SB 514 -- HEALTH CARE

TASK FORCE ON SUBSTANCE ABUSE PREVENTION AND TREATMENT

This bill establishes the "Task Force on Substance Abuse Prevention and Treatment". The task force is made up of six members of the House of Representatives appointed by the Speaker, six members of the Senate appointed by the President Pro Tem, and four members appointed by the Governor. The task force must meet at least once during each legislative session and will conduct hearings on current and future drug and substance abuse, explore solutions to substance abuse issues, and draft or modify legislation as necessary to reach the goals of finding and funding education and treatment solutions to combat drug and substance use and abuse. The task force will send a report of recommendations for legislation to the Governor and the General Assembly each year (Section 21.790, RSMo).

HEALTH PROFESSIONAL STUDENT LOAN REPAYMENT PROGRAM

This provision adds psychiatrists to the Health Professional Student Loan Repayment Program. The Department of Health and Senior Services shall designate areas of need for psychiatric services when such areas have been designated as mental health care professional shortage areas by the federal Department of Health and Human Services or when the Director of the Department of Health and Senior Services has determined such areas to have an extraordinary need (Sections 191.603, 191.605, and 191.607).

REPORTS REGARDING CHILDREN EXPOSED TO CONTROLLED SUBSTANCES

This provision requires health care providers to refer to children's division families in which infants are born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder (Section 191.737).

MEDICATION-ASSISTED TREATMENT

The "Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act" provisions apply to all health insurance plans delivered in the state and specify that medication-assisted treatment (MAT) services shall include, but not be limited to, pharmacologic and behavioral therapies. Formularies used by a health insurer or managed by a pharmacy benefits manager, and medical benefit coverage in the case of medications dispensed through an opioid treatment program, shall include all certain specified medications. All MAT medications required for compliance with these provisions shall be placed on the lowest cost-sharing

tier of the formulary.

MAT services provided under these provisions shall not be subject to: annual or lifetime dollar limits; limits to predesignated facilities, specific numbers of visits, days of coverage, days in a waiting period, scope or duration of treatment, or other similar limits; financial requirements and quantitative treatment limitations that do not comply with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA); step therapy or other similar strategies when it interferes with a prescribed or recommended course of treatment from a licensed health care professional; or prior authorization (Sections 191.1164, 191.1165, 191.1167, and 191.1168).

PREGNANCY-ASSOCIATED MORTALITY

This bill establishes the "Pregnancy-Associated Mortality Review Board" within the Department of Health and Senior Services. It is designated to improve data collection and reporting regarding maternal mortality and to develop initiatives that support at-risk populations. Before June 30, 2020, and each year thereafter, the board shall submit a report on maternal mortality in the state and proposed recommendations to the Director of the Centers for Disease Control and Prevention, the Director of the Department of Health and Senior Services, the Governor, and the General Assembly (Sections 192.067 and 192.990).

INFECTION DATA REPORTING

This bill specifies that hospitals and the Department of Health and Senior Services shall not be required to comply with infection data reporting requirements if the Centers for Medicare and Medicaid Services (CMS) also requires the submission of such data, except that the department shall post a link on its website to the publicly reported data on CMS's website.

Additionally, hospitals that have established antimicrobial stewardship programs shall meet the National Healthcare Safety Network requirements for reporting antimicrobial usage or resistance when CMS's conditions of participation become effective. Nothing shall prohibit a hospital from voluntarily reporting the data prior to the effective date of the conditions of participation (Section 192.667).

PHYSICIAN ASSISTANTS

These provisions modify current law relating to supervision agreements between physicians assistants and supervising physicians by changing such agreements to collaborative practice arrangements

with collaborating physicians. Collaborative practice arrangements shall delegate to the physician assistant the authority to prescribe, administer, or dispense drugs, including certain controlled substances, and provide treatment to patients.

Geographic proximity requirements shall be determined by the Board of Registration for the Healing Arts. Further requirements of collaborative practice arrangements are specified in the bill. No collaborative practice arrangement shall supercede existing hospital licensing regulations governing hospital medication orders for inpatient or emergency care. Additionally, the physician assistant program accrediting entity is changed under this bill to include other accreditation programs (Sections 193.015, 195.100, 334.037, 334.104, 334.108, 334.735, 334.736, 334.747, 334.749, 338.010, 630.175, and 630.875).

