FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE NO. 2 FOR

SENATE BILL NO. 79

103RD GENERAL ASSEMBLY

0769H.11C JOSEPH ENGLER, Chief Clerk

AN ACT

To repeal sections 96.192, 96.196, 190.053, 190.098, 190.101, 190.109, 190.800, 191.648, 191.1145, 191.1146, 192.769, 206.110, 208.152, 210.030, 334.108, and 354.465, RSMo, and to enact in lieu thereof twenty-seven new sections relating to health care, with penalty provisions.

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

Section A. Sections 96.192, 96.196, 190.053, 190.098, 190.101, 190.109, 190.800, 191.648, 191.1145, 191.1146, 192.769, 206.110, 208.152, 210.030, 334.108, and 354.465, RSMo, are repealed and twenty-seven new sections enacted in lieu thereof, to be known as sections 96.192, 96.196, 190.053, 190.076, 190.098, 190.101, 190.109, 190.112, 190.166, 190.800, 191.648, 191.1145, 191.1146, 192.2521, 206.110, 206.158, 208.152, 210.030, 334.108, 354.465, 376.1240, 376.1850, 376.2100, 376.2102, 376.2104, 376.2106, and 376.2108, to read as follows:

96.192. 1. The board of trustees of any hospital authorized under subsection 2 of this section, and established and organized under the provisions of sections 96.150 to 96.229**[**~~,~~**]:**

(1) May invest up to **[**~~twenty-five~~**] fifty** percent of the hospital's **"available funds", defined in this section as** funds not required for immediate disbursement in obligations or for the operation of the hospital **[**~~in any United States investment grade fixed income funds or any diversified stock funds, or both.~~**], into:**

(a) Any mutual funds that invest in stocks, bonds, or real estate, or any combination thereof;

(b) Bonds that have:

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.

a. One of the five highest long-term ratings or the highest short-term rating issued by a nationally recognized rating agency; and

b. A final maturity of ten years or less;

(c) Money market investments; or

(d) Any combination of investments described in paragraphs (a) to (c) of this subdivision; and

(2) Shall invest the remaining percentage of any available funds not invested as allowed under subdivision (1) of this subsection into any investment in which the state treasurer is allowed to invest.

2. The provisions of this section shall only apply if the hospital:

(1) Receives less than **[**~~one~~**] three** percent of its annual revenues from municipal, county, or state taxes; and

(2) Receives less than **[**~~one~~**] three** percent of its annual revenue from appropriated funds from the municipality in which such hospital is located.

96.196. 1. A hospital organized under this chapter may purchase, operate or lease, as lessor or lessee, related facilities or engage in health care activities, except in counties of the third or fourth classification (other than the county in which the hospital is located) where there already exists a hospital organized pursuant to this chapter **[**~~and chapter 205 or 206~~**]**; provided, however, that this exception shall not prohibit the continuation of existing activities otherwise allowed by law.

2. If a hospital organized pursuant to this chapter accepts appropriated funds from the city during the twelve months immediately preceding the date that the hospital purchases, operates or leases its first related facility outside the city boundaries or engages in its first health care activity outside the city boundaries, the governing body of the city shall approve the hospital's plan for such purchase, operation or lease prior to implementation of the plan.

190.053. 1. All members of the board of directors of an ambulance district first elected on or after January 1, 2008, shall attend and complete an educational seminar or conference or other suitable training on the role and duties of a board member of an ambulance district. The training required under this section shall be offered by a statewide association organized for the benefit of ambulance districts or be approved by the state advisory council on emergency medical services. Such training shall include, at a minimum:

(1) Information relating to the roles and duties of an ambulance district director;

(2) A review of all state statutes and regulations relevant to ambulance districts;

(3) State ethics laws;

(4) State sunshine laws, chapter 610;

(5) Financial and fiduciary responsibility;

(6) State laws relating to the setting of tax rates; and

(7) State laws relating to revenue limitations.

2. **[**~~If any ambulance district board member fails to attend a training session within twelve months after taking office, the board member shall not be compensated for attendance at meetings thereafter until the board member has completed such training session. If any ambulance district board member fails to attend a training session within twelve months of taking office regardless of whether the board member received an attendance fee for a training session, the board member shall be ineligible to run for reelection for another term of office until the board member satisfies the training requirement of this section; however, this requirement shall only apply to board members elected after August 28, 2022~~**] All members of the board of directors of an ambulance district shall complete three hours of continuing education for each term of office. The continuing education shall be offered by a statewide association organized for the benefit of ambulance districts or be approved by the state advisory council on emergency medical services.**

3. Any ambulance district board member who fails to complete the initial training and continuing education requirements on or before the anniversary date of the member's election or appointment as required under this section shall immediately be disqualified from office. Upon such disqualification, the member's position shall be deemed vacant without further process or declaration. The vacancy shall be filled in the manner provided for in section 190.052.

190.076. In addition to the annual audit required under section 190.075, each ambulance district shall, at least once every three years, arrange for a certified public accountant or a firm of certified public accountants to audit the records and accounts of the district. The audit shall be made freely available to the public on the district's website or by other electronic means.

190.098. 1. **As used in this section, the term "community paramedic services" shall mean services provided by any entity that employs licensed paramedics who are certified by the department as community paramedics for services that are:**

(1) Provided in a nonemergent setting that is independent of an emergency telephone service, 911 system, or emergency summons;

(2) Consistent with the training and education requirements described in subdivision (2) of subsection 2 of this section, the scope of skill and practice for community paramedics, and the supervisory standard approved by the entity's medical director; and

(3) Reflected and documented in the entity's patient care plans or protocols approved by the medical director in accordance with the provisions of section 190.142.

2. In order for a person to be eligible for certification by the department as a community paramedic, an individual shall:

(1) Be currently **[**~~certified~~**] licensed** as a paramedic;

(2) Successfully complete or have successfully completed a community paramedic certification program from a college, university, or educational institution that has been approved by the department or accredited by a national accreditation organization approved by the department; and

(3) Complete an application form approved by the department.

[~~2.~~**] 3.** A community paramedic shall practice in accordance with protocols and supervisory standards established by the medical director. A community paramedic shall provide services of a health care plan if the plan has been developed by the patient's physician or by an advanced practice registered nurse through a collaborative practice arrangement with a physician or a physician assistant through a collaborative practice arrangement with a physician and there is no duplication of services to the patient from another provider.

