FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 38

98TH GENERAL ASSEMBLY

0419H.04C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 191.237, 195.070, 208.670, 208.952, 262.960, 262.962, 301.142, 334.037, 334.104, and 348.407, RSMo, and to enact in lieu thereof twenty-five new sections relating to health care, with penalty provisions and an effective date for certain sections.

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

Section A. Sections 191.237, 195.070, 208.670, 208.952, 262.960, 262.962, 301.142, 334.037, 334.104, and 348.407, RSMo, are repealed and twenty-five new sections enacted in lieu thereof, to be known as sections 191.236, 191.237, 191.238, 192.380, 192.500, 195.070, 197.130, 208.065, 208.078, 208.670, 208.671, 208.673, 208.675, 208.677, 208.686, 208.952, 262.960, 262.962, 301.142, 334.037, 334.104, 348.407, 376.379, 376.388, and 376.685, to read as follows:

191.236. As used in sections 191.236 to 191.238, the following terms shall mean:

(1) "Approved health information organization", a health information organization approved under section 191.238;

(2) "Fine or penalty", any civil or criminal penalty or fine, tax, salary or wage withholding, or surcharge established by law or by rule promulgated by a state agency pursuant to chapter 536;

(3) "Health care system", any public or private entity whose function or purpose is the management of, processing of, or enrollment of individuals for or payment for, in full or in part, health care services or health care data or health care information for its participants;

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

(4) "Health information organization", an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

191.237. 1. No law or rule promulgated by an agency of the state of Missouri may impose a fine or penalty against a health care provider, hospital, or health care system for failing to participate in any particular health information organization.

2. A health information organization shall not restrict the exchange of state agency data or standards-based clinical summaries for patients for federal Health Insurance Portability and Accountability Act (HIPAA) allowable uses. Charges for such service shall not exceed the cost of the actual technology connection or recurring maintenance thereof.

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

(1) "Fine or penalty", any civil or criminal penalty or fine, tax, salary or wage withholding, or surcharge established by law or by rule promulgated by a state agency pursuant to chapter 536;

(2) "Health care system", any public or private entity whose function or purpose is the management of, processing of, or enrollment of individuals for or payment for, in full or in part, health care services or health care data or health care information for its participants;

(3) "Health information organization", an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.**] All approved health information organizations shall exchange standards-based clinical summaries for patients and all clinical and claims data from any agency within the state with all other approved health information organizations within the state. Failure to exchange such information shall result in the suspension or revocation of approval status by the Missouri health information exchange commission and the immediate termination of any contracts, grants, and any other forms of state funding.**

4. (1) The state, including all administrative agencies and departments, shall not convey "state designated entity" status to any health information organization. The state shall recognize all approved health information organizations as being equally eligible for any financial support from the state, or assistance or support from the state in securing any other source of funding. The state shall not exchange health information with any nonapproved health information organization unless otherwise required by law.

(2) Only approved health information organizations shall be qualified to respond to contracting procurement opportunities and shall be awarded contracts, subject to the provisions of chapter 34, provided that the state shall not award any contract to any health information organization as a single feasible source vendor under section 34.044.

(3) Beginning August 28, 2015, all existing single feasible source vendor contracts awarded to health information organizations operating within the state shall receive no further appropriations.

5. The state shall not restrict the availability of or access to any state agency-sponsored data sets including, but not limited to, MO HealthNet patient level claims data and MO HealthNet patient level clinical data to any approved health information organization.

6. A health care provider or nonapproved health information organization may disclose protected health information to any state agency for any public health purpose that is required by law without authorization from the Missouri health information exchange commission. Nothing in this act shall be construed to limit the use, transfer, or disclosure of protected health information as required or permitted by the Health Insurance Portability and Accountability Act (HIPAA) or any other provision of law.

191.238. 1. There is hereby created a "Missouri Health Information Exchange Commission". The commission shall consist of seven members, one of which shall be a member of the senate appointed by the president pro tempore of the senate, one of which shall be a member of the house of representatives appointed by the speaker of the house of representatives, one of which shall be the chair of the joint committee on administrative rules, one of which shall either be the chair of the house budget committee or the chair of the senate appropriations committee on an annual revolving appointment, and with one primary care provider appointed by the speaker of the house of representatives and one health systems representative and one health information technology professional serving as a chief information officer with an understanding of information sharing, Health Insurance Portability and Accountability Act (HIPAA) regulations, and data security best practices appointed by the president pro tempore of the senate. The commission members shall be residents of Missouri and shall not have any common membership with the entities and individuals appointed to the Missouri health information technology advisory board, the Missouri health information organization board of directors, the Missouri health connection board of directors, or any entities or individuals appointed to any board of any health information organization with an interest in providing health information exchange services within the state.

2. Commission members shall elect annually from the members a chairperson and a vice-chairperson.

3. The term of office for each member of the commission shall coincide with the term of his or her elected office if he or she is an elected official. The term of office for nonelected members shall be three years, except that of the initial appointments, one

member shall be appointed for a term of one year and two members shall be appointed for a term of two years. Any member may be removed from the commission if four or more members vote for his or her removal in any regularly held or emergency scheduled meeting. Three months before the expiration of the term of an elected official member appointed by the speaker of the house of representatives and the president pro tempore of the senate, the speaker and the president pro tempore shall appoint a successor whose term begins on January first next following. Three months before the expiration of the term of any nonelected member, the members of the current commission shall submit recommendations to the speaker of the house of representatives and the president pro tempore of the senate to fill the position. All nonelected members shall be eligible for reappointment. If there is a vacancy for an elected official member for any cause, the speaker of the house of representatives and the president pro tempore of the senate shall make an appointment to become effective immediately for the unexpired term. If there is a vacancy for a nonelected member for any cause, the chairperson or vice-chairperson shall call an emergency meeting and the commission shall make an appointment for the vacant seat to become effective immediately for the unexpired term.

4. Each member of the commission shall serve without compensation but shall be reimbursed for actual and necessary expenses incurred in the performance of his or her duties.

5. The commission shall have the authority to:

(1) Develop a process by which a health information organization may receive approval status from the commission. The approval process shall include compliance with commonly and equally applied standards designed to ensure the following:

(a) Adherence to nationally recognized standards for interoperability between approved health information organizations and the promotion of standards that allow data to flow as seamlessly as possible between the approved health information organizations;

(b) Conduct operations in a transparent manner to promote consumer confidence;

(c) Adoption and adherence to rules promulgated by the commission regarding access to and use and disclosure of protected health information maintained by or on an approved health information organization;

(d) Financial and operational sustainability in the absence of state and federal funding; and

(e) Maintenance of policies and procedures to address data security including breaches, mandatory cyber insurance coverage, data usage policies and guidelines, and oversight processes and internal auditing practices for addressing data requests;

(2) Develop a process for the investigation of reported complaints and concerns regarding an approved health information organization, as well as develop and impose the appropriate proactive and remedial measures to address any identified deficiencies; and

(3) Develop a process by which an approved health information organization shall be reapproved at appropriate intervals, provided that the health information organization demonstrates continuing compliance with the approval standards under subdivision (1) of this subsection. The reapproval process shall include the following:

(a) An application for reapproval that shall be mailed to each previously approved health information organization in the state at its last known address. Failure to receive the application form shall not relieve a health information organization of the duty to apply for reapproval or the duty to pay any applicable application fees. The application shall include, but not be limited to, disclosure of the following:

a. The applicant organization's name and office address;

b. A listing of all connections with approved health information organizations in this state for the purpose of exchanging standards-based clinical summaries for patients and all clinical and claims data from any agency within the state;

c. The presence of any past or current data security issues and breaches;

d. Proof of mandatory cyber insurance coverage;

e. Copies of all data usage policies and guidelines;

f. A description of oversight processes and internal auditing processes;

g. Cash flow projections for the next two years depicting all forms of revenues and expenses; and

h. Financial documents including the most recent audited financial statement, the most recent monthly income and balance sheet, and the most recent profit-loss statement;

(b) Failure to apply for reapproval status by the deadline set by the commission shall be cause for immediate suspension of approved status; and

(c) The commission shall establish application fees as deemed necessary to sustain essential administrative functions.

