House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND House Committee Substitute for Senate Substitute for Senate Bill No. 7, Page 6, Section 190.098, Line 40, by inserting after the number "(3)" the following:

"(a) An ambulance service that provides community paramedic services and that has executed formal contracts or agreements with health care institutions, hospitals, health clinics, or insurance companies for the provision of community paramedic services shall be permitted to honor such agreements within the county boundaries of the ambulance service's primary location, irrespective of the ambulance service area boundaries described under section 190.105.

(b) For sustained services that are provided outside of the county of the ambulance service's primary 911 response territory where another licensed ambulance service also offers community paramedic services, the community paramedic program shall coordinate with the local ambulance service.

(c) To minimize potential confusion and maintain operational discretion, any agency providing community paramedic services outside its primary district boundaries may use an unmarked vehicle when operating in another ambulance service area.

(4)"; and

Further amend said bill, page, and section, by renumbering subsection subdivisions accordingly; and

Further amend said bill, Page 8, Section 190.101, Lines 25-26, by deleting said lines and inserting in lieu thereof the following:

"(j) The statewide professional association representing emergency physicians;

(k) The statewide professional association representing emergency medical services;

(l) The statewide association representing hospitals; and

(m) The statewide association representing pediatric emergency professionals;"; and

Further amend said bill, page, and section, Line 30, by deleting said line and inserting in lieu thereof the following:

"(3) One member shall be appointed from each regional EMS advisory committee based upon the recommendations from each committee to the department of health and senior services; and"; and

Further amend said bill and section, Page 9, Line 59, by inserting after the word "of" the words "the Missouri delegate to the interstate commission and"; and

Further amend said bill, Page 14, Section 190.166, Line 60, by inserting after all of said section and line the following:

Action Taken_____ Date _____

"190.241. 1. Except as provided for in subsection 4 of this section, the department shall designate a hospital as an adult, pediatric or adult and pediatric trauma center when a hospital, upon proper application submitted by the hospital and site review, has been found by the department to meet the applicable level of trauma center criteria for designation in accordance with rules adopted by the department as prescribed by section 190.185. Site review may occur on-site or by any reasonable means of communication, or by any combination thereof. Such rules shall include designation as a trauma center without site review if such hospital is verified by a national verifying or designating body at the level which corresponds to a level approved in rule. In developing trauma center designation criteria, the department shall use, as it deems practicable, peer-reviewed and evidence-based clinical research and guidelines including, but not limited to, the most recent guidelines of the American College of Surgeons. The department shall not deny a qualified hospital designation as a level I, II, or III trauma center based solely on the distance or mileage between trauma centers.

2. Except as provided for in subsection 4 of this section, the department shall designate a hospital as a STEMI or stroke center when such hospital, upon proper application and site review, has been found by the department to meet the applicable level of STEMI or stroke center criteria for designation in accordance with rules adopted by the department as prescribed by section 190.185. Site review may occur on-site or by any reasonable means of communication, or by any combination thereof. In developing STEMI center and stroke center designation criteria, the department shall use, as it deems practicable, peer-reviewed and evidence-based clinical research and guidelines including, but not limited to, the most recent guidelines of the American College of Cardiology, the American Heart Association, or the American Stroke Association. Such rules shall include designation as a STEMI center or stroke center without site review if such hospital is certified by a national body.

3. The department of health and senior services shall, not less than once every three years, conduct a site review of every trauma, STEMI, and stroke center through appropriate department personnel or a qualified contractor, with the exception of trauma centers, STEMI centers, and stroke centers designated pursuant to subsection 4 of this section; however, this provision is not intended to limit the department's ability to conduct a complaint investigation pursuant to subdivision (3) of subsection 2 of section 197.080 of any trauma, STEMI, or stroke center. Site reviews shall be coordinated for the different types of centers to the extent practicable with hospital licensure inspections conducted under chapter 197. No person shall be a qualified contractor for purposes of this subsection who has a substantial conflict of interest in the operation of any trauma, STEMI, or stroke center under review. The department may deny, place on probation, suspend or revoke such designation in any case in which it has determined there has been a substantial failure to comply with the provisions of this chapter or any rules or regulations promulgated pursuant to this chapter. Centers that are placed on probationary status shall be required to demonstrate compliance with the provisions of this chapter and any rules or regulations promulgated under this chapter within twelve months of the date of the receipt of the notice of probationary status, unless otherwise provided by a settlement agreement with a duration of a maximum of eighteen months between the department and the designated center. If the department of health and senior services has determined that a hospital is not in compliance with such provisions or regulations, it may conduct additional announced or unannounced site reviews of the

hospital to verify compliance. If a trauma, STEMI, or stroke center fails two consecutive site reviews because of substantial noncompliance with standards prescribed by sections 190.001 to 190.245 or rules adopted by the department pursuant to sections 190.001 to 190.245, its center designation shall be revoked.

4. (1) Instead of applying for trauma, STEMI, or stroke center designation under subsection 1 or 2 of this section, a hospital may apply for trauma, STEMI, or stroke center designation under this subsection. Upon receipt of an application on a form prescribed by the department, the department shall designate such hospital at a state level that corresponds to a similar national designation as set forth in rules promulgated by the department. The rules shall be based on standards of nationally recognized organizations and the recommendations of the time-critical diagnosis advisory committee.

