House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND House Committee Substitute for House Bill No. 2372, Page 10, Section 192.021, Line 12, by inserting after said section and line the following:

"192.258. 1. For purposes of this section, the following terms mean:

(1) "Local public health agency", a county health center board established under chapter 205, a county health department, a city health department or agency, a combined city and county health department or agency, a multicounty health department or agency, or any other county or city health authority;

(2) "Term infants", infants who are at thirty-six weeks or more of gestation.

2. (1) Each county shall annually report infant deaths to the local public health agency or agencies with jurisdiction over the county or any part of the county.

(2) The data shall be aggregated to ensure data reflects how regionalized care systems are, or should be, collaborating to improve fetal and infant health outcomes based on standard statistical methods for accurate dissemination of public health data without risking a confidentiality or other disclosure breach.

(3) The data shall be disaggregated by racial and ethnic identity.

3. Subject to appropriation, a local public health agency shall establish a fetal and infant mortality review committee to investigate infant deaths to prevent fetal and infant death if both of the following apply with respect to the local public health agency's jurisdiction:

(1) The jurisdiction has five or more infant deaths in a single year; and

(2) The jurisdiction has an infant death rate that is higher than the state's infant death rate for two consecutive years.

4. The department of health and senior services shall establish a fetal and infant mortality review process in which all local public health agencies may voluntarily participate. A local public health agency that participates in the fetal and infant mortality review process established by the department of health and senior services shall do all of the following:

(1) Annually investigate, track, and review a minimum amount of twenty percent of the jurisdiction's cases of term infants who were born following labor with the outcome of intrapartum stillbirth, early neonatal death, or postneonatal death, focusing on demographic

Action Taken_____ Date _____

groups that are disproportionately impacted by infant death. A jurisdiction that has fewer than five infant deaths in a year shall investigate at least one infant death;

(2) Establish a committee for fetal and infant mortality reviews led by local public health agencies. The committee shall include members of the community but shall not include anyone employed by a law enforcement agency. In jurisdictions in which the coroner, medical examiner, or other medical professional is employed by law enforcement, these individuals can share information with the committee in their medical professional capacity only. The committee shall be subject to the following provisions:

(a) All data and records obtained, prepared, created, and maintained in anticipation of a review meeting shall be confidential. Data and records prepared, created, and maintained in anticipation of a review meeting shall not be subject to public records requests, subpoena, or civil processes and shall not be admissible in evidence in connection with any administrative, judicial, executive, legislative, or other proceeding;

(b) All participants engaged in and associated with the review process shall sign a confidentiality agreement that states such participants will not discuss or share information about individual cases and the proceedings of the review meeting outside the meeting. This shall not preclude the committee from publishing, or from otherwise making available for public inspection, statistical compilations or reports that are based on confidential information, provided that those compilations or reports shall not contain personally identifying information or other information that could be used to ultimately identify the individuals concerned and shall utilize standard public health reporting practices for accurate dissemination of these data elements, especially with regard to the reporting of small numbers so as not to inadvertently risk a breach of confidentiality or other disclosure; and

(c) To the extent prescribed by section 537.035, members of the committee, persons attending a committee meeting, and persons who present information to a committee shall not be questioned in any administrative, civil, or criminal proceeding regarding information presented in, or opinions formed as a result of, a meeting. This paragraph shall not prohibit a person from testifying to information obtained independently of the committee or that is public information. A health care provider, health care facility, or pharmacy providing access to medical records under this section shall not be held liable for civil damages or be subject to any criminal or disciplinary action for good faith efforts in providing the records;

(3) Conduct voluntary interviews with individuals who have experienced child loss or surviving family members of maternal or infant death who have knowledge of the event. The interview shall include questions to determine if the pregnant person had concerns about perinatal care during any point in the person's pregnancy or postpartum care, whether there were disagreements about care offered and received, and whether the pregnant person had asked for certain care that was denied or not received;

(4) Conduct a report or investigation, to the degree practicable, with all medical staff involved with a maternal or infant death; and

(5) Offer grief counseling to surviving family members.

5. Counties, hospitals, birthing centers, and state entities shall provide to local public health agencies death records, medical records, autopsy reports, toxicology reports, hospital discharge records, birth records, and any other information that will help the local public health agency conduct the fetal and infant mortality review within thirty days of a request made in writing by a local public health agency. The local public health agency shall not request, and health care providers shall not provide, reports, testimony, or other information produced as a result of activities undertaken by a peer review committee, as defined in section 537.035, that has the responsibility to evaluate or improve the quality of care rendered in a hospital.