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

(1) "Birthing center", any hospital as defined under section 197.020 with more than one licensed obstetric bed or a neonatal intensive care unit or a hospital operated by a state university or a birthing center staffed by certified professional midwives or certified nurse midwives;

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

(3) "High-risk pregnancy", a pregnancy in which the mother or baby is at increased risk for poor health or complications during pregnancy or childbirth;

(4) "Perinatal regional center", a comprehensive maternal and newborn service for women who have been assessed as high-risk patients or are bearing high-risk babies, as determined by a standardized risk assessment tool, who will require the highest level of specialized care. Centers may be comprised of more than one licensed facility.

2. There is hereby created the "Perinatal Advisory Council" which shall be composed of representatives from the following organizations who shall focus on and have experience in perinatal care or infant mortality, one of which shall be elected chair by a majority of the members, to be appointed by the governor with the advice and consent of the senate:

(1) One practicing physician who is a fellow from the Missouri section of the American Congress of Obstetricians and Gynecologists;

(2) One practicing physician from the Missouri chapter of the American Academy of Pediatrics section of Perinatal Pediatrics;

(3) One representative from the March of Dimes;

(4) One representative from the National Association for Nurse Practitioners in Women's Health;

(5) One representative from the Missouri affiliate of the American College of Nurse-Midwives;

(6) One representative from the Missouri section of the Association of Women's Health, Obstetric and Neonatal Nurses or the National Association of Neonatal Nurses;

(7) One practicing physician from the Missouri Academy of Family Physicians;

(8) One representative from a community coalition engaged in infant mortality prevention;

(9) Four representatives from regional Missouri hospitals with one representative from a hospital with perinatal care equivalent to each level;

(10) One practicing physician from the Society for Maternal-Fetal Medicine;

(11) Three active private practice physicians specializing in obstetrics and gynecology, family medicine practicing obstetrics, or pediatrics, at least one of which shall be in active practice in a rural area; and

(12) One representative from the show-me extension for community health care outcomes (ECHO) program.

The director of the department of health and senior services and the director of the department of social services or their designees shall serve as ex officio members of the council and shall not have a vote. The department shall provide necessary staffing support to the council.

3. After seeking broad public and stakeholder input, the perinatal advisory council shall make recommendations for the division of the state into neonatal and maternal care regions. When making such recommendations the council shall consider:

(1) Geographic proximity of facilities;

(2) Hospital systems;

(3) Insurance networks;

(4) Consistent geographic boundaries for neonatal and maternal care regions, where appropriate; and

(5) Existing referral networks and referral patterns to appropriate birthing facilities.

4. The perinatal advisory council shall establish criteria for levels of birthing center care including regional perinatal centers. The levels developed under this section shall be based upon:

(1) Evidence and best practices as outlined by the most current version of the "Levels of Neonatal Care" prepared by the American Academy of Pediatrics;

(2) The most current published version of the "Levels of Maternal Care" developed by the American Congress of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine; and

(3) Necessary variance when considering the geographic and varied needs of citizens of this state.

5. Nothing in this section shall be construed in any way to modify or expand the licensure of any health care professional.

6. Nothing in this section shall be construed in any way to require a patient be transferred to a different facility.

7. The department shall promulgate rules to implement the provisions of this section no later than January 1, 2017. Such rules shall be limited to those necessary for the establishment of levels of neonatal and maternal birthing center care under subsection 4 of this section and the division of the state into neonatal and maternal care regions under subsection 3 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, 2015, shall be invalid and void.

8. Beginning January 1, 2017, hospital applications for license shall include the appropriate level of maternal care designation and neonatal care designation as determined by the perinatal advisory council under subsection 4 of this section.

9. Beginning January 1, 2017, any hospital operated by a state university shall report, as requested by the department, the appropriate level of maternal care designation and neonatal care designation as determined by the perinatal advisory council under subsection 4 of this section.

10. Nothing in this section shall be construed to impose liability for referral or failure to refer in accordance with the recommendations of the perinatal advisory council.

11. The department may partner with appropriate nationally recognized nonprofit organizations with demonstrated expertise in maternal and neonatal standards of care to administer the provisions of this section.

12. The criteria for levels of birthing care developed under subsection 4 of this section shall not include pregnancy termination, or counseling or referral for pregnancy termination.

13. All certified professional midwives may consult with and participate in educational opportunities through the regional perinatal center.

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

(1) "Cone beam computed tomography system", a medical imaging device using x-ray computed tomography to capture data using a cone-shaped x-ray beam;

(2) "Panoramic x-ray system", an imaging device that captures the entire mouth in a single, two-dimensional image including the teeth, upper and lower jaws, and surrounding structures and tissues.

2. Cone beam computed tomography systems and panoramic x-ray systems shall not be required to be inspected more frequently than every six years.

3. Under section 23.253 of the Missouri sunset act:

(1) The provisions of the new program authorized under this section shall automatically sunset on December thirty-first two years after August 28, 2015, unless reauthorized by an act of the general assembly;

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

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

195.070. 1. A physician, podiatrist, dentist, a registered optometrist certified to administer pharmaceutical agents as provided in section 336.220, or an assistant physician in

accordance with section 334.037 or a physician assistant in accordance with section 334.747 in good faith and in the course of his or her professional practice only, may prescribe, administer, and dispense controlled substances or he or she may cause the same to be administered or dispensed by an individual as authorized by statute.

2. An advanced practice registered nurse, as defined in section 335.016, but not a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016, who holds a certificate of controlled substance prescriptive authority from the board of nursing under section 335.019 and who is delegated the authority to prescribe controlled substances under a collaborative practice arrangement under section 334.104 may prescribe any controlled substances listed in Schedules III, IV, and V of section 195.017**, and may have restricted authority in Schedule II. Prescriptions for Schedule II medications prescribed by an advanced practice registered nurse who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone**. However, no such certified advanced practice registered nurse shall prescribe controlled substance for his or her own self or family. Schedule III narcotic controlled substance **and Schedule II - hydrocodone** prescriptions shall be limited to a one hundred twenty-hour supply without refill.

3. A veterinarian, in good faith and in the course of the veterinarian's professional practice only, and not for use by a human being, may prescribe, administer, and dispense controlled substances and the veterinarian may cause them to be administered by an assistant or orderly under his or her direction and supervision.

4. A practitioner shall not accept any portion of a controlled substance unused by a patient, for any reason, if such practitioner did not originally dispense the drug.

5. An individual practitioner shall not prescribe or dispense a controlled substance for such practitioner's personal use except in a medical emergency.

197.130. 1. All hospitals licensed under this chapter shall require admission staff to provide written notice to each patient when the patient is admitted to the hospital under observational status:

(1) During the intake process;

(2) At any time the patient's status changes; and

(3) Upon discharge.

Upon discharge the hospital admission staff shall provide written notice to the patient regarding the duration of the patient's inpatient status, observational status, or both.

2. Each written notice shall include:

(1) A statement regarding whether the patient is being admitted to the hospital under inpatient status or observational status;

(2) A statement that observation status may affect the patient's Medicare, MO HealthNet, or private insurance coverage for hospital services including medications and pharmaceutical supplies and for home- and community-based care or rehabilitative services at a skilled nursing facility if needed upon discharge from the hospital; and

(3) A recommendation that the patient contact his or her health insurance provider to better understand the implications of a patient's placement in observation status.