[~~3.~~**] 4. (1)** Any ambulance service shall enter into a written contract to provide community paramedic services in another ambulance service area, as that term is defined in section 190.100. The contract that is agreed upon may be for an indefinite period of time, as long as it includes at least a sixty-day cancellation notice by either ambulance service.

(2) Any ambulance service that seeks to provide community paramedic services outside of the ambulance service's service area:

(a) Shall have a memorandum of understanding regarding the provision of such services with the ambulance service in that service area if that ambulance service is already providing community paramedic services; or

(b) Shall not be required to have a memorandum of understanding with the ambulance service in that service area if that ambulance service is not already providing community paramedic services, provided that the ambulance service seeking to provide such services shall provide notification to the other ambulance service of the community paramedic services to be provided.

(3) Any emergency medical response agency that seeks to provide community paramedic services within its designated response service area may do so if the ground ambulance service area within which the emergency medical response agency operates does not already provide such services. If the ground ambulance service does provide community paramedic services, the ground ambulance service may enter into a memorandum of understanding with the emergency medical response agency in order to coordinate programs and avoid service duplication. If the emergency medical response agency provides community paramedic services in the ground ambulance service's service area prior to the provision of such services by the ground ambulance service, the emergency medical response agency and the ground ambulance service shall enter into a memorandum of understanding for the coordination of services.

(4) Any community paramedic program shall notify the appropriate local ambulance service when providing services within the service area of an ambulance service.

(5) The department shall promulgate rules and regulations for the purpose of identifying the community paramedic services entities that have met the standards necessary to provide community paramedic services including, but not limited to, physician medical oversight, training, patient record retention, formal relationships with primary care services as needed, and quality improvement policies. Community paramedic services entities shall be certified by the department. Any such certification shall allow the entity to provide community paramedic services for a period of five years.

[~~4.~~**] 5.** A community paramedic is subject to the provisions of sections 190.001 to 190.245 and rules promulgated under sections 190.001 to 190.245.

[~~5.~~**] 6.** No person shall hold himself or herself out as a community paramedic or provide the services of a community paramedic unless such person is certified by the department.

[~~6.~~**] 7.** The medical director shall approve the implementation of the community paramedic program.

[~~7.~~**] 8.** 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, 2013, shall be invalid and void.

190.101. 1. There is hereby established a "State Advisory Council on Emergency Medical Services" which shall consist of **[**~~sixteen~~**] no more than twenty-three** members, one of which shall be **[**~~a resident~~**] the chief paramedic** of a city not within a county. The members of the council shall be appointed **[**~~by the governor with the advice and consent of the senate~~**] in accordance with subsection 2 of this section** and shall serve terms of four years. The **[**~~governor shall designate one of the members as chairperson~~**] council members shall annually select a chairperson, along with other officers as the council deems necessary**. The chairperson may appoint subcommittees that include noncouncil members.

2. **Council members shall be appointed as follows:**

(1) The director of the department of health and senior services shall make appointments to the council from the recommendations provided by the following:

(a) The statewide professional association representing ambulance service managers;

(b) The statewide professional association representing emergency medical technicians and paramedics;

(c) The statewide professional association representing ambulance districts;

(d) The statewide professional association representing fire chiefs;

(e) The statewide professional association representing fire protection districts;

(f) The statewide professional association representing firefighters;

(g) The statewide professional association representing emergency nurses;

(h) The statewide professional association representing the air ambulance industry;

(i) The statewide professional association representing emergency medicine physicians;

(j) The statewide association representing hospitals; and

(k) The statewide association representing pediatric emergency professionals;

(2) The director of health and senior services shall appoint a member to the council with a background in mobile integrated health care-community paramedicine (MIH-CP);

(3) Each regional EMS advisory committee shall appoint one member; and

(4) The time-critical diagnosis advisory committee established under section 190.257 shall appoint one member.

3. The state EMS medical directors advisory committee and the regional EMS advisory committees will be recognized as subcommittees of the state advisory council on emergency medical services.

[~~3.~~**] 4.** The council shall have geographical representation and representation from appropriate areas of expertise in emergency medical services including volunteers, professional organizations involved in emergency medical services, EMT's, paramedics, nurses, firefighters, physicians, ambulance service administrators, hospital administrators and other health care providers concerned with emergency medical services. **[**~~The regional EMS advisory committees shall serve as a resource for the identification of potential members of the state advisory council on emergency medical services.~~

~~4.~~**] 5.** The state EMS medical director, as described under section 190.103, shall serve as an ex officio member of the council.

[~~5.~~**] 6.** The members of the council and subcommittees shall serve without compensation except that members of the council shall, subject to appropriations, be reimbursed for reasonable travel expenses and meeting expenses related to the functions of the council.

[~~6.~~] 7. The purpose of the council is to make recommendations to the governor, the general assembly, and the department on policies, plans, procedures and proposed regulations on how to improve the statewide emergency medical services system. The council shall advise the governor, the general assembly, and the department on all aspects of the emergency medical services system.

[~~7.~~] 8. (1) There is hereby established a standing subcommittee of the council to monitor the implementation of the recognition of the EMS personnel licensure interstate compact under sections 190.900 to 190.939, the interstate commission for EMS personnel practice, and the involvement of the state of Missouri. The subcommittee shall meet at least biannually and receive reports from the Missouri delegate to the interstate commission for EMS personnel practice. The subcommittee shall consist of at least seven members appointed by the chair of the council, to include at least two members as recommended by the Missouri state council of firefighters and one member as recommended by the Missouri Association of Fire Chiefs. The subcommittee may submit reports and recommendations to the council, the department of health and senior services, the general assembly, and the governor regarding the participation of Missouri with the recognition of the EMS personnel licensure interstate compact.

(2) The subcommittee shall formally request a public hearing for any rule proposed by the interstate commission for EMS personnel practice in accordance with subsection 7 of section 190.930. The hearing request shall include the request that the hearing be presented live through the internet. The Missouri delegate to the interstate commission for EMS personnel practice shall be responsible for ensuring that all hearings, notices of, and related rulemaking communications as required by the compact be communicated to the council and emergency medical services personnel under the provisions of subsections 4, 5, 6, and 8 of section 190.930.

