilities designated and trained by the blood bank in the collection and handling of umbilical cord blood specimens.

DIABETES CARE, CONTROL, AND PREVENTION (Section 191.990)

The MO HealthNet Division within the Department of Social Services and the Department of Health and Senior Services must collaborate to coordinate goals and benchmarks in each individual agency's plans to reduce the incidence of diabetes in Missouri, improve diabetes care, and control complications associated with diabetes. The division and the Department of Health and Senior Services must submit a report that includes specified information to the General Assembly by January 1 of each odd-numbered year.

The requirements of these provisions must be limited to diabetes information, data, initiatives, and programs within each agency prior to the effective date of these provisions unless there is unobligated funding for diabetes in each agency that may be used for new research, data collection, reporting, or other requirements.

SHOW-ME ECHO PROGRAM (Section 191.1140)

The bill requires, subject to appropriations, the University of Missouri to manage the Show-Me Extension for Community Health Care Outcomes (ECHO) Program. The Department of Health and Senior Services must collaborate with the university in utilizing the program to expand the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved areas of the state and to monitor outcomes of the treatment. The program is designed to utilize current telehealth technology to disseminate knowledge of best practices for the treatment of chronic, common, and complex diseases from a multidisciplinary team of medical experts to local primary care providers who will deliver the treatment protocol to patients, which will alleviate the need of many patients to travel to see specialists and will allow patients to receive treatment more quickly. The program must utilize local community health care workers with knowledge of local social determinants as a force multiplier to obtain better patient compliance and improved health outcomes.

MAMMOGRAPHY REPORTS (Section 192.769)

Beginning January 1, 2015, a mammography facility, upon completion of a mammogram, must provide to the patient a specified notice regarding dense breast tissue stating that if the mammogram demonstrates that the patient has dense breast tissue which could hide abnormalities and has other risk factors that have been identified, the patient might benefit from a supplemental screening that may be suggested by the ordering physician.

These provisions must not be construed to create a duty of care beyond the duty to provide the notice required under the bill.

The information required by the bill or evidence that a person violated these provisions is not admissible in a civil, judicial, or administrative proceeding.

ASSISTANT PHYSICIAN PRESCRIPTIVE AUTHORITY (Section 195.070)

The bill adds an assistant physician participating in a collaborative practice arrangement to the list of persons granted authority to prescribe, administer, and dispense controlled substances as authorized by statute.

IMMUNIZATIONS AGAINST INFLUENZA (Section 197.168)

The bill requires each hospital licensed under Chapter 197 to offer, prior to discharge and with the approval of the attending physician or other authorized practitioner authorized to order vaccinations or as authorized by physician-approved hospital policies or protocols pursuant to state hospital regulations, immunizations against influenza virus to all inpatients 65 years of age or older between October 1 and March 1 of each year in accordance with the latest recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention unless contraindicated for the patient and contingent upon the availability of the vaccine.

DONOR BREAST MILK (Section 208.141)

The Department of Social Services must reimburse a hospital for donor human milk provided to a MO HealthNet participant if the participant is a critically ill infant under three months of age in the neonatal intensive care unit, the physician orders the milk, the department determines it is medically necessary, the parent or guardian signs an informed consent form, and the donor milk is obtained from a donor bank that meets the department's quality guidelines. An electronic web-based prior authorization system must be used to verify medical need.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (Sections 208.631 - 208.646)

The bill removes references to the Uninsured Women's Health Program in the provisions regarding the State Children's Health Insurance Program (SCHIP).

Currently, the provisions regarding SCHIP define "uninsured children" as persons up to 19 years of age who meet specified criteria or persons whose parent or guardian have not had access to affordable health care coverage for their children for six months prior to application for the program. The bill removes the

requirement that the parent or guardian has not had access to coverage for six months prior to application. The bill changes the eligibility requirements for SCHIP by removing the requirement that the parent or guardian demonstrate annually that their total net worth does not exceed $250,000 in total value. The bill changes, from six months to 90 days, the time that a child must be ineligible for SCHIP coverage after notification from the department when his or parent or guardian with an income of more than 250% of the federal poverty level fails to pay the required co-payment or premium.