(2) Except as provided by subsection 5 of this section, the department shall not require compliance with any additional standards for establishing or renewing trauma, STEMI, or stroke designations under this subsection. The designation shall continue if such hospital remains certified or verified. The department may remove a hospital's designation as a trauma center, STEMI center, or stroke center if the hospital requests removal of the designation or the department determines that the certificate or verification that qualified the hospital for the designation under this subsection has been suspended or revoked. Any decision made by the department to withdraw its designation of a center pursuant to this subsection that is based on the revocation or suspension of a certification or verification by a certifying or verifying organization shall not be subject to judicial review. The department shall report to the certifying or verifying organization any complaint it receives related to the center designated pursuant to this subsection. The department shall also advise the complainant which organization certified or verified the center and provide the necessary contact information should the complainant wish to pursue a complaint with the certifying or verifying organization.

5. Any hospital receiving designation as a trauma center, STEMI center, or stroke center pursuant to subsection 4 of this section shall:

(1) Within thirty days of any changes or receipt of a certificate or verification, submit to the department proof of certification or verification and the names and contact information of the center's medical director and the program manager; and

(2) Participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes.

Any hospital receiving designation as a level III stroke center pursuant to subsection 4 of this section shall have a formal agreement with a level I or level II stroke center for physician consultative services for evaluation of stroke patients for thrombolytic therapy and the care of the patient post-thrombolytic therapy.

6. Hospitals designated as a trauma center, STEMI center, or stroke center by the department shall submit data by one of the following methods:

(1) Entering hospital data into a state registry; or

(2) Entering hospital data into a national registry or data bank. A hospital submitting data pursuant to this subdivision shall not be required to collect and submit any additional trauma, STEMI, or stroke center data elements. No hospital submitting data to a national data registry or data bank under this subdivision shall withhold authorization for the department to access such data through such national data registry or data

bank. Nothing in this subdivision shall be construed as requiring duplicative data entry by a hospital that is otherwise complying with the provisions of this subsection. Failure of the department to obtain access to data submitted to a national data registry or data bank shall not be construed as hospital noncompliance under this subsection.

7. When collecting and analyzing data pursuant to the provisions of this section, the department shall comply with the following requirements:

(1) Names of any health care professionals, as defined in section 376.1350, shall not be subject to disclosure;

(2) The data shall not be disclosed in a manner that permits the identification of an individual patient or encounter;

(3) The data shall be used for the evaluation and improvement of hospital and emergency medical services' trauma, stroke, and STEMI care; and

(4) Trauma, STEMI, and stroke center data elements shall conform to national registry or data bank data elements, and include published detailed measure specifications, data coding instructions, and patient population inclusion and exclusion criteria to ensure data reliability and validity.

8. The department shall not have authority to establish additional education requirements for physicians who are emergency medicine board-certified or board-eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department of a facility designated as a trauma center, STEMI center, or stroke center by the department under this section. The department shall deem the education requirements promulgated by ABEM or AOBEM to meet the standards for designations under this section. Education requirements for non-ABEM or non-AOBEM certified physicians, nurses, and other providers who provide care at a facility designated as a trauma center, STEMI center, or stroke center by the department under this section shall mirror but not exceed those established by national designating or verifying bodies of trauma centers, STEMI centers, or stroke centers.

9. The department of health and senior services may establish appropriate fees to offset only the costs of trauma, STEMI, and stroke center surveys.

10. No hospital shall hold itself out to the public as a STEMI center, stroke center, adult trauma center, pediatric trauma center, or an adult and pediatric trauma center unless it is designated as such by the department of health and senior services.

11. Any person aggrieved by an action of the department of health and senior services affecting the trauma, STEMI, or stroke center designation pursuant to this chapter, including the revocation, the suspension, or the granting of, refusal to grant, or failure to renew a designation, may seek a determination thereon by the administrative hearing commission under chapter 621. It shall not be a condition to such determination that the person aggrieved seek a reconsideration, a rehearing, or exhaust any other procedure within the department."; and

Further amend said bill, Page 17, Section 191.227, Line 82, by inserting after the word "section" the following: ", or in response to a subpoena or court order"; and

Further amend said bill, page, and section, Lines 86-88, by deleting said lines and inserting in lieu thereof the

following:

"(3) Personal health information, including patient health history and treatment, shall not be considered a public record, as described under chapter 610. Nothing in this section shall limit the release of information or public records with personal health information that is redacted regarding the general nature of the event."; and

Further amend said bill, Page 22, Section 191.648, Line 43, by inserting after all of said section and line the following:

"191.708. 1. The chief medical officer or chief medical director of the department of health and senior services, the department of mental health, or the MO HealthNet division of the department of social services, or any licensed physician acting with the express written consent of the director of any such department or division, may, within his or her scope of practice, issue:

(1) Nonspecific recommendations for doula services;

(2) A medical standing order for prenatal vitamins; or

(3) A medical standing order for any other purpose, other than for controlled substances, that is promulgated by rule in compliance with chapter 536.