(3) The department of health and senior services shall not establish or increase fees for Missouri emergency medical services personnel licensure in accordance with this chapter for the purpose of creating the funds necessary for payment of an annual assessment under subdivision (3) of subsection 5 of section 190.924.

[~~8.~~] 9. The council shall consult with the time-critical diagnosis advisory committee, as described under section 190.257, regarding time-critical diagnosis.

190.109. 1. The department shall, within a reasonable time after receipt of an application, cause such investigation as the department deems necessary to be made of the applicant for a ground ambulance license.

2. Any person that owned and operated a licensed ambulance on December 31, 1997, shall receive an ambulance service license from the department, unless suspended, revoked or terminated, for that ambulance service area which was, on December 31, 1997, described and

filed with the department as the primary service area for its licensed ambulances on August 28, 1998, provided that the person makes application and adheres to the rules and regulations promulgated by the department pursuant to sections 190.001 to 190.245.

3. The department shall issue a new ground ambulance service license to an ambulance service that is not currently licensed by the department, or is currently licensed by the department and is seeking to expand its ambulance service area, except as provided in subsection 4 of this section, to be valid for a period of five years, unless suspended, revoked or terminated, when the director finds that the applicant meets the requirements of ambulance service licensure established pursuant to sections 190.100 to 190.245 and the rules adopted by the department pursuant to sections 190.001 to 190.245. In order to be considered for a new ambulance service license, an ambulance service shall submit to the department a letter of endorsement from each ambulance district or fire protection district that is authorized to provide ambulance service, or from each municipality not within an ambulance district or fire protection district that is authorized to provide ambulance service, in which the ambulance service proposes to operate. If an ambulance service proposes to operate in unincorporated portions of a county not within an ambulance district or fire protection district that is authorized to provide ambulance service, in order to be considered for a new ambulance service license, the ambulance service shall submit to the department a letter of endorsement from the county. Any letter of endorsement required pursuant to this section shall verify that the political subdivision has conducted a public hearing regarding the endorsement and that the governing body of the political subdivision has adopted a resolution approving the endorsement. The letter of endorsement shall affirmatively state that the proposed ambulance service:

(1) Will provide a benefit to public health that outweighs the associated costs;

(2) Will maintain or enhance the public's access to ambulance services;

(3) Will maintain or improve the public health and promote the continued development of the regional emergency medical service system;

(4) Has demonstrated the appropriate expertise in the operation of ambulance services; and

(5) Has demonstrated the financial resources necessary for the operation of the proposed ambulance service.

4. A contract between a political subdivision and a licensed ambulance service for the provision of ambulance services for that political subdivision shall expand, without further action by the department, the ambulance service area of the licensed ambulance service to include the jurisdictional boundaries of the political subdivision. The termination of the aforementioned contract shall result in a reduction of the licensed ambulance service's ambulance service area by removing the geographic area of the political subdivision from its

ambulance service area, except that licensed ambulance service providers may provide ambulance services as are needed at and around the state fair grounds for protection of attendees at the state fair.

5. The department shall renew a ground ambulance service license if the applicant meets the requirements established pursuant to sections 190.001 to 190.245, and the rules adopted by the department pursuant to sections 190.001 to 190.245.

6. The department shall promulgate rules relating to the requirements for a ground ambulance service license including, but not limited to:

(1) Vehicle design, specification, operation and maintenance standards;

(2) Equipment requirements;

(3) Staffing requirements;

(4) Five-year license renewal;

(5) Records and forms;

(6) Medical control plans;

(7) Medical director qualifications;

(8) Standards for medical communications;

(9) Memorandums of understanding with emergency medical response agencies that provide advanced life support;

(10) Quality improvement committees; **[**~~and~~**]**

(11) Response time, patient care and transportation standards**;**

(12) Participation with regional EMS advisory committees; and

(13) Ambulance service administrator qualifications.

7. Application for a ground ambulance service license shall be made upon such forms as prescribed by the department in rules adopted pursuant to sections 190.001 to 190.245. The application form shall contain such information as the department deems necessary to make a determination as to whether the ground ambulance service meets all the requirements of sections 190.001 to 190.245 and rules promulgated pursuant to sections 190.001 to 190.245.

190.112. 1. Each ambulance service licensed under this chapter shall identify to the department an individual as the ambulance service administrator, who shall be responsible for the operations and staffing of the ambulance service.

2. Any individual identified as the ambulance service administrator under subsection 1 of this section shall be required to have achieved basic training of at least forty hours regarding the operations of an ambulance service and to complete two hours of annual continuing education to maintain the individual's status as the ambulance service administrator.

3. The training required under this section shall be offered by a statewide association organized for the benefit of ambulance districts or be approved by the state advisory council on emergency medical services. Such training shall include information on:

(1) Basic principles of accounting and economics;

(2) State and federal laws applicable to ambulance services;

(3) Regulatory requirements applicable to ambulance services;

(4) Human resources management and laws;

(5) Grant writing, contracts, and fundraising;

(6) The state sunshine law requirements under chapter 610 and state ethics laws; and

(7) Volunteer and community involvement.

4. Any individual serving as an ambulance service administrator as of August 28, 2025, shall have until January 1, 2027, to demonstrate compliance with the provisions of this section.

190.166. 1. In addition to the provisions of section 190.165, the department of health and senior services may refuse to issue, deny renewal of, or suspend a license required under section 190.109, or take other corrective actions as described in this section, based on the following considerations:

(1) The license holder is determined to be financially insolvent;

(2) The ambulance service has inadequate personnel to operate the ambulance service to provide basic emergency operations. The ambulance service shall not be deemed to have such inadequate personnel as long as the ambulance service is staffed to meet the needs of its emergency call volume. Each ambulance service shall have the ability to staff a minimum of one ambulance unit twenty-four hours each day, seven days each week, with at least two licensed emergency medical technicians. Any ambulance service operating only one ambulance unit shall have a reasonable plan and schedule for the services of a second ambulance unit;

(3) The ambulance service requires an inordinate amount of mutual aid from neighboring services, such as more than ten percent of the total runs in the service area in any given month or more than would be considered prudent, and thus cannot provide an appropriate level of emergency response for the service area as would be considered prudent by the typical ground ambulance services operator;

(4) The principal manager, board members, or other executives are determined to be criminally liable for actions related to the license or service provided;

(5) The license holder or principal manager, board members, or other executives are determined by the Centers for Medicare and Medicaid Services to be ineligible for participation in Medicare;

(6) The license holder or principal manager, board members, or other executives are determined by the MO HealthNet division to be ineligible for participation in MO HealthNet;

(7) The ambulance service administrator has failed to meet the required qualifications or failed to complete the training required under section 190.112; or

(8) If the ambulance service is an ambulance district, three or more board members have failed to complete required training under section 190.053.