SHOW-ME HEALTHY BABIES PROGRAM (Section 208.662)

The Show-Me Healthy Babies Program is established within the Department of Social Services as a separate children's health insurance program for any low-income unborn child.

For an unborn child to be eligible for enrollment in the program, the mother of the child must not be eligible for coverage under Title XIX of the federal Social Security Act or the Medicaid Program as administered by the state and must not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. The unborn child must be in a family with income eligibility of no more than 300% of the federal poverty level or the equivalent modified adjusted gross income unless the income eligibility is set lower by the General Assembly through appropriations. When calculating family size as it relates to income eligibility, the family must include in addition to other family members, the unborn child, or in the case of a mother with a multiple pregnancy, all unborn children.

Coverage for an unborn child enrolled in the program must include all prenatal care and pregnancy-related services that benefit the health of the unborn child and promote healthy labor, delivery, and birth. Coverage does not need to include services that are solely for the benefit of the pregnant mother, are unrelated to maintaining or promoting a healthy pregnancy, and provide no benefit to the unborn child.

The bill specifies that there must not be a waiting period before an unborn child may be enrolled in the program. Coverage must include the period from conception to birth and the department must develop a presumptive eligibility procedure for enrolling an unborn child.

Coverage for the child must continue for up to one year after birth unless otherwise prohibited by law or limited by the General Assembly through appropriations. Coverage for the mother is

limited to pregnancy-related and postpartum care beginning on the day the pregnancy ends and extends through the last day of the month that includes the sixtieth day after the pregnancy ends unless otherwise prohibited by law or limited by the General Assembly through appropriations. The department must provide coverage for an unborn child enrolled in the program in the same manner in which the department provides coverage for the Children's Health Insurance Program in the county of the primary residence of the mother.

The department must provide information about the program to maternity homes, pregnancy resource centers, and other similar agencies and programs in the state that assist unborn children and their mothers. The department must consider allowing these agencies and programs to assist in enrolling unborn children in the program and in making determinations about presumptive eligibility and verification of the pregnancy.

Within 60 days after the effective date of these provisions, the department must submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the program.

At least annually, the Department of Social Services must prepare and submit a report to the Governor, the Speaker of the House of Representatives, and the President Pro Tem of the Senate analyzing and projecting the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement agencies, correctional centers, health care providers, employers, other public and private entities, and persons by enrolling unborn children in the program. The bill specifies the information that must be included in this analysis.

The program must not be deemed an entitlement program, but instead must be subject to a federal allotment or other federal appropriations and matching state appropriations.

The state is not obligated to continue the program if the allotment or payments from the federal government end or are not sufficient for the program to operate or if the General Assembly does not appropriate funds for the program.

These provisions must not be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state.

MISSOURI RX PLAN (Sections 208.790 and 208.798)

The bill requires applicant household income limits for Missouri Rx

Plan eligibility to be subject to appropriations, but in no event can an applicant have a household income that is greater than 185% of the federal poverty level for the applicable family size for the applicable year as converted to the modified adjusted gross income equivalent net income standard.

The bill changes the termination of the provisions regarding the Missouri Rx Plan from August 28, 2014, to August 28, 2017.

ASSISTANT PHYSICIANS (Sections 334.035 and 334.036)

The bill establishes provisions for the licensing of an assistant physician. An assistant physician is any medical school graduate who is a resident and citizen of the United States or is a legal resident alien; has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination or the equivalent of the 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; has not completed an approved postgraduate residency and has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent as specified in the bill; and has proficiency in the English language.

An assistant physician collaborative practice arrangement must 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. 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, an assistant physician must be considered a physician assistant for purposes of regulations of the Centers for Medicare and Medicaid Services (CMS) and no supervision requirements in addition to the minimum federal law must be required.