3. The department of health and senior services shall promulgate rules to implement the provisions of this section and shall develop an acknowledgment form to meet the written notice requirements 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, 2015, shall be invalid and void.

208.065. 1. No later than January 1, 2016, the department of social services shall procure and enter into a competitively bid contract with a contractor to provide verification of initial and ongoing eligibility data for assistance under the supplemental nutrition assistance program (SNAP); temporary assistance for needy families (TANF) program; child care assistance program; and MO HealthNet program. The contractor shall conduct data matches using the name, date of birth, address, Social Security number of each applicant and recipient, and additional data provided by the applicant or recipient relevant to eligibility against public records and other data sources to verify eligibility data.

2. The contractor shall evaluate the income, resources, and assets of each applicant and recipient no less than quarterly. In addition to quarterly eligibility data verification, the contractor shall identify on a monthly basis any program participants who have died, moved out of state, or have been incarcerated longer than ninety days.

3. The contractor, upon completing an eligibility data verification of an applicant or recipient, shall notify the department of the results, except that the contractor shall not verify the eligibility data of persons residing in long-term care facilities whose income and resources were at or below the applicable financial eligibility standards at the time of their last review. Within twenty business days of such notification, the department shall make an eligibility determination. The department shall retain final authority over eligibility

determinations. The contractor shall keep a record of all eligibility data verifications communicated to the department.

4. Within thirty days of the end of each calendar year, the department and contractor shall file a joint report on a yearly basis to the governor, the speaker of the house of representatives, and the president pro tempore of the senate. The report shall include, but shall not be limited to, the number of applicants and recipients determined ineligible for assistance programs based on the eligibility data verification by the contractor and the stated reasons for the determination of ineligibility by the department.

208.078. When the department or its designated division receives information, including from a MO HealthNet managed care plan, that a MO HealthNet participant, excluding a child in the custody of the state, resides out of state, such participant's MO HealthNet services shall be terminated as provided for under this chapter.

208.670. 1. As used in this section, these terms shall have the following meaning:

(1) "Provider", any provider of medical services and mental health services, including all other medical disciplines;

(2) "Telehealth", the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient.

2. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the practice of telehealth in the MO HealthNet program. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth, certification of agencies offering telehealth, and payment for services by providers. Telehealth providers shall be required to obtain patient consent before telehealth services are initiated and to ensure confidentiality of medical information.

3. Telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. Reimbursement for such services shall be made in the same way as reimbursement for in-person contacts.

4. The provisions of section 208.671 shall apply to the use of asynchronous store-and-forward technology in the practice of telehealth.

208.671. 1. As used in this section and section 208.673, the following terms shall mean:

(1) "Asynchronous store-and-forward", the transfer of a patient's clinically important digital samples, such as still images, videos, audio, and text files, and relevant data from an originating site through the use of a camera or similar recording device that stores digital samples that are forwarded via telecommunication to a distant site for consultation by a consulting provider without requiring the simultaneous presence of the patient and the patient's treating provider;

(2) "Asynchronous store-and-forward technology", cameras or other recording devices that store images which may be forwarded via telecommunication devices at a later time;

(3) "Consultation", a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association;

(4) "Consulting provider", a provider who, upon referral by the treating provider, evaluates a patient and appropriate medical data or images delivered through asynchronous store-and-forward technology.

If a consulting provider is unable to render an opinion due to insufficient information, the consulting provider may request additional information to facilitate the rendering of an opinion or decline to render an opinion;

(5) "Distant site", a site where the consulting provider is located at the time the consultation service is provided;

(6) "Originating site", the site where a MO HealthNet participant receiving services and such participant's treating provider are both physically located;

(7) "Provider", any provider of medical services or mental health services, including all other medical disciplines, licensed in this state who has the authority to refer patients for medical services or mental health services or dental health services within the scope of practice and licensure of the provider;

(8) "Telehealth", the same meaning as such term is defined in section 208.670. Telehealth shall include the use of asynchronous store-and-forward technology for orthopedics, dermatology, ophthalmology in cases of diabetic retinopathy, burn and wound care, and maternal-fetal medicine ultrasounds;

(9) "Treating provider", a provider who:

(a) Evaluates a patient;

(b) Determines the need for a consultation;

(c) Arranges the services of a consulting provider for the purpose of diagnosis and treatment;

(d) Provides or supplements the patient's history and provides pertinent physical examination findings and medical information to the consulting provider; and

(e) Is physically present in the same location as the patient during the time of the asynchronous store-and-forward services.

2. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the use of

asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program. Such rules shall address, but not be limited to:

(1) Appropriate standards for the use of asynchronous store-and-forward technology in the practice of telehealth;

(2) Certification of agencies offering asynchronous store-and-forward technology in the practice of telehealth;

(3) Time lines for completion and communication of a consulting provider's consultation or opinion, or if the consulting provider is unable to render an opinion, time lines for communicating a request for additional information or that the consulting provider declines to render an opinion;

(4) Length of time digital files of such asynchronous store-and-forward services are to be maintained;

(5) Security and privacy of such digital files;

(6) Patient consent for asynchronous store-and-forward services; and

(7) Payment for services by providers; except that, consulting providers who decline to render an opinion shall not receive payment under this section unless and until an opinion is rendered.

Telehealth providers using asynchronous store-and-forward technology shall be required to obtain patient consent before asynchronous store-and-forward services are initiated and to ensure confidentiality of medical information.

3. Asynchronous store-and-forward technology in the practice of telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. Reimbursement for such asynchronous store-and-forward services shall be made so that the total payment for the consultation shall be divided between the treating provider and the consulting provider. The total payment for both the treating provider and the consulting provider shall not exceed the payment for a face-to-face consultation of the same level.

4. The standard of care for the use of asynchronous store-and-forward technology in the practice of telehealth shall be the same as the standard of care for face-to-face care.

208.673. 1. There is hereby established the "Telehealth Services Advisory Committee" to advise the department of social services and propose rules regarding the coverage of telehealth services utilizing asynchronous store-and-forward technology.

2. The committee shall be comprised of the following members:

(1) The director of the MO HealthNet division, or the director's designee;

(2) The medical director of the MO HealthNet division;

(3) A representative from a Missouri institution of higher education with expertise in telemedicine;

(4) A representative from the Missouri office of primary care and rural health;

(5) Two board-certified specialists licensed to practice medicine in this state;

(6) A representative from a hospital located in this state that utilizes telehealth medicine;

(7) A primary care provider from a federally qualified health center (FQHC) or rural health clinic; and

(8) A primary care provider from a rural setting other than from an FQHC or rural health clinic.

3. Members of the committee listed in subdivisions (3) to (8) of subsection 2 of this section shall be appointed by the governor, with the advice and consent of the senate. The first appointments to the committee shall consist of three members to serve three-year terms, two members to serve two-year terms, and two members to serve one-year terms as designated by the governor. Each member of the committee shall serve for a term of three years thereafter.

4. Members of the committee shall not receive any compensation for their services but shall be reimbursed for any actual and necessary expenses incurred in the performance of their duties.

5. Any member appointed by the governor may be removed from office by the governor without cause. If there is a vacancy for any cause, the governor shall make an appointment to become effective immediately for the unexpired term.

6. 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, 2015, shall be invalid and void.

208.675. For purposes of the provision of telehealth services, the following individuals, licensed in Missouri, shall be considered eligible health care providers:

(1) Physicians, assistant physicians, and physician assistants;

(2) Advanced registered nurse practitioners;

(3) Dentists, oral surgeons, and dental hygienists under the supervision of a currently registered and licensed dentist;

(4) Psychologists and provisionally licensed psychologists;

(5) Pharmacists;

(6) Speech, occupational, or physical therapists;

(7) Clinical social workers;

(8) Podiatrists;

(9) Licensed professional counselors; and

(10) Eligible health care providers under subdivisions (1) to (9) of this section practicing in a rural health clinic or federally qualified health center or community mental health center.