2. If the department makes a determination of insolvency or insufficiency of operations of a license holder under subsection 1 of this section, the department may require the license holder to submit a corrective plan within fifteen days and require implementation of the corrective plan within thirty days.

3. The department shall be required to provide notice of any determination by the department of insolvency or insufficiency of operations of a license holder to other license holders operating in the license holder's vicinity, members of the general assembly who represent the license holder's service area, the governing officials of any county or municipal entity in the license holder's service area, the appropriate regional emergency medical services advisory committee, and the state advisory council on emergency medical services.

4. The department shall immediately engage with other license holders in the area to determine the extent to which ground ambulance service may be provided to the affected service area during the time in which the license holder is unable to provide adequate services, including any long-term service arrangements. The nature of the agreement between the license holder and other license holders providing services to the affected area may include an agreement to provide services, a joint powers agreement, formal consideration, or some payment for services rendered.

5. Any license holder who provides assistance in the service area of another license holder whose license has been suspended under this section shall have the right to seek reasonable compensation from the license holder whose license to operate has been suspended for all calls, stand-by time, and responses to medical emergencies during such time as the license remains suspended. The reasonable compensation shall not be limited to those expenses incurred in actual responses but may also include reasonable expenses to maintain ambulance service including, but not limited to, the daily operation costs of maintaining the service, personnel wages and benefits, equipment purchases and maintenance, and other costs incurred in the operation of a

ground ambulance service. The license holder providing assistance shall be entitled to an award of costs and reasonable attorney's fees in any action to enforce the provisions of this subsection.

190.800. 1. Each ground ambulance service**[**~~, except for any ambulance service owned and operated by an entity owned and operated by the state of Missouri, including but not limited to any hospital owned or operated by the board of curators, as defined in chapter 172, or any department of the state,~~**]** shall, in addition to all other fees and taxes now required or paid, pay an ambulance service reimbursement allowance tax for the privilege of engaging in the business of providing ambulance services in this state.

2. For the purpose of this section, the following terms shall mean:

(1) "Ambulance", the same meaning as such term is defined in section 190.100;

(2) "Ambulance service", the same meaning as such term is defined in section 190.100;

(3) "Engaging in the business of providing ambulance services in this state", accepting payment for such services.

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

(1) "Designated sexually transmitted infection", chlamydia, gonorrhea, trichomoniasis, or any other sexually transmitted infection designated as appropriate for expedited partner therapy by the department of health and senior services or for which expedited partner therapy was recommended in the most recent Centers for Disease Control and Prevention guidelines for the prevention or treatment of sexually transmitted infections;

(2) "Expedited partner therapy" **[**~~means~~**],** the practice of treating the sex partners of persons with **[**~~chlamydia or gonorrhea~~**] designated sexually transmitted infections** without an intervening medical evaluation or professional prevention counseling**;**

(3) "Health care professional", a member of any profession regulated by chapter 334 or 335 authorized to prescribe medications.

2. Any licensed **[**~~physician~~**] health care professional** may, but shall not be required to, utilize expedited partner therapy for the management of the partners of persons with **[**~~chlamydia or gonorrhea~~**] designated sexually transmitted infections**. Notwithstanding the requirements of 20 CSR 2150- 5.020 (5) or any other law to the contrary, a licensed **[**~~physician~~**] health care professional** utilizing expedited partner therapy may prescribe and dispense medications for the treatment of **[**~~chlamydia or gonorrhea~~**] a designated sexually transmitted infection** for an individual who is the partner of a person with **[**~~chlamydia or gonorrhea~~**] a designated sexually transmitted infection** and who does not have an established **[**~~physician/patient~~**] health care professional/patient** relationship with such

[~~physician~~**] health care professional**. **[**~~Any antibiotic medications prescribed and dispensed for the treatment of chlamydia or gonorrhea under this section shall be in pill form.~~**]**

3. Any licensed **[**~~physician~~**] health care professional** utilizing expedited partner therapy for the management of the partners with **[**~~chlamydia or gonorrhea~~**] designated sexually transmitted infections** shall provide explanation and guidance to **[**~~a~~**] each** patient **[**~~diagnosed with chlamydia or gonorrhea~~**]** of the preventative measures that can be taken by the patient to stop the **[**~~spread~~**] transmission** of such **[**~~diagnosis~~**] infection**.

4. Any licensed **[**~~physician~~**] health care professional** utilizing expedited partner therapy for the management of partners of persons with **[**~~chlamydia or gonorrhea~~**] designated sexually transmitted infections** under this section shall have immunity from any civil liability that may otherwise result by reason of such actions, unless such **[**~~physician~~**] health care professional** acts negligently, recklessly, in bad faith, or with malicious purpose.

5. The department of health and senior services and the division of professional registration within the department of commerce and insurance shall by rule develop guidelines for the implementation of subsection 2 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, 2010, shall be invalid and void.

191.1145. 1. As used in sections 191.1145 and 191.1146, the following terms shall mean:

(1) "Asynchronous store-and-forward transfer", the collection of a patient's relevant health information and the subsequent transmission of that information from an originating site to a health care provider at a distant site without the patient being present;

(2) "Clinical staff", any health care provider licensed in this state;

(3) "Distant site", a site at which a health care provider is located while providing health care services by means of telemedicine;

(4) "Health care provider", as that term is defined in section 376.1350;

(5) "Originating site", a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine. For the purposes of asynchronous store-and-forward transfer, originating site shall also mean the location at which the health care provider transfers information to the distant site;

(6) "Telehealth" or "telemedicine", the delivery of health care services by means of information and communication technologies**, including audiovisual and audio-only**

technologies, which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology. **Health care providers shall not be limited in their choice of electronic platforms used to deliver telehealth or telemedicine, provided that all services delivered are in accordance with the Health Insurance Portability and Accountability Act of 1996.**

2. Any licensed health care provider shall be authorized to provide telehealth services if such services are within the scope of practice for which the health care provider is licensed and are provided with the same standard of care as services provided in person. This section shall not be construed to prohibit a health carrier, as defined in section 376.1350, from reimbursing nonclinical staff for services otherwise allowed by law.