2. Any standing order issued under this section shall:

(1) Be made available on the relevant department's website while in effect;

(2) Terminate upon removal of the issuing medical professional's authority under this section by vacancy of his or her position or otherwise; and

(3) If not terminated sooner under subdivision (2) of this subsection, expire within one year of issuance unless renewed.

3. The chief medical officer, chief medical director, or other authorized and licensed physician described in subsection 1 of this section shall be immune from criminal prosecution, disciplinary action from his or her professional licensing board, and civil liability for issuing a medical standing order or recommendation in accordance with this section, including for any outcome related to the standing order or recommendation."; and

Further amend said bill, Page 23, Section 191.1145, Line 52, by inserting after all of said section and line the following:

"191.1146. 1. Physicians licensed under chapter 334 who use telemedicine shall ensure that a properly established physician-patient relationship exists with the person who receives the telemedicine services. The physician-patient relationship may be established by:

(1) An in-person encounter through a medical **[**~~interview~~**]** evaluation and physical examination;

(2) Consultation with another physician, or that physician's delegate, who has an established relationship with the patient and an agreement with the physician to participate in the patient's care; or

(3) A telemedicine encounter, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

2. In order to establish a physician-patient relationship through telemedicine:

(1) The technology utilized shall be sufficient to establish an informed diagnosis as though the medical **[**~~interview~~**]** evaluation and, if required to meet the standard of care, the physical examination has been performed in person; **[**~~and~~**]**

(2) Prior to providing treatment, including issuing prescriptions or physician certifications under Article XIV of the Missouri Constitution, a physician who uses telemedicine shall **[**~~interview~~**]** evaluate the patient, collect or review the patient's relevant medical history, and perform an examination sufficient for the diagnosis and treatment of the patient. **[**~~A~~**]** Any questionnaire completed by the patient, whether via the internet or telephone, shall be reviewed by the treating health care professional, as defined in section 376.1350, and shall include such information sufficient to provide the information as though the medical evaluation has been performed in person, otherwise such questionnaire does not constitute an acceptable medical **[**~~interview~~**]** evaluation and examination for the provision of treatment by telehealth; and

(3) Any provider that uses a questionnaire to establish a physician-patient relationship through telemedicine shall be employed or contracted with a business entity that is licensed to provide health care in this state.

3. A health care provider, utilizing a medical evaluation questionnaire completed by the patient by way of the internet or telephone, shall provide a written report to the patient's primary health care provider within fourteen days of evaluation, if provided by the patient, that contains:

(1) The identity of the patient;

(2) The date of the evaluation;

(3) The diagnosis and treatment provided, if any; and

(4) Any further instructions provided to the patient.

192.021. 1. The department of health and senior services shall be authorized to contract directly with a designated Missouri affiliate of the National Network of Public Health Institutes, or a similar or successor entity, in order to assist in carrying out its duties to promote the health and wellbeing of the residents of this state. Such contracts may include, but not be limited to, efforts to assist in the delivery of health services to residents throughout the state and the administration of grant funds and related programs.

2. Within sixty days after the end of each fiscal year, the department and the designated affiliate shall provide the general assembly with an annual report and accounting of any appropriations and grant funds received and expended by the designated affiliate pursuant to this section during the immediate prior fiscal year and may provide recommendations and suggestions for improvement in services provided."; and

Further amend said bill, Page 28, Section 196.990, Line 88, by inserting after all of said section and line the following:

"198.022. 1. Upon receipt of an application for a license to operate a facility, the department shall review the application, investigate the applicant and the statements sworn to in the application for license and conduct any necessary inspections. A license shall be issued if the following requirements are met:

(1) The statements in the application are true and correct;

(2) The facility and the operator are in substantial compliance with the provisions of sections 198.003 to 198.096 and the standards established thereunder;

(3) The applicant has the financial capacity to operate the facility;

(4) The administrator of an assisted living facility, a skilled nursing facility, or an intermediate care facility is currently licensed under the provisions of chapter 344;

(5) Neither the operator nor any principals in the operation of the facility have ever been convicted

of a felony offense concerning the operation of a long-term health care facility or other health care facility or ever knowingly acted or knowingly failed to perform any duty which materially and adversely affected the health, safety, welfare or property of a resident, while acting in a management capacity. The operator of the facility or any principal in the operation of the facility shall not be under exclusion from participation in the Title XVIII (Medicare) or Title XIX (Medicaid) program of any state or territory;

(6) Neither the operator nor any principals involved in the operation of the facility have ever been convicted of a felony in any state or federal court arising out of conduct involving either management of a long-term care facility or the provision or receipt of health care;

(7) All fees due to the state have been paid.

2. Upon denial of any application for a license, the department shall so notify the applicant in writing, setting forth therein the reasons and grounds for denial.