ELECTRONIC PRESCRIBING

Beginning January 1, 2021, no person shall issue a prescription for any Schedule II, III, or IV controlled substance unless the prescription is electronic and made to a pharmacy, excluding prescriptions issued in circumstances specified. Pharmacists receiving a written, oral, or faxed prescription shall not be required to verify that the prescription falls into one of the exceptions and may continue to dispense medication from an otherwise valid non-electronic prescription. An individual who violates this provision may be subject to disciplinary action by his or her professional licensing board (Sections 195.060, 195.550, 196.100, 221.111, 338.015, 338.055, and 338.056).

OPIOID PRESCRIPTIONS FOR SICKLE CELL PATIENTS

This provision excludes patients undergoing treatment for sickle cell disease from the initial opioid prescription limitations in current law (Section 195.080).

VETERANS' HEALTH CARE FUND

Allows the Department of Health and Senior Services to establish a fee if the funds in the Missouri Veterans' Health Care Fund are insufficient to provide for the administration of the provisions of Article XIV of the Constitution (Section 195.820).

HOSPITAL INSPECTIONS

The Department of Health and Senior Services is prohibited from assigning an individual to inspect or survey a hospital if the inspector or surveyor was an employee of such hospital or another hospital within its organization or a competing hospital within 50

miles of the hospital to be inspected or surveyed within the previous two years. The department shall require inspectors or surveyors to disclose the name of every hospital in which he or she was employed in the previous 10 years, the length of service, and the job title held, as well as the same information for any immediate family member employed at a hospital. Such information shall be considered a public record. If any person has reason to believe that an inspector or surveyor has any personal or business affiliation that would result in a conflict of interest, he or she may notify the department. If the department has reason to believe the information to be true, the department shall not assign the inspector or surveyor to the hospital or any hospital within its organization (Section 197.108).

CERTIFIED NURSING ASSISTANTS

This bill requires certified nursing assistant training programs to be offered at skilled nursing or intermediate care facility units in Missouri veterans homes and hospitals. Certified nursing assistants shall include certain employees at such units and hospitals who have completed the training and passed the certification examination. The Department of Health and Senior Services may offer additional training programs and certifications to students already certified as nursing assistants as specified in the bill (Section 198.082).

TICKET TO WORK HEALTH ASSURANCE PROGRAM

This bill extends the Ticket to Work Health Assurance Program's expiration date from August 28, 2019, to August 28, 2025 (Section 208.146).

MO HEALTHNET BENEFITS FOR FORMER FOSTER YOUTH

Persons between the ages of 18 and 26 who currently reside in Missouri but have received foster care for at least six months in another state shall be eligible for MO HealthNet benefits under certain circumstances (Section 208.151).

MEDICAID PER DIEM REIMBURSEMENT RATES

Any intermediate care facility or skilled nursing facility participating in MO HealthNet that incurs total capital expenditures in excess of $2,000 per bed shall be entitled to obtain a recalculation of its Medicaid per diem reimbursement rate based on its additional capital costs or all costs incurred during the facility fiscal year during which such capital expenditures were made (Section 208.225).

MISSOURI RX PLAN

Currently, only Medicaid dual eligible individuals meeting certain income limitations are eligible to participate in the Missouri RX Plan. This provision removes the Medicaid dual eligible requirement, while retaining the income limitations (Section 208.790).

SUSPENSION OF MO HEALTHNET BENEFITS OF OFFENDERS IN CORRECTIONAL FACILITIES AND JAILS

MO HealthNet benefits shall be suspended, rather than canceled or terminated, for offenders entering into a correctional facility or jail if the Department of Social Services is notified of the person's entry into the correctional center or jail, the person was enrolled in MO HealthNet at the time of his or her incarceration, and the person is otherwise eligible for MO HealthNet benefits but for his or her incarcerated status. Upon release from incarceration, the suspension shall end and the person shall continue to be eligible for MO HealthNet benefits until such time as he or she is otherwise ineligible.

The Department of Corrections shall notify the Department of Social Services within 20 days of receiving information that a person receiving MO HealthNet benefits is or will become an offender in a correctional center and within 45 days prior to the release of such person whose benefits have been suspended under this bill. Likewise, city, county, and private jails shall notify the Department of Social Services within 10 days of receiving information that a person receiving MO HealthNet benefits is or will be in the jail (Sections 217.930 and 221.125).