3. In order to treat patients in this state through the use of telemedicine or telehealth, health care providers shall be fully licensed to practice in this state and shall be subject to regulation by their respective professional boards.

4. Nothing in subsection 3 of this section shall apply to:

(1) Informal consultation performed by a health care provider licensed in another state, outside of the context of a contractual relationship, and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation;

(2) Furnishing of health care services by a health care provider licensed and located in another state in case of an emergency or disaster; provided that, no charge is made for the medical assistance; or

(3) Episodic consultation by a health care provider licensed and located in another state who provides such consultation services on request to a physician in this state.

5. Nothing in this section shall be construed to alter the scope of practice of any health care provider or to authorize the delivery of health care services in a setting or in a manner not otherwise authorized by the laws of this state.

6. No originating site for services or activities provided under this section shall be required to maintain immediate availability of on-site clinical staff during the telehealth services, except as necessary to meet the standard of care for the treatment of the patient's medical condition if such condition is being treated by an eligible health care provider who is not at the originating site, has not previously seen the patient in person in a clinical setting, and is not providing coverage for a health care provider who has an established relationship with the patient. **Health care providers shall not be limited in their choice of electronic platforms used to deliver telehealth or telemedicine.**

7. Nothing in this section shall be construed to alter any collaborative practice requirement as provided in chapters 334 and 335.

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.

192.2521. A specialty hospital is exempt from the provisions of sections 192.2520 and 197.135 if such hospital has a policy for transfer of a victim of a sexual assault to an appropriate hospital with an emergency department. As used in this section, "specialty hospital" means a hospital that has been designated by the department of health and senior services as something other than a general acute care hospital.

206.110. 1. A hospital district, both within and outside such district, except in counties of the third or fourth classification (other than within the district boundaries) where there already exists a hospital organized pursuant to **[**~~chapters 96, 205 or~~**]** this chapter; provided, however, that this exception shall not prohibit the continuation or expansion of existing activities otherwise allowed by law, shall have and exercise the following governmental powers, and all other powers incidental, necessary, convenient or desirable to carry out and effectuate the express powers:

(1) To establish and maintain a hospital or hospitals and hospital facilities, and to construct, acquire, develop, expand, extend and improve any such hospital or hospital facility including medical office buildings to provide offices for rental to physicians and dentists on the district hospital's medical or dental staff, and the providing of sites therefor, including offstreet parking space for motor vehicles;

(2) To acquire land in fee simple, rights in land and easements upon, over or across land and leasehold interest in land and tangible and intangible personal property used or useful for the location, establishment, maintenance, development, expansion, extension or improvement of any hospital or hospital facility. The acquisition may be by dedication, purchase, gift, agreement, lease, use or adverse possession or by condemnation;

(3) To operate, maintain and manage a hospital and hospital facilities, and to make and enter into contracts, for the use, operation or management of a hospital or hospital facilities; to engage in health care activities; and to make and enter into leases of equipment and real property, a hospital or hospital facilities, as lessor or lessee, regardless of the duration of such lease; and to provide rules and regulations for the operation, management or use of a hospital or hospital facilities. Any agreement entered into pursuant to this subsection pertaining to the lease of the hospital shall have a definite termination date as negotiated by the parties, but this shall not preclude the trustees from entering into a renewal of the agreement with the same or other parties pertaining to the same or other subjects upon such terms and conditions as the parties may agree;

(4) To fix, charge and collect reasonable fees and compensation for the use or occupancy of the hospital or any part thereof, or any hospital facility, and for nursing care, medicine, attendance, or other services furnished by the hospital or hospital facilities, according to the rules and regulations prescribed by the board from time to time;

(5) To borrow money and to issue bonds, notes, certificates, or other evidences of indebtedness for the purpose of accomplishing any of its corporate purposes, subject to compliance with any condition or limitation set forth in this chapter or otherwise provided by the Constitution of the state of Missouri;

(6) To employ or enter into contracts for the employment of any person, firm, or corporation, and for professional services, necessary or desirable for the accomplishment of the corporate objects of the district or the proper administration, management, protection or control of its property;

(7) To maintain the hospital for the benefit of the inhabitants of the area comprising the district who are sick, injured, or maimed regardless of race, creed or color, and to adopt such reasonable rules and regulations as may be necessary to render the use of the hospital of the greatest benefit to the greatest number; to exclude from the use of the hospital all persons who willfully disregard any of the rules and regulations so established; to extend the privileges and use of the hospital to persons residing outside the area of the district upon such terms and conditions as the board of directors prescribes by its rules and regulations;

(8) To police its property and to exercise police powers in respect thereto or in respect to the enforcement of any rule or regulation provided by the ordinances of the district and to employ and commission police officers and other qualified persons to enforce the same;

(9) To lease to or allow for any institution of higher education to use or occupy the hospital, any real estate or facility owned or leased by the district or any part thereof for the purpose of health care-related and general education or training.

2. The use of any hospital or hospital facility of a district shall be subject to the reasonable regulation and control of the district and upon such reasonable terms and conditions as shall be established by its board of directors.

3. A regulatory ordinance of a district adopted under any provision of this section may provide for a suspension or revocation of any rights or privileges within the control of the district for a violation of any such regulatory ordinance.

4. Nothing in this section or in other provisions of this chapter shall be construed to authorize the district or board to establish or enforce any regulation or rule in respect to hospitalization or the operation or maintenance of such hospital or any hospital facilities within its jurisdiction which is in conflict with any federal or state law or regulation applicable to the same subject matter.

206.158. 1. The board of directors of any hospital district authorized under subsection 2 of this section, and established and organized under the provisions of this chapter:

(1) May invest up to fifty percent of its "available funds", defined in this section as funds not required for immediate disbursement in obligations or for the operation of the hospital district, into:

(a) Any mutual funds that invest in stocks, bonds, or real estate, or any combination thereof;

(b) Bonds that have:

a. One of the five highest long-term ratings or the highest short-term rating issued by a nationally recognized rating agency; and

b. A final maturity of ten years or less;

(c) Money market investments; or

(d) Any combination of investments described in paragraphs (a) to (c) of this subdivision; and

(2) Shall invest the remaining percentage of any available funds not invested as allowed under subdivision (1) of this subsection into any investment in which the state treasurer is allowed to invest.