3. The department may inspect any facility and any records and may make copies of records, at the facility, at the department's own expense, required to be maintained by sections 198.003 to 198.096 or by the rules and regulations promulgated thereunder at any time if a license has been issued to or an application for a license has been filed by the operator of such facility. Copies of any records requested by the department shall be prepared by the staff of such facility within two business days or as determined by the department. The department shall not remove or disassemble any medical record during any inspection of the facility, but may observe the photocopying or may make its own copies if the facility does not have the technology to make the copies. In accordance with the provisions of section 198.525, the department shall make at least one inspection per year, which shall be unannounced to the operator. The department may make such other inspections, announced or unannounced, as it deems necessary to carry out the provisions of sections 198.003 to 198.136.

4. Whenever the department has reasonable grounds to believe that a facility required to be licensed under sections 198.003 to 198.096 is operating without a license, and the department is not permitted access to inspect the facility, or when a licensed operator refuses to permit access to the department to inspect the facility, the department shall apply to the circuit court of the county in which the premises is located for an order authorizing entry for such inspection, and the court shall issue the order if it finds reasonable grounds for inspection or if it finds that a licensed operator has refused to permit the department access to inspect the facility.

5. Whenever the department is inspecting a facility in response to an application from an operator located outside of Missouri not previously licensed by the department, the department may request from the applicant the past five years compliance history of all facilities owned by the applicant located outside of this state.

6. (1) In lieu of any inspection required by sections 198.003 to 198.186, the department may accept, in whole or in part, written reports of the survey of any state or federal agency, or of any professional accrediting agency, if such survey:

(a) Is comparable in scope and method to the department's surveys; and

(b) Is conducted in accordance with Title XVIII of the Social Security Act.

(2) Failure by a residential care facility or assisted living facility to maintain an accredited status by a recognized accrediting entity shall result in the assisted living facility or residential care facility being subject to an inspection pursuant to section 198.525.

(3) The residential care facility or the assisted living facility shall provide to the department the accreditation report verifying accreditation status to be published on the department's website and made publicly available pursuant to section 198.030.

(4) The residential care facility or the assisted living facility shall immediately forward any complaint or report of suspected abuse or neglect that is reported to the accrediting entity to the department in the same manner as provided under section 198.070.

198.070. 1. When any adult day care worker; chiropractor; Christian Science practitioner; coroner; dentist; embalmer; employee of the departments of social services, mental health, or health and senior services; employee of a local area agency on aging or an organized area agency on aging program; funeral director; home health agency or home health agency employee; hospital and clinic personnel engaged in examination, care, or treatment of persons; in-home services owner, provider, operator, or employee; law enforcement officer; long-term care facility administrator or employee; medical examiner; medical resident or

intern; mental health professional; minister; nurse; nurse practitioner; optometrist; other health practitioner; peace officer; pharmacist; physical therapist; physician; physician's assistant; podiatrist; probation or parole officer; psychologist; social worker; or other person with the care of a person sixty years of age or older or an eligible adult, as defined in section 192.2400, has reasonable cause to believe that a resident of a facility has been abused or neglected, he or she shall immediately report or cause a report to be made to the department.

2. (1) The report shall contain the name and address of the facility, the name of the resident, information regarding the nature of the abuse or neglect, the name of the complainant, and any other information which might be helpful in an investigation.

(2) In the event of suspected sexual assault of the resident, in addition to the report to be made to the department, a report shall be made to the appropriate local law enforcement agency in accordance with federal law under the provisions of 42 U.S.C. Section 1320b-25.

3. Any person required in subsection 1 of this section to report or cause a report to be made to the department who knowingly fails to make a report within a reasonable time after the act of abuse or neglect as required in this subsection is guilty of a class A misdemeanor.

4. In addition to the penalties imposed by this section, any administrator who knowingly conceals any act of abuse or neglect resulting in death or serious physical injury, as defined in section 556.061, is guilty of a class E felony.

5. In addition to those persons required to report pursuant to subsection 1 of this section, any other person having reasonable cause to believe that a resident has been abused or neglected may report such information to the department.

6. Upon receipt of a report, the department shall initiate an investigation within twenty-four hours and, as soon as possible during the course of the investigation, shall notify the resident's next of kin or responsible party of the report and the investigation and further notify them whether the report was substantiated or unsubstantiated unless such person is the alleged perpetrator of the abuse or neglect. As provided in section 192.2425, substantiated reports of elder abuse shall be promptly reported by the department to the appropriate law enforcement agency and prosecutor.

7. If the investigation indicates possible abuse or neglect of a resident, the investigator shall refer the complaint together with the investigator's report to the department director or the director's designee for appropriate action. If, during the investigation or at its completion, the department has reasonable cause to believe that immediate removal is necessary to protect the resident from abuse or neglect, the department or the local prosecuting attorney may, or the attorney general upon request of the department shall, file a petition for temporary care and protection of the resident in a circuit court of competent jurisdiction. The circuit court in which the petition is filed shall have equitable jurisdiction to issue an ex parte order granting the department authority for the temporary care and protection of the resident, for a period not to exceed thirty days.

8. Reports shall be confidential, as provided pursuant to section 192.2500.

9. Anyone, except any person who has abused or neglected a resident in a facility, who makes a report pursuant to this section or who testifies in any administrative or judicial proceeding arising from the report shall be immune from any civil or criminal liability for making such a report or for testifying except for liability for perjury, unless such person acted negligently, recklessly, in bad faith or with malicious purpose. It is a crime under section 565.189 for any person to knowingly file a false report of elder abuse or neglect.