208.677. For purposes of the provision of telehealth services, the term "originating site" shall mean a telehealth site where the MO HealthNet participant receiving the telehealth service is located for the encounter, and the term "clinical staff" shall mean any health care provider licensed in this state. The originating site shall ensure immediate availability of clinical staff during a telehealth encounter if a participant requires assistance. No originating site for services or activities provided under section 208.686 shall be required to maintain immediate availability of on-site clinical staff during the telemonitoring services or activities. An originating site shall be one of the following locations:

(1) Office of a physician or health care provider;

(2) Hospital;

(3) Critical access hospital;

(4) Rural health clinic;

(5) Federally qualified health center;

(6) Long-term care facility licensed under chapter 198;

(7) Dialysis center;

(8) Missouri state habilitation center or regional office;

(9) Community mental health center;

(10) Missouri state mental health facility;

(11) Missouri state facility;

(12) Missouri residential treatment facility licensed by and under contract with the children's division that has a contract with the children's division. Facilities shall have multiple campuses and have the ability to adhere to technology requirements. Only Missouri licensed psychiatrists, licensed psychologists, or provisionally licensed psychologists, and advanced registered nurse practitioners who are enrolled MO HealthNet providers shall be consulting providers at these locations;

(13) Comprehensive substance treatment and rehabilitation (CSTAR) program;

(14) School;

(15) The MO HealthNet recipient's home; and

(16) Clinical designated area in a pharmacy.

208.686. 1. Subject to appropriations, the department shall establish a statewide program that permits reimbursement under the MO HealthNet program for home telemonitoring services. For the purposes of this section, "home telemonitoring service" shall mean a health care service that requires scheduled remote monitoring of data related to a patient's health and transmission of the data to a Utilization Review Accreditation Commission (URAC) accredited health call center.

2. The program shall:

(1) Provide that home telemonitoring services are available only to persons who:

(a) Are diagnosed with one or more of the following conditions:

a. Pregnancy;

b. Diabetes;

c. Heart disease;

d. Cancer;

e. Chronic obstructive pulmonary disease;

f. Hypertension;

g. Congestive heart failure;

h. Mental illness or serious emotional disturbance;

i. Asthma;

j. Myocardial infarction; or

k. Stroke; and

(b) Exhibit two or more of the following risk factors:

a. Two or more hospitalizations in the prior twelve-month period;

b. Frequent or recurrent emergency department admissions;

c. A documented history of poor adherence to ordered medication regimens;

d. A documented history of falls in the prior six-month period;

e. Limited or absent informal support systems;

f. Living alone or being home alone for extended periods of time; or

g. A documented history of care access challenges;

(2) Ensure that clinical information gathered by a home health agency or hospital while providing home telemonitoring services is shared with the patient's physician; and

(3) Ensure that the program does not duplicate any disease management program services provided by MO HealthNet.

3. If, after implementation, the department determines that the program established under this section is not cost effective, the department may discontinue the program and stop providing reimbursement under the MO HealthNet program for home telemonitoring services.

4. The department shall determine whether the provision of home telemonitoring services to persons who are eligible to receive benefits under both the MO HealthNet and Medicare programs achieves cost savings for the Medicare program.

5. If, before implementing any provision of this section, the department determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the department shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

6. The department shall promulgate rules and regulations 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, 2015, shall be invalid and void.

208.952. 1. There is hereby established **[**the**]** **a permanent** "Joint Committee on **[**MO HealthNet**]** **Public Assistance**". The committee shall have **[**as its purpose the study of**]** the **following purposes:**

(1) Studying, monitoring, and reviewing the efficacy of the public assistance programs within the state;

(2) Determining the level of resources needed **[**to continue and improve the MO HealthNet program over time**]** **for the public assistance programs within the state; and**

(3) Developing recommendations to the general assembly on reducing dependency on the public assistance programs within the state and promoting self-sufficiency among public assistance recipients as may be appropriate.

The committee shall receive and obtain information from the departments of social services, mental health, health and senior services, and elementary and secondary education, and any other department as applicable, regarding the public assistance programs within the state including, but not limited to, MO HealthNet, supplemental nutrition assistance program (SNAP), and temporary assistance for needy families (TANF).

Such information shall include projected enrollment growth, budgetary matters, and any other information deemed to be relevant to the committee's purpose.

2. The committee shall consist of ten members:

(1) The chair and the ranking minority member of the house committee on the budget;

(2) The chair and the ranking minority member of the senate committee on appropriations **[**committee**]**;

(3) The chair and the ranking minority member of the house committee on appropriations **[**for health, mental health, and social services**] designated to consider public assistance legislation and matters**;

(4) The chair and the ranking minority member of the **standing** senate committee **[**on health and mental health**] designated to consider public assistance legislation and matters**;

(5) A representative chosen by the speaker of the house of representatives; and

(6) A senator chosen by the president pro **[**tem**] tempore** of the senate.

No more than **[**three**] four** members from each house shall be of the same political party.

[2.**] 3.** A chair of the committee shall be selected by the members of the committee.

[3.**] 4.** The committee shall meet **[**as necessary**] at least twice a year. A portion of the meeting shall be set aside for the purpose of receiving public testimony. The committee shall seek from recommendations from social, economic, and public assistance experts on ways to improve the effectiveness of public assistance programs, to improve program efficiency and reduce costs, and to promote self-sufficiency among public assistance recipients as may be appropriate**.

[4. Nothing in this section shall be construed as authorizing the committee to hire employees or enter into any employment contracts.

5. The committee shall receive and study the five-year rolling MO HealthNet budget forecast issued annually by the legislative budget office.

6.**] 5. The committee is authorized to hire staff and enter into employment contracts including, but not limited to, an executive director to conduct special reviews or investigations of the public assistance programs within the state in order to assist the committee with its duties. Staff appointments shall be approved by the president pro tempore of the senate and the speaker of the house of representatives. The compensation of comittee staff and the expenses of the committee shall be paid from the joint contingent fund or jointly from the senate and house contingent funds until an appropriation is made therefor.**

6. The committee shall **annually conduct a rolling five-year forecast of the public assistance programs within the state and** make recommendations in a report to the general

assembly by January first each year, beginning in **[**2008**]** **2017**, on anticipated growth **[**in the MO HealthNet program**]** **of the public assistance programs within the state**, needed improvements, anticipated needed appropriations, and suggested strategies on ways to structure the state budget in order to satisfy the future needs of **[**the program**]** **such programs**.

262.960. 1. This section shall be known and may be cited as the "**[**Farm-to-School**]** **Farm-to-Table** Act".

2. There is hereby created within the department of agriculture the "**[**Farm-to-School**]** **Farm-to-Table** Program" to connect Missouri farmers and **[**schools**]** **institutions** in order to provide **[**schools**]** **institutions** with locally grown agricultural products for inclusion in **[**school**]** meals and snacks and to strengthen local farming economies. **The department shall establish parameters for program goals, which shall include, but not be limited to, participating institutions purchasing at least five percent of their food products locally by December 31, 2018.** The department shall designate an employee to administer and monitor the **[**farm-to-school**]** **farm-to-table** program and to serve as liaison between Missouri farmers and **[**schools**]** **institutions**.

3. The following agencies shall make staff available to the Missouri **[**farm-to-school**]** **farm-to-table** program for the purpose of providing professional consultation and staff support to assist the implementation of this section:

(1) The department of health and senior services;

(2) The department of elementary and secondary education; **[**and**]**

(3) The office of administration**; and**

(4) The department of corrections.