The licensure of assistant physicians must take place within processes established by rules of the State Board of Registration for the Healing Arts within the Department of Insurance, Financial Institutions and Professional Registration. 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 the other standards of conduct set by the board by rule.

An assistant physician must clearly identify himself or herself as an assistant physician and must be permitted to use the terms "doctor," "Dr.," or "doc." An assistant physician is prohibited

from practicing or attempting to practice without an assistant physician collaborative practice arrangement, except as otherwise provided in these provisions and in an emergency situation. 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.

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

ASSISTANT PHYSICIAN COLLABORATIVE PRACTICE ARRANGEMENTS (Section 334.037)

A physician may enter into a collaborative practice arrangement with an assistant physician. A collaborative practice arrangement must be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. A collaborative practice arrangement may delegate to an assistant physician the authority to administer or dispense drugs and provide treatment as long as the delivery of the 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. The arrangement must contain specified provisions.

The State Board of Registration for the Healing Arts must promulgate rules regulating the use of collaborative practice arrangements for assistant physicians. The rules must specify geographic areas to be covered; the methods of treatment that may be covered by collaborative practice arrangements; 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 must 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 the documented educational achievements acceptable; and 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 these provisions must 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 these provisions must 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 must promulgate rules applicable to assistant physicians that must be consistent with guidelines for federally funded clinics. The rulemaking authority granted under these provisions must 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.

The bill prohibits the State Board of Registration for the Healing Arts from denying, revoking, suspending, or otherwise taking disciplinary action against a collaborating physician for health care services delegated to an assistant physician if these provisions and the rules promulgated under these provisions are satisfied.

Within 30 days of any change and on each renewal, the State Board of Registration for the Healing Arts must require every physician to identify whether the physician is engaged in any collaborative practice arrangement, including arrangements 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 an arrangement. The board may make the information available to the public. The board must track the reported information and may routinely conduct random reviews of the arrangements to ensure that they are carried out for compliance under Chapter 334.

A collaborating physician is prohibited from entering into a collaborative practice arrangement with more than three full-time equivalent assistant physicians. The limitation must 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.

The collaborating physician must determine and document the completion of at least a one-month period of time during which the assistant physician must practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. The

limitation must 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. An agreement made under these provisions cannot 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 the protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

A contract or other agreement cannot require a physician to act as a collaborating physician for an assistant physician against the physician's will. A physician must have the right to refuse to act as a collaborating physician, without penalty, for a particular assistant physician. A contract or other agreement cannot 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 the requirement must not authorize a physician in implementing the protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff. A contract or other agreement cannot require any assistant physician to serve as a collaborating assistant physician for any collaborating physician against the assistant physician's will. An assistant physician must have the right to refuse to collaborate, without penalty, with a particular physician.

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

PHYSICIAN ASSISTANTS AS MO HEALTHNET PROVIDERS (Section 334.735)

The bill specifies that the provisions of Section 334.735.5 must not be construed to prohibit a physician assistant from enrolling with the Department of Social Services as a MO HealthNet provider while acting under a supervision agreement between a physician and the physician assistant.

PHARMACIST-ADMINISTERED IMMUNIZATIONS (Section 338.010)

The bill specifies that the "practice of pharmacy" also includes the administration of hepatitis A, hepatitis B, diphtheria, tetanus, and pertussis vaccines by written protocol authorized by a physician for individuals 12 years of age or older. In addition to other requirements established by the joint promulgation of rules

by the Board of Pharmacy and the State Board of Registration for the Healing Arts, a pharmacist must administer vaccines in accordance with the treatment guidelines established by the Centers for Disease Control and Prevention, request a patient to remain in the pharmacy for a safe amount of time after administration of a vaccine to observe any adverse reactions, and receive additional training for the administration of vaccines as required by the Board of Pharmacy. Within 14 days of administering a vaccine, a pharmacist must provide specified information regarding the immunization to the patient's primary health care provider if provided by the patient.

PHARMACISTS AND PHARMACIES (Sections 338.059 - 338.220)

The bill specifies that a licensed pharmacist or physician may label a prescription drug container using either a sequential number or other unique identifier.