10. Within five working days after a report required to be made pursuant to this section is received, the person making the report shall be notified in writing of its receipt and of the initiation of the investigation.

11. No person who directs or exercises any authority in a facility shall evict, harass, dismiss or retaliate against a resident or employee because such resident or employee or any member of such resident's or employee's family has made a report of any violation or suspected violation of laws, ordinances or regulations applying to the facility which the resident, the resident's family or an employee has reasonable cause to believe has been committed or has occurred. Through the existing department information and referral telephone contact line, residents, their families and employees of a facility shall be able to obtain information about their rights, protections and options in cases of eviction, harassment, dismissal or retaliation due to a report being made pursuant to this section.

12. Any person who abuses or neglects a resident of a facility is subject to criminal prosecution

under section 565.184.

13. The department shall maintain the employee disqualification list and place on the employee disqualification list the names of any persons who are or have been employed in any facility and who have been finally determined by the department pursuant to section 192.2490 to have knowingly or recklessly abused or neglected a resident. For purposes of this section only, "knowingly" and "recklessly" shall have the meanings that are ascribed to them in this section. A person acts "knowingly" with respect to the person's conduct when a reasonable person should be aware of the result caused by his or her conduct. A person acts "recklessly" when the person consciously disregards a substantial and unjustifiable risk that the person's conduct will result in serious physical injury and such disregard constitutes a gross deviation from the standard of care that a reasonable person would exercise in the situation.

14. The timely self-reporting of incidents to the central registry by a facility shall continue to be investigated in accordance with department policy, and shall not be counted or reported by the department as a hot-line call but rather a self-reported incident. If the self-reported incident results in a regulatory violation, such incident shall be reported as a substantiated report.

15. If a facility that is exempted from an annual inspection under subsection 6 of section 198.022 has one or more violations of a Class I standard under section 198.085, such facility shall be subject to a full survey by a state under section 198.022."; and

Further amend said bill, Page 30, Section 206.158, Line 20, by inserting after all of said section and line the following:

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

(1) "Clinical pathology services", professional medical services provided by a pathologist for the examination, diagnosis, and interpretation of laboratory tests performed on patient specimens to aid in the diagnosis and treatment of disease. Clinical pathology services include, but are not limited to, hematology, microbiology, immunology, clinical chemistry, molecular pathology, and other laboratory-based diagnostic procedures;

(2) "Hospital-based pathologist", a licensed physician specializing in pathology who provides clinical pathology services within a hospital setting;

(3) "Professional component of clinical pathology services", the portion of clinical pathology services that involves the pathologist's professional expertise in interpreting and supervising laboratory tests, excluding the technical component of performing the laboratory tests.

2. The fee for the professional component of clinical pathology services shall be paid by MO HealthNet for professional services provided by a hospital-based pathologist for inpatient clinical pathology services rendered to patients covered by the MO HealthNet program.

3. The reimbursement amount for the professional component of clinical pathology services shall be set at thirty percent of the approved outpatient simplified fee schedule based on Medicare's clinical laboratory fee schedule for the corresponding clinical pathology services payable by MO HealthNet.

4. (1) If the fee for the professional component of clinical pathology services is paid for professional services provided by a pathologist employed by the hospital where the clinical pathology services are rendered to covered MO HealthNet patients, the professional fee shall be paid directly to the hospital.

(2) If the fee for the professional component of clinical pathology services is paid for professional services provided by a pathologist who is not employed by the hospital where clinical pathology services are rendered to covered MO HealthNet patients, the professional fee shall be paid directly to the third party providing the services.

5. The department of social services shall promulgate all necessary rules and regulations for the administration 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, 2025, shall be invalid and void."; and

Further amend said bill, Page 36, Section 208.152, Line 216, by inserting after the number "(26)" the following:

"Doula services in accordance with sections 208.1400 to 208.1425;

(27) Childbirth education classes for pregnant women and a support person;

(28)"; and

Further amend said bill and section, Page 40, Line 347, by inserting after said line the following:

"16. The department of social services shall study the impact that the childbirth education classes provided under subdivision (26) of subsection 1 of this section have on infant and maternal mortality among pregnant women. The department of social services shall submit a report to the general assembly with the results of the study before January 1, 2028.

208.662. 1. There is hereby established within the department of social services the "Show-Me Healthy Babies Program" as a separate children's health insurance program (CHIP) for any low-income unborn child. The program shall be established under the authority of Title XXI of the federal Social Security Act, the State Children's Health Insurance Program, as amended, and 42 CFR 457.1.

2. For an unborn child to be enrolled in the show-me healthy babies program, his or her mother shall not be eligible for coverage under Title XIX of the federal Social Security Act, the Medicaid program, as it is administered by the state, and shall not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. In addition, the unborn child shall be in a family with income eligibility of no more than three hundred percent of the federal poverty level, or the equivalent modified adjusted gross income, unless the income eligibility is set lower by the general assembly through appropriations. In calculating family size as it relates to income eligibility, the family shall include, in addition to other family members, the unborn child, or in the case of a mother with a multiple pregnancy, all unborn children.