FAMILY CAREGIVING AND PERSONAL CARE ASSISTANT SERVICES

Structured in-home family caregiving will be an agency-directed model under MO HealthNet to ensure availability of comprehensive and cost-effective choices for persons with Alzheimer's or a related disorder. This bill directs the Department of Social Services to apply to the United States Secretary of Health and Human Services for a structured family caregiver waiver under Section 1915(c) of the Federal Social Security Act, if needed. The department must request an effective date of not later than July 1, 2020. The bill specifies a cap of 300 participants. This bill also extends the sunset date for financial assistance for consumer-directed personal care assistance services from June 30, 2019 to June 30, 2025 (Sections 208.896 and 208.930).

PRESCRIBING OF LONG-ACTING OR EXTENDED RELEASE OPIOIDS BY DENTISTS

Long-acting or extended-release opioids shall not be used to treat acute pain in dentistry, unless it is necessary in the professional judgment of the dentist and the dentist explains his or her reasoning in the patient's dental record. Dentists shall avoid prescribing doses greater than 50 morphine milligram equivalents (MME) per day for treatment of acute pain. If the dentist believes doses greater than 50 MME are necessary to treat the patient, the dentist shall document and explain the reason for the dose greater than 50 MME. The Missouri Dental Board is required to maintain an MME conversion chart and instructions for calculating MMEs on its website (Section 332.361).

TELEHEALTH

This bill repeals the sunset provision on the utilization of telehealth for advanced practice registered nurses in rural areas of need (Section 335.175).

SUICIDE ASSESSMENT

This change requires marital and family therapists to complete two hours of suicide assessment, referral, treatment, and management training as a condition of initial licensure and as a condition of license renewal (Section 337.712).

TOBACCO CESSATION

The practice of pharmacy shall include the prescribing and dispensing of any nicotine replacement therapy product. A nicotine replacement therapy product is defined as any drug, regardless of whether it is available over-the-counter, that delivers small doses of nicotine to a person and that is approved by the Food and Drug Administration (FDA) for the sole purpose of aiding in tobacco or smoking cessation. The Board of Pharmacy and the Board of Healing Arts shall jointly adopt regulations governing a pharmacist's authority to prescribe and dispense nicotine replacement therapy products (Sections 338.010 and 338.665).

PHARMACIST VOLUNTARY COMPLIANCE AGREEMENTS

Currently, the Board of Pharmacy may issue letters of reprimand, censure, or warning to any pharmacist licensed, registered, or with a permit in the state for any violation that could result in disciplinary action. This bill specifies that the board may enter into a voluntary compliance agreement with a pharmacist to ensure or promote compliance with current law and the rules of the board, in lieu of disciplinary action. The agreement shall be a public record, and the time limitation set forth for commencing a disciplinary proceeding shall be tolled while an agreement

authorized under this bill is in effect (Section 338.140).

PHARMACY PILOT PROJECTS

The Board of Pharmacy may approve, modify, and establish requirements for pharmacy pilot or demonstration research projects related to technology assisted verification or remote medication dispensing that are designed to enhance patient care or safety, improve patient outcomes, or expand access to pharmacy services. Board approval of such pilot or research projects shall be limited to a period of up to 18 months. The board may rescind approval at any time, or approve an additional six month expansion if it is deemed necessary or appropriate to gather or complete research data or if it is deemed to be in the best interests of the patient. The provisions of this bill shall expire on August 28, 2023. The board shall provide a final report on the approved projects and related data or findings to the General Assembly on or before December 31, 2022. The name, location, approval dates, general description of and responsibilities for an approved pilot project shall be deemed an open record (Section 338.143).

UNANTICIPATED OUT-OF-NETWORK HEALTH CARE SERVICES

This specifies that health care professionals shall, rather than may, utilize the process outlined in statute for claims for unanticipated out-of-network care (Section 376.690).

UTILIZATION REVIEWS

This bill replaces "utilization review organization" with "utilization review entity," and "prospective review" with "prior authorization review" throughout the statutes relating to utilization reviews. Additionally, other terms in the section have been modified.