The Department of Health and Senior Services must have sole authority and responsibility for the inspection and licensure of hospitals. However, the Board of Pharmacy within the Department of Insurance, Financial Institutions and Professional Registration may inspect a class B hospital pharmacy, as defined in the bill, or any portion of it that is not under the inspection authority of the department to determine compliance with specified laws and rules. The department must have authority to promulgate rules in conjunction with the board governing medication distribution and the provision of medication therapy services by a pharmacist at or within a hospital. A pharmacist providing medication therapy services must obtain a certificate of medication therapeutic plan authority as provided by rule of the board. Medication therapy services may be provided by a pharmacist for patients of a hospital pursuant to a protocol with a physician or to a protocol approved by the medical staff committee. A medical staff protocol must include a process whereby an exemption to the protocol for a patient may be granted for clinical efficacy if the patient's physician makes the request and an appeals process to request a change in a specific protocol based on medical evidence presented by a staff physician.

Medication may be dispensed by a class B hospital pharmacy pursuant to a prescription or a medication order. A drug distributor license must not be required to transfer medication from a class B hospital pharmacy to a hospital clinic or facility for patient care or treatment. Medication dispensed by a class A pharmacy located in a hospital to a hospital patient for use or administration outside of the hospital must be dispensed only by a prescription order from an individual physician for a specific patient. Medication dispensed by a hospital to a hospital patient for use or

administration outside of the hospital must be labeled as provided by rules jointly promulgated by the department and the board.

The board must appoint an advisory committee with specified members to review and make recommendations to the board on the merit of all rules and regulations to be jointly promulgated by the board and the department.

Upon application to the board, any hospital that holds a pharmacy permit or license on the effective date of the bill must be entitled to obtain a class B pharmacy permit or license without the payment of a fee if the application is submitted by January 1, 2015.

MEDICAL CLINICS IN MEDICALLY UNDERSERVED AREAS (Section 1)

The Department of Health and Senior Services must establish and administer a program to increase the number of medical clinics in medically underserved areas. A county or municipality in this state that includes a medically underserved area as specified in the bill may establish a medical clinic in the medically underserved area by contributing start-up money for the medical clinic and having the contribution matched wholly or partly by grant moneys from the newly created Medical Clinics in Medically Underserved Areas Fund. The department is required to seek all available moneys from any source whatsoever including, but not limited to, health care foundations to assist in funding the program. A participating county or municipality that includes a medically underserved area may provide start-up money for a medical clinic over a two-year period. The department must not provide more than $100,000 to the county or municipality in a fiscal year unless the department makes a specific finding of need in the medically underserved area. The department must establish priorities so that the counties or municipalities that include the neediest medically underserved areas eligible for assistance under these provisions are assured the receipt of a grant.

To be eligible to receive a matching grant from the department, a county or municipality that includes a medically underserved area must apply for the matching grant and provide evidence satisfactory to the department that it has entered into an agreement or combination of agreements with a collaborating physician for the collaborating physician and assistant physician in accordance with a collaborative practice arrangement under Section 334.037 to provide primary care in the medically underserved area for at least two years.

The department is required to promulgate rules necessary for the implementation of these provisions, including rules addressing

specified topics.

JOINT COMMITTEE ON EATING DISORDERS (Section 2)

The Joint Committee on Eating Disorders is established composed of three members of the Senate appointed by the President Pro Tem, three members of the House of Representatives appointed by the Speaker, and three members appointed by the Governor as specified in the bill.

The committee must:

(1) Review issues pertaining to the regulation of insurance and other matters impacting the lives of those diagnosed with an eating disorder by taking public testimony from interested parties; and

(2) Consider and review the actuarial analysis conducted under Section 376.1192.

By December 31, 2014, the committee must provide a report to the members of the General Assembly and the Governor that includes recommendations for legislation pertaining to the regulation of insurance and other matters impacting the lives of those diagnosed with an eating disorder.