3. Coverage for an unborn child enrolled in the show-me healthy babies program shall include all prenatal care and pregnancy-related services that benefit the health of the unborn child and that promote healthy labor, delivery, and birth, including childbirth education classes. Coverage need not include services that are solely for the benefit of the pregnant mother, that are unrelated to maintaining or promoting a healthy pregnancy, and that provide no benefit to the unborn child. However, the department may include pregnancy-

related assistance as defined in 42 U.S.C. Section 1397ll.

4. There shall be no waiting period before an unborn child may be enrolled in the show-me healthy babies program. In accordance with the definition of child in 42 CFR 457.10, coverage shall include the period from conception to birth. The department shall develop a presumptive eligibility procedure for enrolling an unborn child. There shall be verification of the pregnancy.

5. Coverage for the child shall continue for up to one year after birth, unless otherwise prohibited by law or unless otherwise limited by the general assembly through appropriations.

6. (1) Pregnancy-related and postpartum coverage for the mother shall begin on the day the pregnancy ends and extend through the last day of the month that includes the sixtieth day after the pregnancy ends, unless otherwise prohibited by law or unless otherwise limited by the general assembly through appropriations. The department may include pregnancy-related assistance as defined in 42 U.S.C. Section 1397ll.

(2) (a) Subject to approval of any necessary state plan amendments or waivers, beginning on July 6, 2023, mothers eligible to receive coverage under this section shall receive medical assistance benefits during the pregnancy and during the twelve-month period that begins on the last day of the woman's pregnancy and ends on the last day of the month in which such twelve-month period ends, consistent with the provisions of 42 U.S.C. Section 1397gg(e)(1)(J). The department shall seek any necessary state plan amendments or waivers to implement the provisions of this subdivision when the number of ineligible MO HealthNet participants removed from the program in 2023 pursuant to section 208.239 exceeds the projected number of beneficiaries likely to enroll in benefits in 2023 under this subdivision and subdivision (28) of subsection 1 of section 208.151, as determined by the department, by at least one hundred individuals.

(b) The provisions of this subdivision shall remain in effect for any period of time during which the federal authority under 42 U.S.C. Section 1397gg(e)(1)(J), as amended, or any successor statutes or implementing regulations, is in effect.

7. The department shall provide coverage for an unborn child enrolled in the show-me healthy babies program in the same manner in which the department provides coverage for the children's health insurance program (CHIP) in the county of the primary residence of the mother.

8. The department shall provide information about the show-me healthy babies program to maternity homes as defined in section 135.600, pregnancy resource centers as defined in section 135.630, and other similar agencies and programs in the state that assist unborn children and their mothers. The department shall consider allowing such agencies and programs to assist in the enrollment of unborn children in the program, and in making determinations about presumptive eligibility and verification of the pregnancy.

9. Within sixty days after August 28, 2014, the department shall submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the show-me healthy babies program.

10. At least annually, the department shall prepare and submit a report to the governor, the speaker of the house of representatives, and the president pro tempore of the senate analyzing and projecting the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement agencies, correctional centers, health care providers, employers, other public and private entities, and persons

by enrolling unborn children in the show-me healthy babies program. The analysis and projection of cost savings and benefits, if any, may include but need not be limited to:

(1) The higher federal matching rate for having an unborn child enrolled in the show-me healthy babies program versus the lower federal matching rate for a pregnant woman being enrolled in MO HealthNet or other federal programs;

(2) The efficacy in providing services to unborn children through managed care organizations, group or individual health insurance providers or premium assistance, or through other nontraditional arrangements of providing health care;

(3) The change in the proportion of unborn children who receive care in the first trimester of pregnancy due to a lack of waiting periods, by allowing presumptive eligibility, or by removal of other barriers, and any resulting or projected decrease in health problems and other problems for unborn children and women throughout pregnancy; at labor, delivery, and birth; and during infancy and childhood;

(4) The change in healthy behaviors by pregnant women, such as the cessation of the use of tobacco, alcohol, illicit drugs, or other harmful practices, and any resulting or projected short-term and long-term decrease in birth defects; poor motor skills; vision, speech, and hearing problems; breathing and respiratory problems; feeding and digestive problems; and other physical, mental, educational, and behavioral problems; and

(5) The change in infant and maternal mortality, preterm births and low birth weight babies and any resulting or projected decrease in short-term and long-term medical and other interventions.

11. The show-me healthy babies program shall not be deemed an entitlement program, but instead shall be subject to a federal allotment or other federal appropriations and matching state appropriations.

12. Nothing in this section shall be construed as obligating the state to continue the show-me healthy babies program if the allotment or payments from the federal government end or are not sufficient for the program to operate, or if the general assembly does not appropriate funds for the program.