4. The duties of the department employee coordinating the **[**farm-to-school**]** **farm-to-table** program shall include, but not be limited to:

(1) Establishing and maintaining a website database to allow farmers and **[**schools**]** **institutions** to connect whereby farmers can enter the locally grown agricultural products they produce along with pricing information, the times such products are available, and where they are willing to distribute such products;

(2) Providing leadership at the state level to encourage **[**schools**]** **institutions** to procure and use locally grown agricultural products;

(3) Conducting workshops and training sessions and providing technical assistance to **[**school**]** **institution** food service directors, personnel, farmers, and produce distributors and processors regarding the **[**farm-to-school**]** **farm-to-table** program; and

(4) Seeking grants, private donations, or other funding sources to support the **[**farm-to-school**]** **farm-to-table** program.

262.962. 1. As used in this section, section 262.960, and subsection 5 of section 348.407, the following terms shall mean:

(1) **"Institutions", facilities including, but not limited to, schools, correctional facilities, hospitals, nursing homes, and military bases;**

(2) "Locally grown agricultural products", food or fiber produced or processed by a small agribusiness or small farm;

[(2)**] (3)** "Schools", includes any school in this state that maintains a food service program under the United States Department of Agriculture and administered by the school;

[(3)**] (4)** "Small agribusiness", a qualifying agribusiness as defined in section 348.400, and located in Missouri with gross annual sales of less than five million dollars;

[(4)**] (5)** "Small farm", a family-owned farm or family farm corporation as defined in section 350.010, and located in Missouri with less than two hundred fifty thousand dollars in gross sales per year.

2. There is hereby created a taskforce under the AgriMissouri **marketing** program established in section 261.230, which shall be known as the "**[**Farm-to-School**] Farm-to-Table** Taskforce". The taskforce shall be made up of at least one representative from each of the following **[**agencies**]**: the University of Missouri extension service, the department of agriculture, **the department of corrections, the department of health and senior services,** the department of elementary and secondary education, **[**and**]** the office of administration**, and a representative from one of the military bases in the state**. In addition, the director of the department of agriculture shall appoint **[**two persons**] one person** actively engaged in the practice of small agribusiness. In addition, the **[**director of the department of elementary and secondary**] commissioner of** education shall appoint **[**two persons**] one person** from schools within the state who direct a food service program. **The director of the department of corrections shall appoint one person employed as a correctional facility food service director. The director of the department of health and senior services shall appoint one person employed as a hospital or nursing home food service director.** One representative for the department of agriculture shall serve as the chairperson for the taskforce and shall coordinate the taskforce meetings. The taskforce shall hold at least two meetings, but may hold more as it deems necessary to fulfill its requirements under this section. Staff of the department of agriculture may provide administrative assistance to the taskforce if such assistance is required.

3. The mission of the taskforce is to provide recommendations for strategies that:

(1) Allow **[**schools**] institutions** to more easily incorporate locally grown agricultural products into their cafeteria offerings, salad bars, and vending machines; and

(2) Allow **[**schools**]** **institutions** to work with food service providers to ensure greater use of locally grown agricultural products by developing standardized language for food service contracts.

4. In fulfilling its mission under this section, the taskforce shall review various food service contracts of **[**schools**]** **institutions** within the state to identify standardized language that could be included in such contracts to allow **[**schools**]** **institutions** to more easily procure and use locally grown agricultural products.

5. The taskforce shall prepare a report containing its findings and recommendations and shall deliver such report to the governor, the general assembly, and to the director of each **[**agency**]** **entity** represented on the taskforce **[**by no later than December 31, 2015**]** **no later than December thirty-first of each year**.

6. In conducting its work, the taskforce may hold public meetings at which it may invite testimony from experts, or it may solicit information from any party it deems may have information relevant to its duties under this section.

[7. This section shall expire on December 31, 2015.**]**

301.142. 1. As used in sections 301.141 to 301.143, the following terms mean:

(1) "Department", the department of revenue;

(2) "Director", the director of the department of revenue;

(3) "Other authorized health care practitioner" includes advanced practice registered nurses licensed pursuant to chapter 335, physician assistants licensed pursuant to chapter 334, chiropractors licensed pursuant to chapter 331, podiatrists licensed pursuant to chapter 330, **physical therapists licensed pursuant to chapter 334,** and optometrists licensed pursuant to chapter 336;

(4) "Physically disabled", a natural person who is blind, as defined in section 8.700, or a natural person with medical disabilities which prohibits, limits, or severely impairs one's ability to ambulate or walk, as determined by a licensed physician or other authorized health care practitioner as follows:

(a) The person cannot ambulate or walk fifty or less feet without stopping to rest due to a severe and disabling arthritic, neurological, orthopedic condition, or other severe and disabling condition; or

(b) The person cannot ambulate or walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device; or

(c) Is restricted by a respiratory or other disease to such an extent that the person's forced respiratory expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/hg on room air at rest; or

(d) Uses portable oxygen; or

(e) Has a cardiac condition to the extent that the person's functional limitations are classified in severity as class III or class IV according to standards set by the American Heart Association; or

(f) A person's age, in and of itself, shall not be a factor in determining whether such person is physically disabled or is otherwise entitled to disabled license plates and/or disabled windshield hanging placards within the meaning of sections 301.141 to 301.143;

(5) "Physician", a person licensed to practice medicine pursuant to chapter 334;

(6) "Physician's statement", a statement personally signed by a duly authorized person which certifies that a person is disabled as defined in this section;

(7) "Temporarily disabled person", a disabled person as defined in this section whose disability or incapacity is expected to last no more than one hundred eighty days;

(8) "Temporary windshield placard", a placard to be issued to persons who are temporarily disabled persons as defined in this section, certification of which shall be indicated on the physician's statement;

(9) "Windshield placard", a placard to be issued to persons who are physically disabled as defined in this section, certification of which shall be indicated on the physician's statement.

2. Other authorized health care practitioners may furnish to a disabled or temporarily disabled person a physician's statement for only those physical health care conditions for which such health care practitioner is legally authorized to diagnose and treat.

3. A physician's statement shall:

(1) Be on a form prescribed by the director of revenue;

(2) Set forth the specific diagnosis and medical condition which renders the person physically disabled or temporarily disabled as defined in this section;

(3) Include the physician's or other authorized health care practitioner's license number; and

(4) Be personally signed by the issuing physician or other authorized health care practitioner.

4. If it is the professional opinion of the physician or other authorized health care practitioner issuing the statement that the physical disability of the applicant, user, or member of the applicant's household is permanent, it shall be noted on the statement. Otherwise, the physician or other authorized health care practitioner shall note on the statement the anticipated length of the disability which period may not exceed one hundred eighty days. If the physician or health care practitioner fails to record an expiration date on the physician's statement, the director shall issue a temporary windshield placard for a period of thirty days.

5. A physician or other authorized health care practitioner who issues or signs a physician's statement so that disabled plates or a disabled windshield placard may be obtained

shall maintain in such disabled person's medical chart documentation that such a certificate has been issued, the date the statement was signed, the diagnosis or condition which existed that qualified the person as disabled pursuant to this section and shall contain sufficient documentation so as to objectively confirm that such condition exists.

6. The medical or other records of the physician or other authorized health care practitioner who issued a physician's statement shall be open to inspection and review by such practitioner's licensing board, in order to verify compliance with this section. Information contained within such records shall be confidential unless required for prosecution, disciplinary purposes, or otherwise required to be disclosed by law.

7. Owners of motor vehicles who are residents of the state of Missouri, and who are physically disabled, owners of motor vehicles operated at least fifty percent of the time by a physically disabled person, or owners of motor vehicles used to primarily transport physically disabled members of the owner's household may obtain disabled person license plates. Such owners, upon application, accompanied by the documents and fees provided for in this section, a current physician's statement which has been issued within ninety days proceeding the date the application is made and proof of compliance with the state motor vehicle laws relating to registration and licensing of motor vehicles, shall be issued motor vehicle license plates for vehicles, other than commercial vehicles with a gross weight in excess of twenty-four thousand pounds, upon which shall be inscribed the international wheelchair accessibility symbol and the word "DISABLED" in addition to a combination of letters and numbers. Such license plates shall be made with fully reflective material with a common color scheme and design, shall be clearly visible at night, and shall be aesthetically attractive, as prescribed by section 301.130.