This bill also replaces references to "initial certification" with "certification" and "initial determination" with "determination." Currently, notice of an adverse determination is required to include instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. These requirements are repealed, and it now specifies that the adverse determination notice shall include a written statement of the clinical rationale, requires notice to the health care provider, and repeals the requirement that notice of the adverse determination must be requested. Written procedures to address a failure or inability of a provider or enrollee to provide all information necessary to make a decision shall be made available on the health carrier's website or provider portal. Provided the patient is an enrollee of the health benefit plan, no

utilization review entity shall revoke, limit, condition, or otherwise restrict a prior authorization within 45 working days of its receipt by a health care provider. Provided the patient is an enrollee of the health benefit plan at the time the service is provided, no health carrier, utilization review entity, or health care provider shall bill an enrollee for any health care service for which a prior authorization was in effect at the time the service was provided, except as consistent with cost-sharing requirements applicable to covered benefits.

Any utilization review entity performing prior authorization review shall provide a unique confirmation number to a provider upon receipt from that provider of a request for prior authorization. Confirmation numbers shall be transmitted or otherwise communicated through the same medium through which the requests for prior authorization were made. No later than January 1, 2021, utilization review entities shall accept and respond to requests for prior authorization of drug benefits through a secure electronic transmission using the National Council for Prescription Drugs SCRIPT Standard Version 2017071 or a backwards-compatible successor adopted by the United States Department of Health and Human Services.

Also, no later than January 1, 2021, utilization review entities shall accept and respond to requests for prior authorization of health care services and mental health services electronically, which shall not include facsimile, proprietary payer portals, and electronic forms. And, utilization review entities shall develop a single secure prior authorization cover page for all its health benefit plans utilizing prior authorization review, which the carrier or its utilization review entity shall use to accept and respond to, and providers shall use to submit, requests for prior authorization. The cover page shall include, but not be limited to, fields for certain information as specified.

Health carriers and utilization review entities to make available on its website or provider portal any current prior authorization requirements or restrictions, including written clinical criteria. Requirements and restrictions, including step therapy protocols, shall be described in detail. No health carrier or utilization review entity shall amend or implement a new prior authorization requirement or restriction prior to the change being reflected on the carrier or review entity's website or provider portal. Health carriers and utilization review entities shall provide in-network health care providers with written or electronic notice of the new or amended requirement not less than 60 days prior to implementing the requirement or restriction.

This bill also modifies the panel for a second-level grievance

review for an adverse determination to require a majority of persons that are "clinical peers licensed to practice" rather than "appropriate clinical peers" in the same or similar specialty as would typically manage the case being reviewed (Sections 374.500, 376.1350, 376.1356, 376.1363, 376.1364, 376.1372, and 376.1385).

HEALTH INSURANCE REIMBURSEMENT

Prohibits health carriers and entities acting on their behalf from restricting methods of reimbursement to a method requiring health care providers to pay a fee to redeem the amount of their claim for reimbursement, discount the amount of their claim for reimbursement, or remit any other form of remuneration in order to redeem the amount of their claim for reimbursement. Health carriers initiating or changing the method of reimbursement to such forms shall notify health care providers of the fee, discount, or other remuneration required to receive reimbursement through the new or different method and provide clear instructions to the provider as to how to select an alternative payment method. A health carrier shall allow the provider to select to be reimbursed electronically. Violation of these provisions shall be deemed an unfair trade practice under the Unfair Trade Practice Act (Section 376.1345).

VARIOUS INSURANCE PROVISIONS

Multiple employer self-insured health plans having a certificate of authority approved by the Director of the Department of Insurance, Financial Institutions and Professional Registration may offer such plans to the public. Health carriers acting as an administrator for a plan shall permit any willing licensed broker to market such plans.

Third-party payers for health care services shall not limit coverage or deny reimbursement for treatment for physical, cognitive, emotional, mental, or developmental disabilities in specified situations (Sections 376.1040, 376.1042, and 376.1224).

This bill makes changes regarding second-level reviews of grievances. When a grievance receives an adverse determination and the advisory panel makes a preliminary decision that the determination should be upheld, the heath carrier shall submit the grievance for review to two independent clinical peers in the same or similar specialty as would typically manage the case being reviewed, and who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance. In the event that both independent reviews agree with the grievance advisory panel's preliminary decision, the panel's decision shall stand. In the event that both

independent reviewers disagree with the grievance advisory panel's preliminary decision, the initial adverse determination shall be overturned. In the event that one of the two independent reviewers disagrees with the grievance advisory panel's preliminary decision, the panel shall reconvene and make a final decision in its discretion (Sections 376.1372 and 376.1385).