13. Nothing in this section shall be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state.

208.1400. Sections 208.1400 to 208.1425 shall be known and may be cited as the "Missouri Doula Reimbursement Act".

208.1405. For purposes of sections 208.1400 to 208.1425, the following terms mean:

(1) "Community-based network", a network that is representative of a community or significant segments of a community and engaged in meeting that community's needs in the area of social, human, or health services;

(2) "Community navigation services", services that connect pregnant individuals and their families with available resources using a community-based approach including, but not limited to, an approach that understands the services and supports available to pregnant and postpartum individuals receiving MO HealthNet benefits and facilitates access to those resources based upon an assessment of social service needs;

(3) "Doula", a trained professional providing continuous physical, emotional, and informational support to a pregnant individual, from the prenatal, the intrapartum, and up to the first twelve months of the postpartum periods. Doulas also provide assistance by referring pregnant individuals to community-based

networks and certified and licensed perinatal professionals in multiple disciplines;

(4) "Doula services", services provided by a doula;

(5) "Fee-for-service", a payment model where services are unbundled and paid for separately;

(6) "Intrapartum", the period of pregnancy during labor and delivery or childbirth. Services provided during this period are rendered to the pregnant individual;

(7) "Managed care", the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations that accept a set per member per month (capitation) payment for these services;

(8) "Postpartum", the one-year period after a pregnancy ends;

(9) "Prenatal", the period of pregnancy before labor or childbirth. Services provided during this period are rendered to the pregnant individual.

208.1410. The following doula services shall be covered by the MO HealthNet program:

(1) A combined total of six prenatal and postpartum support sessions;

(2) One birth attendance;

(3) Up to two visits for general consultation on lactation at any time during the prenatal and postpartum periods; and

(4) Community navigation services, except that any community navigation services provided outside any visit or session billed under subdivisions (1) to (3) of this section shall be billed only up to ten times total over the course of the pregnancy and postpartum period.

208.1415. A doula shall be eligible for participation as a provider of doula services covered by the MO HealthNet program only if the doula:

(1) Is enrolled as a MO HealthNet provider;

(2) Is eighteen years of age or older;

(3) Holds liability insurance as an individual or through a supervising organization; and

(4) Either:

(a) Possesses a current certificate issued by a national or Missouri-based doula training organization whose curriculum meets guidelines established by the MO HealthNet division by rule; or

(b) Received training from a source not described in paragraph (a) of this subdivision, or from multiple sources, whose curriculum meets the guidelines established under paragraph (a) of this subdivision as verified by a public roster maintained by a statewide organization composed of doula trainers from three or more independent, well-established doula training organizations located in Missouri whose purpose includes the validation of core competencies of training.

208.1420. 1. Once enrolled as a MO HealthNet provider, a doula shall be eligible to enroll as a provider with fee-for-service and managed care payers affiliated with the MO HealthNet program.

2. Doula services shall be reimbursed on a fee-for-service schedule.

208.1425. The MO HealthNet division shall promulgate all necessary rules and regulations for the administration of sections 208.1400 to 208.1425. 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, 2025, shall be invalid and void."; and

Further amend said bill, Page 41, Section 210.030, Lines 33-34, by deleting said lines and inserting in lieu thereof the following:

"3. No treatment administered under this section shall be provided without the patient's consent."; and

Further amend said bill, Page 81, Section 332.760, Line 6, by inserting after all of said section and line the following:

"334.108. 1. Prior to prescribing any drug, controlled substance, or other treatment through telemedicine, as defined in section 191.1145, or the internet, a physician shall establish a valid physician-patient relationship as described in section 191.1146. This relationship shall include:

(1) Obtaining a reliable medical history and, if required to meet the standard of care, performing a physical examination of the patient, adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions or contraindications to the treatment recommended or provided;

(2) Having sufficient **[**~~dialogue~~**]** exchange with the patient regarding treatment options and the risks and benefits of treatment or treatments;

(3) If appropriate, following up with the patient to assess the therapeutic outcome;

(4) Maintaining a contemporaneous medical record that is readily available to the patient and, subject to the patient's consent, to the patient's other health care professionals; and

(5) Maintaining the electronic prescription information as part of the patient's medical record.

2. The requirements of subsection 1 of this section may be satisfied by the prescribing physician's designee when treatment is provided in:

(1) A hospital as defined in section 197.020;

(2) A hospice program as defined in section 197.250;

(3) Home health services provided by a home health agency as defined in section 197.400;

(4) Accordance with a collaborative practice agreement as **[**~~defined~~**]** described in section 334.104;

(5) Conjunction with a physician assistant licensed pursuant to section 334.738;

(6) Conjunction with an assistant physician licensed under section 334.036;

(7) Consultation with another physician who has an ongoing physician-patient relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications; or

(8) On-call or cross-coverage situations.

3. No health care provider, as defined in section 376.1350, shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an evaluation **[**~~over the telephone~~**]** through

telemedicine; except that, a physician or such physician's on-call designee, or an advanced practice registered nurse, a physician assistant, or an assistant physician in a collaborative practice arrangement with such physician, may prescribe any drug, controlled substance, or other treatment that is within his or her scope of practice to a patient based solely on a **[**~~telephone~~**]** telemedicine evaluation if a previously established and ongoing physician-patient relationship exists between such physician and the patient being treated.