2. The provisions of this section shall apply only if the hospital district receives less than three percent of its annual revenues from hospital district or state taxes.

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as described in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO

HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section **[**~~301,~~**]** **1396** et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere, provided, that no funds shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate, as defined in section 188.015, of such abortion facility;

(7) Subject to appropriation, up to twenty visits per year for services limited to examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned articulations and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand MO HealthNet services;

(8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an

advanced practice registered nurse may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(9) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(10) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and federal regulations promulgated thereunder;

(11) Home health care services;

(12) Family planning as defined by federal rules and regulations; provided, that no funds shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate, as defined in section 188.015, of such abortion facility; and further provided, however, that such family planning services shall not include abortions or any abortifacient drug or device that is used for the purpose of inducing an abortion unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(13) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);

(14) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(15) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the

average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(16) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section **[**~~301~~**] 1396 et seq.**, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately

established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(17) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;

(18) The services of an advanced practice registered nurse with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

(19) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(20) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(21) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(22) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(24) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(25) **Medically necessary cochlear implants and hearing instruments, as defined in section 345.015, that are:**

(a) Prescribed by an audiologist, as defined in section 345.015; or

(b) Dispensed by a hearing instrument specialist, as defined in section 346.010;

(26) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as described in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, **[**~~hearing aids,~~**]** and wheelchairs;

(5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other

physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. 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 subdivision 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, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (15) and (16) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made

by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).

10. The MO HealthNet division may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining eligibility under this section.

12. If the Missouri Medicaid audit and compliance unit changes any interpretation or application of the requirements for reimbursement for MO HealthNet services from the interpretation or application that has been applied previously by the state in any audit of a MO HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO HealthNet providers five business days before such change shall take effect. Failure of the Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to continue to receive and retain reimbursement until such notification is provided and shall waive any liability of such provider for recoupment or other loss of any payments previously made prior to the five business days after such notice has been sent. Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall agree to receive communications electronically. The notification required under this section shall be delivered in writing by the United States Postal Service or electronic mail to each provider.

13. Nothing in this section shall be construed to abrogate or limit the department's statutory requirement to promulgate rules under chapter 536.

14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems shall be reimbursed utilizing the behavior assessment and intervention reimbursement codes 96150 to 96154 or their successor codes under the Current Procedural Terminology (CPT) coding system. Providers eligible for such reimbursement shall include psychologists.

15. There shall be no payments made under this section for gender transition surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section 191.1720, for the purpose of a gender transition.

210.030. 1. Every licensed physician, midwife, registered nurse and all persons who may undertake, in a professional way, the obstetrical and gynecological care of a pregnant woman in the state of Missouri shall, if the woman consents, take or cause to be taken a sample of venous blood of such woman at the time of the first prenatal examination, or not later than twenty days after the first prenatal examination, **another sample at twenty-eight weeks of pregnancy, and another sample immediately after birth** and subject such **[**~~sample~~**] samples** to an approved and standard serological test for syphilis**[**~~, an~~**] and** approved serological **[**~~test~~**] tests** for hepatitis B**, hepatitis C, human immunodeficiency virus (HIV),** and such other treatable diseases and metabolic disorders as are prescribed by the department of health and senior services. **[**~~In any area of the state designated as a syphilis outbreak area by the department of health and senior services, if the mother consents, a sample of her venous blood shall be taken later in the course of pregnancy and at delivery for additional testing for syphilis as may be prescribed by the department~~**] If a mother tests positive for syphilis, hepatitis B, hepatitis C, or HIV, or any combination of such diseases, the physician or person providing care shall administer treatment in accordance with the most recent accepted medical practice**. If a mother tests positive for hepatitis B, the physician or person who professionally undertakes the pediatric care of a newborn shall also administer the appropriate doses of hepatitis B vaccine and hepatitis B immune globulin (HBIG) in accordance with the current recommendations of the Advisory Committee on Immunization Practices (ACIP). If the mother's hepatitis B status is unknown, the appropriate dose of hepatitis B vaccine shall be administered to the newborn in accordance with the current ACIP recommendations. If the mother consents, a sample of her venous blood shall be taken. If she tests positive for hepatitis B, hepatitis B immune globulin (HBIG) shall be administered to the newborn in accordance with the current ACIP recommendations.

2. The department of health and senior services shall**[**~~, in consultation with the Missouri genetic disease advisory committee,~~**]** make such rules pertaining to such tests as shall be dictated by accepted medical practice, and tests shall be of the types approved **or accepted** by the **[**~~department of health and senior services. An approved and standard test for syphilis, hepatitis B, and other treatable diseases and metabolic disorders shall mean a test made in a laboratory approved by the department of health and senior services~~**] United States Food and Drug Administration**. No individual shall be denied testing by the department of health and senior services because of inability to pay.

3. Health care providers shall receive informed consent prior to administering any treatment or procedure.

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.

354.465. 1. The director, or any duly appointed representative, may make an examination of the affairs of any health maintenance organization as often as he deems it necessary for the protection of the interests of the people of this state**[**~~, but not less frequently than once every five years~~**]**.

2. All costs incurred by the state as a result of making examinations under this section shall be paid by the organization being examined and remitted as provided in section 374.160.

376.1240. 1. For purposes of this section, terms shall have the same meanings as ascribed to them in section 376.1350, and the term "self-administered hormonal contraceptive" shall mean a drug that is composed of one or more hormones and that is approved by the Food and Drug Administration to prevent pregnancy, excluding emergency contraception. Nothing in this section shall be construed to apply to medications approved by the Food and Drug Administration to terminate an existing pregnancy.

2. Any health benefit plan delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2026, that provides coverage for self-administered hormonal contraceptives shall provide coverage to reimburse a health care provider or dispensing entity for the dispensing of a supply of self-administered hormonal contraceptives intended to last up to one year.