8. The director shall further issue, upon request, to such applicant one, and for good cause shown, as the director may define by rule and regulations, not more than two, removable disabled windshield hanging placards for use when the disabled person is occupying a vehicle or when a vehicle not bearing the permanent handicap plate is being used to pick up, deliver, or collect the physically disabled person issued the disabled motor vehicle license plate or disabled windshield hanging placard.

9. No additional fee shall be paid to the director for the issuance of the special license plates provided in this section, except for special personalized license plates and other license plates described in this subsection. Priority for any specific set of special license plates shall be given to the applicant who received the number in the immediately preceding license period subject to the applicant's compliance with the provisions of this section and any applicable rules or regulations issued by the director. If determined feasible by the advisory committee established in section 301.129, any special license plate issued pursuant to this section may be adapted to also include the international wheelchair accessibility symbol and the word

"DISABLED" as prescribed in this section and such plate may be issued to any applicant who meets the requirements of this section and the other appropriate provision of this chapter, subject to the requirements and fees of the appropriate provision of this chapter.

10. Any physically disabled person, or the parent or guardian of any such person, or any not-for-profit group, organization, or other entity which transports more than one physically disabled person, may apply to the director of revenue for a removable windshield placard. The placard may be used in motor vehicles which do not bear the permanent handicap symbol on the license plate. Such placards must be hung from the front, middle rearview mirror of a parked motor vehicle and may not be hung from the mirror during operation. These placards may only be used during the period of time when the vehicle is being used by a disabled person, or when the vehicle is being used to pick up, deliver, or collect a disabled person. When there is no rearview mirror, the placard shall be displayed on the dashboard on the driver's side.

11. The removable windshield placard shall conform to the specifications, in respect to size, color, and content, as set forth in federal regulations published by the Department of Transportation. The removable windshield placard shall be renewed every four years. The director may stagger the expiration dates to equalize workload. Only one removable placard may be issued to an applicant who has been issued disabled person license plates. Upon request, one additional windshield placard may be issued to an applicant who has not been issued disabled person license plates.

12. A temporary windshield placard shall be issued to any physically disabled person, or the parent or guardian of any such person who otherwise qualifies except that the physical disability, in the opinion of the physician, is not expected to exceed a period of one hundred eighty days. The temporary windshield placard shall conform to the specifications, in respect to size, color, and content, as set forth in federal regulations published by the Department of Transportation. The fee for the temporary windshield placard shall be two dollars. Upon request, and for good cause shown, one additional temporary windshield placard may be issued to an applicant. Temporary windshield placards shall be issued upon presentation of the physician's statement provided by this section and shall be displayed in the same manner as removable windshield placards. A person or entity shall be qualified to possess and display a temporary removable windshield placard for six months and the placard may be renewed once for an additional six months if a physician's statement pursuant to this section is supplied to the director of revenue at the time of renewal.

13. Application for license plates or windshield placards issued pursuant to this section shall be made to the director of revenue and shall be accompanied by a statement signed by a licensed physician or other authorized health care practitioner which certifies that the applicant,

user, or member of the applicant's household is a physically disabled person as defined by this section.

14. The placard shall be renewable only by the person or entity to which the placard was originally issued. Any placard issued pursuant to this section shall only be used when the physically disabled occupant for whom the disabled plate or placard was issued is in the motor vehicle at the time of parking or when a physically disabled person is being delivered or collected. A disabled license plate and/or a removable windshield hanging placard are not transferable and may not be used by any other person whether disabled or not.

15. At the time the disabled plates or windshield hanging placards are issued, the director shall issue a registration certificate which shall include the applicant's name, address, and other identifying information as prescribed by the director, or if issued to an agency, such agency's name and address. This certificate shall further contain the disabled license plate number or, for windshield hanging placards, the registration or identifying number stamped on the placard. The validated registration receipt given to the applicant shall serve as the registration certificate.

16. The director shall, upon issuing any disabled registration certificate for license plates and/or windshield hanging placards, provide information which explains that such plates or windshield hanging placards are nontransferable, and the restrictions explaining who and when a person or vehicle which bears or has the disabled plates or windshield hanging placards may be used or be parked in a disabled reserved parking space, and the penalties prescribed for violations of the provisions of this act.

17. Every new applicant for a disabled license plate or placard shall be required to present a new physician's statement dated no more than ninety days prior to such application. Renewal applicants will be required to submit a physician's statement dated no more than ninety days prior to such application upon their first renewal occurring on or after August 1, 2005. Upon completing subsequent renewal applications, a physician's statement dated no more than ninety days prior to such application shall be required every fourth year. Such physician's statement shall state the expiration date for the temporary windshield placard. If the physician fails to record an expiration date on the physician's statement, the director shall issue the temporary windshield placard for a period of thirty days. The director may stagger the requirement of a physician's statement on all renewals for the initial implementation of a four-year period.

18. The director of revenue upon receiving a physician's statement pursuant to this subsection shall check with the state board of registration for the healing arts created in section 334.120, or the Missouri state board of nursing established in section 335.021, with respect to physician's statements signed by advanced practice registered nurses, **or the advisory commission for physical therapists established in section 334.625, with respect to**

physician's statements signed by licensed physical therapists, or the Missouri state board of chiropractic examiners established in section 331.090, with respect to physician's statements signed by licensed chiropractors, or with the board of optometry established in section 336.130, with respect to physician's statements signed by licensed optometrists, or the state board of podiatric medicine created in section 330.100, with respect to physician's statements signed by physicians of the foot or podiatrists to determine whether the physician is duly licensed and registered pursuant to law. If such applicant obtaining a disabled license plate or placard presents proof of disability in the form of a statement from the United States Veterans' Administration verifying that the person is permanently disabled, the applicant shall be exempt from the four-year certification requirement of this subsection for renewal of the plate or placard. Initial applications shall be accompanied by the physician's statement required by this section. Notwithstanding the provisions of paragraph (f) of subdivision (4) of subsection 1 of this section, any person seventy-five years of age or older who provided the physician's statement with the original application shall not be required to provide a physician's statement for the purpose of renewal of disabled persons license plates or windshield placards.

19. The boards shall cooperate with the director and shall supply information requested pursuant to this subsection. The director shall, in cooperation with the boards which shall assist the director, establish a list of all Missouri physicians and other authorized health care practitioners and of any other information necessary to administer this section.

20. Where the owner's application is based on the fact that the vehicle is used at least fifty percent of the time by a physically disabled person, the applicant shall submit a statement stating this fact, in addition to the physician's statement. The statement shall be signed by both the owner of the vehicle and the physically disabled person. The applicant shall be required to submit this statement with each application for license plates. No person shall willingly or knowingly submit a false statement and any such false statement shall be considered perjury and may be punishable pursuant to section 301.420.

21. The director of revenue shall retain all physicians' statements and all other documents received in connection with a person's application for disabled license plates and/or disabled windshield placards.

22. The director of revenue shall enter into reciprocity agreements with other states or the federal government for the purpose of recognizing disabled person license plates or windshield placards issued to physically disabled persons.

23. When a person to whom disabled person license plates or a removable or temporary windshield placard or both have been issued dies, the personal representative of the decedent or such other person who may come into or otherwise take possession of the disabled license plates

or disabled windshield placard shall return the same to the director of revenue under penalty of law. Failure to return such plates or placards shall constitute a class B misdemeanor.