4. No health care provider shall prescribe any drug, controlled substance, or other treatment to a patient **[**~~based solely on an internet request or an internet questionnaire~~**]** in the absence of a proper provider-patient relationship, as described in section 191.1146.

5. Medical records of any drug, controlled substance, or other treatment prescribed through telemedicine, as defined in section 191.1145, shall be collected, stored, and maintained in accordance with the Health Insurance Portability and Accountability Act of 1996, which allows for the sharing of protected health information for continuity of care between health care providers for treatment, payment, and health care operations."; and

Further amend said bill, Page 86, Section 338.010, Line 121, by inserting after all of said section and line the following:

"338.333. 1. Except as otherwise provided by the board of pharmacy by rule in the event of an emergency or to alleviate a supply shortage, no person or distribution outlet shall act as a wholesale drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider without first obtaining license to do so from the Missouri board of pharmacy and paying the required fee. The board may grant temporary licenses when the wholesale drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider first applies for a license to operate within the state. Temporary licenses shall remain valid until such time as the board shall find that the applicant meets or fails to meet the requirements for regular licensure. No license shall be issued or renewed for a wholesale drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider to operate unless the same shall be operated in a manner prescribed by law and according to the rules and regulations promulgated by the board of pharmacy with respect thereto. Separate licenses shall be required for each distribution site owned or operated by a wholesale drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider, unless such drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider meets the requirements of section 338.335.

2. An agent or employee of any licensed or registered wholesale drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider need not seek licensure under this section and may lawfully possess pharmaceutical drugs, if the agent or employee is acting in the usual course of his or her business or employment.

3. The board may permit out-of-state wholesale drug distributors, drug outsourcers, third-party logistics **[**~~provider~~**]** providers, or out-of-state pharmacy distributors to be licensed as required by sections 338.210 to 338.370 on the basis of reciprocity to the extent that the entity both:

(1) Possesses a valid license granted by another state pursuant to legal standards comparable to those which must be met by a wholesale drug distributor, pharmacy distributor, drug **[**~~outsourcers~~**]** outsourcer, or

third-party logistics provider of this state as prerequisites for obtaining a license under the laws of this state. If a state license is not issued by their resident state, out-of-state wholesale drug distributors and third-party logistics providers with a current and valid drug distributor accreditation from the National Association of Boards of Pharmacy or its successor may be eligible for licensure as provided by the board by rule; and

(2) Distributes into Missouri from a state which would extend reciprocal treatment under its own laws to a wholesale drug distributor, pharmacy distributor, drug outsourcers, or third-party logistics provider of this state."; and

Further amend said bill, Page 87, Section 376.1240, Line 15, by inserting after all of said section and line the following:

"376.1245. 1. As used in this section, the following terms mean:

(1) "Anesthesia time", the period during which an anesthesia practitioner is present with the patient, starting when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ending when the anesthesia practitioner is no longer furnishing anesthesia services to the patient because the patient may be placed safely under postoperative or postanesthesia care. The term "anesthesia time" includes, if counted by the anesthesia practitioner, blocks of time around an interruption in anesthesia time provided the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption;

(2) "Anesthesia time units", time units recognized with appropriate time intervals that do not exceed fifteen minutes in length for each interval and that, taken together, represent the total anesthesia time for a particular anesthesia service;

(3) "Excepted benefit plan", the same meaning given to the term in section 376.998;

(4) "Health benefit plan", the same meaning given to the term in section 376.1350. The term "health benefit plan" shall also include MO HealthNet, the children's health insurance program authorized under chapter 208, the Missouri consolidated health care plan established under chapter 103, and any other state-sponsored health insurance program;

(5) "Health carrier", the same meaning given to the term in section 376.1350. The term "health carrier" shall also include the MO HealthNet division and any Medicaid managed care organization as defined in section 208.431;

(6) "Payment of anesthesia services", an amount paid for anesthesia services:

(a) Determined by using prevailing medical coding and billing standards in the professional medical billing community, such as the Current Procedural Terminology code book published by the American Medical Association, the Medicare Claims Processing Manual, or guidance from nationally recognized anesthesia organizations; and

(b) Calculated as the product obtained by multiplying the following together:

a. The sum of the base units for the appropriate medical code plus anesthesia time units; and

b. An anesthesia conversion factor that is defined in the individual contract between the health carrier or health benefit plan and the anesthesia practitioner or group.

2. No health carrier or health benefit plan shall establish, implement, or enforce any policy, practice, or procedure that imposes a time limit for the payment of anesthesia services provided during a medical or surgical procedure.

3. No health carrier or health benefit plan shall establish, implement, or enforce any policy, practice, or procedure that restricts or excludes all anesthesia time in calculating the payment of anesthesia services.

4. Excepted benefit plans shall be subject to the requirements of this section."; and

Further amend said bill, Pages 87-88, Section 376.1280, Lines 2-9, by deleting said lines and inserting in lieu thereof the following:

"(1) "Acute pain", pain that results from disease, accidental or intentional trauma, or other causes, that a health care provider reasonably expects to last thirty days or fewer;"; and

Further amend said bill and section, Page 88, Line 17, by inserting after the first instance of the word "of" the word "acute"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.