3. The coverage required under this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the health benefit plan.

376.1850. 1. As used in this section, the following terms mean:

(1) "Contract for health care benefits", a self-funded contractual arrangement made in accordance with this section between a qualified membership organization and its members to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(2) "Farm bureau", a nonprofit agricultural membership organization first incorporated in this state at least one hundred years ago, or an affiliate designated by the nonprofit agricultural membership organization;

(3) "Health care service", the same meaning as is ascribed to such term in section 376.1350;

(4) "Member of a qualified membership organization", a natural person who pays periodic dues or fees, other than payments for a contract for health care benefits, for membership in a qualified membership organization and the natural person's spouse or dependent children under twenty-six years of age;

(5) "Qualified membership organization":

(a) A farm bureau; or

(b) An entity that has at least one hundred thousand dues-paying members, that is governed by a council of its members, that has at least five hundred million dollars in assets, and that exists to serve its members beyond solely offering health coverage.

2. The provisions of this chapter relating to health insurance, health maintenance organizations, health benefit plans, group health services, and health carriers shall not apply to contracts for health care benefits provided by a qualified membership organization. A qualified membership organization providing contracts for health care benefits shall not be considered to be engaging in the business of insurance for purposes of any provision of chapters 361 to 385.

3. It is unlawful to provide a contract for health care benefits under this section unless the qualified membership organization providing the contract is registered with the department of commerce and insurance as provided in this subsection. To register as a qualified membership organization, an applicant shall file information with the director demonstrating the applicant meets the requirements of this section and pay an application fee of two hundred fifty dollars. A registration is valid for five years and may be renewed for additional five-year terms if the qualified membership organization continues to meet the requirements of this section and pays a renewal fee of two hundred fifty dollars. All amounts collected as registration or renewal fees shall be deposited into the insurance dedicated fund established under section 374.150.

4. Contracts for health care benefits provided under this section shall be offered only to members of a qualified membership organization who have been members of the organization for at least thirty days and shall be sold, solicited, or negotiated only by insurance producers licensed under chapter 375 to produce accident and health or sickness coverage.

5. Notwithstanding any provision of law to the contrary, a qualified membership organization providing a contract for health care benefits under this section shall use

the services of an administrator permitted to provide services in accordance with sections 376.1075 to 376.1095 and shall agree in the contract with such administrator to utilize processes for benefit determinations and claims payment procedures that conform to the requirements applicable to health carriers and health benefit plans under sections 376.383, 376.690, and 376.1367. A contract for health care benefits provided under this section shall not be subject to the laws of this state relating to insurance or insurance companies except as specified in this section.

6. The risk under contracts provided in accordance with this section may be reinsured in accordance with section 375.246.

7. (1) Contracts for health care benefits under this section shall include the following written disclaimer on the front of the contract and on all related applications and renewal forms in at least sixteen-point, bold font:

NOTICE

This contract is not health insurance and is not subject to federal or state laws relating to health insurance. This contract offers fewer benefits than an ACA-compliant health plan and may exclude coverage for preexisting conditions. You may qualify for income-based subsidies through the ACA Health Insurance Marketplace. This contract is not covered by the Missouri Life and Health Insurance Guaranty Association. You may be financially responsible for costs of medical treatment that may not be covered under this contract.

(2) The written disclaimer required by subdivision (1) of this subsection on applications and renewal forms shall be signed by the member entering into or renewing the contract, specifically acknowledging that the coverage is not considered insurance and is not subject to regulation by the department of commerce and insurance.

(3) The qualified membership organization providing the contract shall retain a copy of the written acknowledgment required under subdivision (2) of this subsection for the duration of the period for which claims may be submitted under the contract. The qualified membership organization shall provide a copy of the acknowledgment to the member upon the member's request.

8. Contracts provided under this section shall not be subject to individual postclaim medical underwriting while coverage remains in effect, and no member covered under a contract provided under this section shall be subject to cancellation, nonrenewal, modification, or an increase in premium for reason of a medical event.

9. Notwithstanding subsection 2 of this section, the department of commerce and insurance shall receive and review complaints and inquiries from members of a qualified membership organization under section 374.085, subject to section 374.071.

10. Before April first of each year, each qualified membership organization providing a contract for health care benefits under this section, or its administrator, shall pay to the director a fee equal to one percent of the Missouri claims paid under this section during the immediately preceding year. Funds collected by the director shall be deposited in the insurance dedicated fund established under section 374.150.

11. No qualified membership organization, or other entity on behalf of a qualified membership organization, shall refer to a contract for health care benefits under this section as insurance or health insurance in any marketing, advertising, or other communication with the public or members of the qualified membership organization. Violation of this subsection shall be an unlawful practice under section 407.020.

12. Contracts for health care benefits provided under this section:

(1) Shall include coverage for:

(a) Ambulatory patient services;

(b) Hospitalization;

(c) Emergency services, as defined in section 376.1350; and

(d) Laboratory services; and

(2) Shall not be subject to an annual limit of less than two million dollars per year.

376.2100. 1. Except as otherwise provided in subsection 1 of section 376.2108, as used in sections 376.2100 to 376.2108, terms shall have the same meanings as are ascribed to them under section 376.1350.

2. As used in sections 376.2100 to 376.2108, the following terms mean:

(1) "Evaluation period", any consecutive twelve months;

(2) "Value-based care agreement", a contractual agreement between a health care provider, either directly or indirectly through a health care provider group or organization, and a health carrier that:

(a) Incentivizes or rewards providers based on one or more of the following:

a. Quality of care;

b. Safety;

c. Patient outcomes;

d. Efficiency;

e. Cost reduction; or

f. Other factors; and

(b) May, but is not required to, include shared financial risk and rewards based on performance metrics.

376.2102. 1. Except as otherwise provided in this section, beginning January 1, 2026, a health carrier or utilization review entity shall not require a health care provider to obtain prior authorization for a health care service unless the health carrier or utilization review entity makes a determination that in the most recent evaluation period the health carrier or utilization review entity has approved or would have approved less than ninety percent of the prior authorization requests submitted by that provider for that health care service.

2. Beginning January 1, 2026, a health carrier or utilization review entity shall not require a health care provider to obtain prior authorization for any health care services unless the health carrier or utilization review entity makes a determination that in the most recent evaluation period the health carrier or utilization review entity has approved or would have approved less than ninety percent of all prior authorization requests submitted by that provider for health care services.