24. The director of revenue may order any person issued disabled person license plates or windshield placards to submit to an examination by a chiropractor, osteopath, or physician, or to such other investigation as will determine whether such person qualifies for the special plates or placards.

25. If such person refuses to submit or is found to no longer qualify for special plates or placards provided for in this section, the director of revenue shall collect the special plates or placards, and shall furnish license plates to replace the ones collected as provided by this chapter.

26. In the event a removable or temporary windshield placard is lost, stolen, or mutilated, the lawful holder thereof shall, within five days, file with the director of revenue an application and an affidavit stating such fact, in order to purchase a new placard. The fee for the replacement windshield placard shall be four dollars.

27. Fraudulent application, renewal, issuance, procurement or use of disabled person license plates or windshield placards shall be a class A misdemeanor. It is a class B misdemeanor for a physician, chiropractor, podiatrist or optometrist to certify that an individual or family member is qualified for a license plate or windshield placard based on a disability, the diagnosis of which is outside their scope of practice or if there is no basis for the diagnosis.

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 if the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics if 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 that 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 arrangement, including collaborative practice 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 such arrangement. 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 arrangements to ensure that arrangements 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.

12. (1) An assistant physician with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017**, and may have restricted authority in Schedule II,** when delegated the authority to prescribe controlled substances in a collaborative practice arrangement. **Prescriptions for Schedule II medications prescribed by an assistant physician who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone.** Such authority shall be filed with the state board of registration for the healing arts. The collaborating physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the assistant physician is permitted to prescribe. Any limitations shall be listed in the collaborative practice arrangement. Assistant physicians shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances **and Schedule II - hydrocodone prescriptions** shall be limited to a five-day supply without refill. Assistant physicians who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

(2) The collaborating physician shall be responsible to determine and document the completion of at least one hundred twenty hours in a four-month period by the assistant physician during which the assistant physician shall practice with the collaborating physician on-site prior to prescribing controlled substances when the collaborating physician is not on-site. Such limitation shall not apply to assistant physicians of population-based public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009.

(3) An assistant physician shall receive a certificate of controlled substance prescriptive authority from the state board of registration for the healing arts upon verification of licensure under section 334.036.

334.104. 1. A physician may enter into collaborative practice arrangements with registered professional nurses. 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 a registered professional nurse 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 registered professional nurse and is consistent with that nurse's skill, training and competence.

2. Collaborative practice arrangements, which shall be in writing, may delegate to a registered professional nurse the authority to administer, dispense or prescribe drugs and provide treatment if the registered professional nurse is an advanced practice registered nurse as defined

in subdivision (2) of section 335.016. Collaborative practice arrangements may delegate to an advanced practice registered nurse, as defined in section 335.016, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017**, and Schedule II - hydrocodone**; except that, the collaborative practice arrangement shall not delegate the authority to administer any controlled substances listed in schedules III, IV, and V of section 195.017**, or Schedule II - hydrocodone** for the purpose of inducing sedation or general anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic controlled substance **and Schedule II - hydrocodone** prescriptions shall be limited to a one hundred twenty-hour supply without refill. Such 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.

3. 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 advanced practice registered nurse;

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

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

(4) All specialty or board certifications of the collaborating physician and all certifications of the advanced practice registered nurse;

(5) The manner of collaboration between the collaborating physician and the advanced practice registered nurse, including how the collaborating physician and the advanced practice registered nurse will:

(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. This 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. 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 is required to maintain documentation related to this requirement and to 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 advanced practice registered nurse's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the nurse 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 advanced practice registered nurse;

(8) The duration of the written practice agreement between the collaborating physician and the advanced practice registered nurse;

(9) A description of the time and manner of the collaborating physician's review of the advanced practice registered nurse's delivery of health care services. The description shall include provisions that the advanced practice registered nurse shall submit a minimum of ten percent of the charts documenting the advanced practice registered nurse'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**. In performing the review, the collaborating physician need not be present at the health care practitioner's site**; 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 advanced practice registered nurse 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.

4. The state board of registration for the healing arts pursuant to section 334.125 and the board of nursing pursuant to section 335.036 may jointly promulgate rules regulating the use of collaborative practice arrangements. Such rules shall be limited to specifying geographic areas to be covered, the methods of treatment that may be covered by collaborative practice arrangements and the requirements for review of services provided pursuant to 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. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither the state board of registration for the healing arts nor the board of nursing may separately promulgate rules relating to collaborative practice arrangements. Such jointly promulgated rules 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 pursuant to chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

5. The state board of registration for the healing arts shall not deny, revoke, suspend or otherwise take disciplinary action against a physician for health care services delegated to a registered professional nurse provided the provisions of this section and the rules promulgated thereunder are satisfied. Upon the written request of a physician subject to a disciplinary action imposed as a result of an agreement between a physician and a registered professional nurse or registered physician assistant, whether written or not, prior to August 28, 1993, all records of such disciplinary licensure action and all records pertaining to the filing, investigation or review of an alleged violation of this chapter incurred as a result of such an agreement shall be removed from the records of the state board of registration for the healing arts and the division of professional registration and shall not be disclosed to any public or private entity seeking such information from the board or the division. The state board of registration for the healing arts shall take action to correct reports of alleged violations and disciplinary actions as described in this section which have been submitted to the National Practitioner Data Bank. In subsequent applications or representations relating to his medical practice, a physician completing forms or documents shall not be required to report any actions of the state board of registration for the healing arts for which the records are subject to removal under this section.

6. 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, or physician assistant agreement and also report to the board the name of each licensed professional with whom the physician has entered into such agreement. The board may make this 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.

7. Notwithstanding any law to the contrary, a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016 shall be permitted to provide anesthesia services without a collaborative practice arrangement provided that he or she is under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if

needed. Nothing in this subsection shall be construed to prohibit or prevent a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016 from entering into a collaborative practice arrangement under this section, except that the collaborative practice arrangement may not delegate the authority to prescribe any controlled substances listed in Schedules III, IV, and V of section 195.017.

8. A collaborating physician shall not enter into a collaborative practice arrangement with more than three full-time equivalent advanced practice registered nurses. This 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.

9. It is the responsibility of the collaborating physician to determine and document the completion of at least a one-month period of time during which the advanced practice registered nurse shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. This 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, **nor to collaborative arrangements between a physician and an advanced practice registered nurse, if the collaborative physician is new to a patient population with which the collaborating advanced practice registered nurse, assistant physician, or assistant physician is already familiar.**

10. 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.

11. No contract or other agreement shall require a physician to act as a collaborating physician for an advanced practice registered nurse against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular advanced practice registered nurse. 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 advanced practice registered nurse, but this requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by hospital's medical staff.

12. No contract or other agreement shall require any advanced practice registered nurse to serve as a collaborating advanced practice registered nurse for any collaborating physician against the advanced practice registered nurse's will. An advance practice registered nurse shall have the right to refuse to collaborate, without penalty, with a particular physician.

348.407. 1. The authority shall develop and implement agricultural products utilization grants as provided in this section.

2. The authority may reject any application for grants pursuant to this section.

3. The authority shall make grants, and may make loans or guaranteed loans from the grant fund to persons for the creation, development and operation, for up to three years from the time of application approval, of rural agricultural businesses whose projects add value to agricultural products and aid the economy of a rural community.

4. The authority may make loan guarantees to qualified agribusinesses for agricultural business development loans for businesses that aid in the economy of a rural community and support production agriculture or add value to agricultural products by providing necessary products and services for production or processing.

5. The authority may make grants, loans, or loan guarantees to Missouri businesses to access resources for accessing and processing locally grown agricultural products for use in **[**schools**]** **institutions, as defined in section 262.962,** within the state.

6. The authority may, upon the provision of a fee by the requesting person in an amount to be determined by the authority, provide for a feasibility study of the person's rural agricultural business concept.