3. (1) Beginning January 1, 2026, a health carrier or utilization review entity may elect to have a hospital, as that term is defined in section 197.020, determine which of the following conditions that such hospital will comply with to obtain an exemption from prior authorization requirements under subsections 1 and 2 of this section:

(a) The hospital entering into, either directly or indirectly through a health care provider group or organization a value-based care agreement with the health carrier;

(b) The hospital's score of three or higher on the Center for Medicare and Medicaid Services Five-Star Quality Rating System, 42 CFR § 412.190, or its successor rating system; or

(c) At least ninety-one percent of the hospital's prior authorization requests submitted for purposes of eligibility for subsections 1 or 2 of this section were approved or would have been approved by the health carrier or utilization review entity.

(2) Critical access hospitals and hospitals that do not participate in the Center for Medicare and Medicaid Services Five-Star Quality Rating System, or its successor rating system, shall be exempt from the provisions of this subsection.

4. The exemption from prior authorization requirements described in subsections 1, 2, and 3 of this section shall not include:

(1) Pharmacy services, not to exceed the amount of one hundred thousand dollars;

(2) Imaging services, not to exceed the amount of one hundred thousand dollars;

(3) Cosmetic procedures that are not medically necessary; or

(4) Investigative or experimental treatments.

5. The amount of the limitations described in subdivisions (1) and (2) of subsection 4 of this section shall be increased every year, rounded to the nearest thousand dollars, beginning January 1, 2027, based on the Consumer Price Index for All Urban Consumers for the United States (CPI-U), or its successor index, as such index is defined and officially reported by the United States Department of Labor, or its successor agency.

6. In making a determination under this section, the health carrier or utilization review entity shall not count:

(1) Any prior authorization requests denied by a health carrier or utilization review entity and being appealed by the health care provider; or

(2) Any request made by a health care provider for a service that is not included in the health carrier's benefit plan

but shall count as approved any prior authorization request that was denied by a health carrier or utilization review entity but that was subsequently authorized.

7. In making a determination under this section, the health carrier or utilization review entity shall use either the provider's national provider identifier or a taxpayer identification number. Such designation shall remain unless requested to be changed by the provider.

8. The exemption from prior authorization requirements described in subsections 1, 2, and 3 of this section may be subject to internal auditing of the most recent consecutive six months, up to a maximum of two times per year, by the health carrier or utilization review entity and may be rescinded if:

(1) Such carrier or utilization review entity determines that the carrier or utilization review entity would have approved less than ninety percent of prior authorization requests for a health care service that the provider was exempt from the prior authorization requirement under subsection 1 of this section;

(2) Such carrier or utilization review entity determines that the carrier or utilization review entity would have approved less than ninety percent of all prior authorization requests if the provider was exempt from the prior authorization requirement under subsection 2 of this section; or

(3) There has been an increase in the provision of exempt procedures by a health care provider of more than fifty percent or more than twenty procedures, whichever amount is greater.

9. The exemption described in subsections 1, 2, and 3 of this section shall be null and void upon a determination that the health care provider has been found by a court

of law to have civilly or criminally engaged in any fraud or abuse after the exemption is granted by a health carrier or utilization review entity.

10. A health carrier or utilization review entity may require health care providers in the health carrier's or utilization review entity's network to use an online portal to submit requests for prior authorization.

11. No adverse determination shall be finalized under subsections 1, 2, 3, or 8 unless reviewed by a clinical peer.

12. Any patient who has received prior authorization for the coverage of a ninety-day supply of medication whose health coverage plan changes following such authorization shall be permitted a ninety-day grace period from the date of such change in order to determine whether such patient's new plan covers the previously authorized medication or whether prior authorization is required.

376.2104. 1. The health carrier or utilization review entity shall notify the health care provider no later than twenty-five days after any determination made under section 376.2102. The notification shall include the statistics, data, and any supporting documentation for making the determination for the relevant evaluation period.

2. The health carrier or utilization review entity shall establish a process for health care providers to appeal any determinations made under section 376.2102.

3. The health carrier or utilization review entity shall maintain an online portal to allow health care providers to access all prior authorization decisions, including determinations made under section 376.2102. For health care providers subject to prior authorizations, the portal shall include the status of each prior authorization request, all notifications to the health care provider, the dates the health care provider received such notifications, and any other information relevant to the determination.

376.2106. No health carrier or utilization review entity shall deny or reduce payment to a health care provider for a health care service for which the provider has a prior authorization unless the provider:

(1) Knowingly and materially misrepresented the health care service in a request for payment submitted to the health carrier or utilization review entity with the specific intent to deceive and obtain an unlawful payment from the carrier or entity; or

(2) Failed to substantially perform the health care service.

376.2108. 1. The provisions of sections 376.2100 to 376.2108 shall not apply to MO HealthNet, except that a Medicaid managed care organization as defined in section 208.431 shall be considered a health carrier for purposes of sections 376.2100 to 376.2108.

2. The provisions of sections 376.2100 to 376.2108 shall not apply to health care providers who have not participated in a health benefit plan offered by the health carrier for at least one full evaluation period.

3. Nothing in sections 376.2100 to 376.2108 shall be construed to:

(1) Authorize a health care provider to provide a health care service outside the scope of his or her applicable license; or

(2) Require a health carrier or utilization review entity to pay for a health care service described in subdivision (1) of this subsection.

[~~192.769. 1. On completion of a mammogram, a mammography facility certified by the United States Food and Drug Administration (FDA) or by a certification agency approved by the FDA shall provide to the patient the following notice:~~

~~"If your mammogram demonstrates that you have dense breast tissue, which could hide abnormalities, and you have other risk factors for breast cancer that have been identified, you might benefit from supplemental screening tests that may be suggested by your ordering physician. Dense breast tissue, in and of itself, is a relatively common condition. Therefore, this information is not provided to cause undue concern, but rather to raise your awareness and to promote discussion with your physician regarding the presence of other risk factors, in addition to dense breast tissue. A report of your mammography results will be sent to you and your physician. You should contact your physician if you have any questions or concerns regarding this report.".~~

~~2. Nothing in this section shall be construed to create a duty of care beyond the duty to provide notice as set forth in this section.~~

~~3. The information required by this section or evidence that a person violated this section is not admissible in a civil, judicial, or administrative proceeding.~~

~~4. A mammography facility is not required to comply with the requirements of this section until January 1, 2015.~~**]**

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