7. Upon a determination by the authority that such concept is feasible and upon the provision of a fee by the requesting person, in an amount to be determined by the authority, the authority may then provide for a marketing study. Such marketing study shall be designed to determine whether such concept may be operated profitably.

8. Upon a determination by the authority that the concept may be operated profitably, the authority may provide for legal assistance to set up the business. Such legal assistance shall include, but not be limited to, providing advice and assistance on the form of business entity, the availability of tax credits and other assistance for which the business may qualify as well as helping the person apply for such assistance.

9. The authority may provide or facilitate loans or guaranteed loans for the business including, but not limited to, loans from the United States Department of Agriculture Rural Development Program, subject to availability. Such financial assistance may only be provided to feasible projects, and for an amount that is the least amount necessary to cause the project to occur, as determined by the authority. The authority may structure the financial assistance in a way that facilitates the project, but also provides for a compensatory return on investment or loan payment to the authority, based on the risk of the project.

10. The authority may provide for consulting services in the building of the physical facilities of the business.

11. The authority may provide for consulting services in the operation of the business.

12. The authority may provide for such services through employees of the state or by contracting with private entities.

13. The authority may consider the following in making the decision:

(1) The applicant's commitment to the project through the applicant's risk;

(2) Community involvement and support;

(3) The phase the project is in on an annual basis;

(4) The leaders and consultants chosen to direct the project;

(5) The amount needed for the project to achieve the bankable stage; and

(6) The project's planning for long-term success through feasibility studies, marketing plans**,** and business plans.

14. The department of agriculture, the department of natural resources, the department of economic development and the University of Missouri may provide such assistance as is necessary for the implementation and operation of this section. The authority may consult with other state and federal agencies as is necessary.

15. The authority may charge fees for the provision of any service pursuant to this section.

16. The authority may adopt rules to implement the provisions of this section.

17. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in sections 348.005 to 348.180 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.

376.379. 1. A health carrier or managed care plan offering a health benefit plan in this state that provides prescription drug coverage shall offer, as part of the plan, medication synchronization services developed by the health carrier or managed care plan that allow for the alignment of refill dates for an enrollee's prescription drugs that are covered benefits.

2. Under its medication synchronization services, a health carrier or managed care plan shall:

(1) Not charge an amount in excess of the otherwise applicable co-payment amount under the health benefit plan for dispensing a prescription drug in a quantity that is less than the prescribed amount if:

(a) The pharmacy dispenses the prescription drug in accordance with the medication synchronization services offered under the health benefit plan. However, a pharmacy shall not be required to process the claims through the health benefit plan if the result is less cost to the patient; and

(b) A participating provider dispenses the prescription drug;

(2) Provide a full dispensing fee to the pharmacy that dispenses the prescription drug to the covered person.

3. For the purposes of this section the terms "health carrier", "managed care plan", "health benefit plan", "enrollee", and "participating provider" shall have the same meaning as defined in section 376.1350.

376.388. 1. As used in this section, unless the context requires otherwise, the following terms shall mean:

(1) "Contracted pharmacy" or "pharmacy", a pharmacy located in Missouri participating in the network of a pharmacy benefit manager through a direct or indirect contract;

(2) "Health carrier", an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services, except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(3) "Maximum allowable cost", the per unit amount that a pharmacy benefits manager reimburses a pharmacist for a prescription drug, excluding a dispensing or professional fee;

(4) "Maximum allowable cost list" or "MAC list", a listing of drug products that meet the standard described in this section;

(5) "Pharmacy", as such term is defined in chapter 338;

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

2. Upon each contract execution or renewal between a pharmacy benefit manager and a pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, a pharmacy benefits manager shall, with respect to such contract or renewal:

(1) Include in such contract or renewal the sources utilized to determine maximum allowable cost and update such pricing information at least every seven days; and

(2) Maintain a procedure to eliminate products from the maximum allowable cost list of drugs subject to such pricing or modify maximum allowable cost pricing within seven days if such drugs do not meet the standards and requirements of this section in order to remain consistent with pricing changes in the marketplace.

3. A pharmacy benefits manager shall reimburse pharmacies for drugs subject to maximum allowable cost pricing based upon pricing information which has been updated within seven days as set forth in subdivision (1) of subsection 2 of this section.

4. A pharmacy benefits manager shall not place a drug on a maximum allowable cost list unless there are at least two therapeutically equivalent multi-source generic drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers.

5. All contracts between a pharmacy benefits manager and a contracted pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, shall include a process to internally appeal, investigate, and resolve disputes regarding maximum allowable cost pricing. The process shall include the following:

(1) The right to appeal shall be limited to fourteen calendar days following the reimbursement of the initial claim; and

(2) A requirement that the health carrier or pharmacy benefits manager shall respond to an appeal described in this subsection no later than fourteen calendar days after the date the appeal was received by such health carrier or pharmacy benefits manager.

6. For appeals that are denied, the pharmacy benefits manager shall provide the reason for the denial and identify the national drug code of a drug product that may be purchased by contracted pharmacies at a price at or below the maximum allowable cost.

7. If the appeal is successful, the health carrier or pharmacy benefits manager shall:

(1) Adjust the maximum allowable cost price that is the subject of the appeal effective on the day after the date the appeal is decided;

(2) Apply the adjusted maximum allowable cost price to all similarly situated pharmacies as determined by the health carrier or pharmacy benefits manager; and

(3) Allow the pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefits claim giving rise to the appeal.

8. Appeals shall be upheld if:

(1) The pharmacy being reimbursed for the drug subject to the maximum allowable cost pricing in question was not reimbursed as required in subsection 3 of this section; or

(2) The drug subject to the maximum allowable cost pricing in question does not meet the requirements set forth in subsection 4 of this section.

9. This section shall not apply to any plans administered by a pharmacy benefits manager that are not Health Carriers as defined by this statute or to a health plan sponsored by the state or a political subdivision of the state, including, but not limited to, plans covering federal employees and plans governed under the Employee Retirement Income Security Act of 1974.

376.685. 1. No agreement between a health carrier or other insurer that writes vision insurance and an optometrist for the provision of vision services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone vision plan, medical plan, health benefit plan, or health insurance policy shall require that an optometrist provide optometric or ophthalmic services or materials at a fee limited or set by the plan or health carrier unless the services or materials are reimbursed as covered services under the contract.

2. No provider shall charge more for services or materials that are not covered under a health benefit or vision plan than his or her usual and customary rate for those services or materials.

3. Reimbursement paid by the health benefit or vision plan for covered services or materials shall be reasonable and shall not provide nominal reimbursement in order to claim that services or materials are covered services. No health carrier shall provide de minimis reimbursement or coverage in an effort to avoid the requirements of this section.

4. No vision care insurance policy or vision care discount plan that provides covered services for materials shall have the effect, directly or indirectly, of limiting the choice of sources and suppliers of materials by a patient of a vision care provider.

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

(1) "Covered services", optometric or ophthalmic services or materials for which reimbursement from the health benefit or vision plan is provided for by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual limitations of deductibles, co-payments, coinsurance, waiting

periods, annual or lifetime maximums, alternative benefit payments, or frequency limitations;

(2) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(3) "Health carrier", the same meaning as such term is defined in section 376.1350;

(4) "Materials", includes, but is not limited to, lenses, frames, devices containing lenses, prisms, lens treatment and coatings, contact lenses, orthoptics, vision training devices, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa;

(5) "Optometric services", any services within the scope of optometric practice under chapter 336;

(6) "Vision plan", any policy, contract of insurance, or discount plan issued by a health carrier, health benefit plan, or company which provides coverage or a discount for optometric or ophthalmic services or materials.

Section B. The repeal and reenactment of sections 262.960, 262.962, and 348.407 of section A shall become effective January 1, 2016.

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