6. (1) There is hereby created in the state treasury the "Fetal and Infant Mortality Review Fund", which shall consist of moneys appropriated to it by the general assembly and any gifts, contributions, grants, or bequests received from federal, private, or other sources. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and, upon appropriation, moneys in this fund shall be used solely as provided in this section.

(2) Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund.

(3) The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

192.990. 1. There is hereby established within the department of health and senior services the "Pregnancy-Associated Mortality Review Board" to improve data collection and reporting with respect to maternal deaths. The department may collaborate with localities and with other states to meet the goals of the initiative.

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

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

(2) "Maternal death" or "maternal mortality", the death of a woman while pregnant or during the one-year period following the date of the end of pregnancy, regardless of the cause of death and regardless of whether a delivery, miscarriage, or death occurs inside or outside of a hospital;

(3) "Severe maternal morbidity", unexpected outcomes of pregnancy, labor, or delivery that result in significant short-term or long-term consequences to the pregnant person's mental or physical health.

3. The board shall be composed of no more than eighteen members, with a chair elected from among its membership. The board shall meet at least twice per year and shall approve the strategic priorities, funding allocations, work processes, and products of the board. Members of

the board shall be appointed by the director of the department. Members shall serve four-year terms, except that the initial terms shall be staggered so that approximately one-third serve three-, four-, and five-year terms.

4. The board shall have a multidisciplinary and diverse membership that represents a variety of medical and nursing specialties, including, but not limited to, obstetrics and maternal-fetal care, as well as state or local public health officials, epidemiologists, statisticians, community organizations, geographic regions, and other individuals or organizations that are most affected by maternal deaths and lack of access to maternal health care services.

5. The duties of the board shall include, but not be limited to:

(1) Conducting ongoing comprehensive, multidisciplinary reviews of all maternal deaths;

(2) Identifying factors associated with maternal deaths;

(3) Reviewing medical records and other relevant data, which shall include, to the extent available:

(a) A description of the maternal deaths determined by matching each death record of a maternal death to a birth certificate of an infant or fetal death record, as applicable, and an indication of whether the delivery, miscarriage, or death occurred inside or outside of a hospital;

(b) Data collected from medical examiner and coroner reports, as appropriate; and

(c) Using other appropriate methods or information to identify maternal deaths, including deaths from pregnancy outcomes not identified under paragraph (a) of this subdivision;

(4) Consulting with relevant experts, as needed;

(5) Analyzing cases to produce recommendations for reducing maternal mortality;

(6) Analyzing common indicators of severe maternal morbidity to identify prevention opportunities and reduce near-miss experiences;

(7) Disseminating recommendations to policy makers, health care providers and facilities, and the general public on best practices to prevent maternal mortality and morbidity including, but not limited to, addressing socioeconomic and environmental impacts, including global warming, on pregnancy outcomes;

[~~(7)~~**]** (8) Recommending and promoting preventative strategies and making recommendations for systems changes, including changes in data collection and investigatory processes;

[~~(8)~~**]** (9) Protecting the confidentiality of the hospitals and individuals involved in any maternal deaths;

[~~(9)~~**]** (10) Examining racial and social disparities in maternal deaths and making recommendations on the prevention of racial and social disparities;

[~~(10)~~**]** (11) Tracking and examining disparities experienced by lesbian, bisexual, transgender, intersex, and gender-nonconforming individuals and reporting findings, to the extent practicable;

(12) Subject to appropriation, providing for voluntary and confidential case reporting of maternal deaths to the appropriate state health agency by family members of the deceased, and other appropriate individuals, for purposes of review by the board;

[~~(11)~~**]** (13) Making publicly available the contact information of the board for use in such reporting;

[~~(12)~~**]** (14) Conducting outreach to local professional organizations, community organizations, and social services agencies regarding the availability of the review board; and

[~~(13)~~**]** (15) Ensuring that data collected under this section is made available, as appropriate and practicable, for research purposes, in a manner that protects individually identifiable or potentially identifiable information and that is consistent with state and federal privacy laws.

6. (1) The board's review of cases of maternal mortality and morbidity shall include, to the degree practicable, for populations experiencing disparity, voluntary interviews with the following individuals:

(a) Pertinent surviving family members or support people present with direct knowledge of, or involvement in, the event, including the patient in cases of severe maternal morbidity. The board shall transcribe or summarize in writing any oral statements received in accordance with this paragraph; and

(b) Members of the medical team who were present or involved in the deceased individual's direct care.

(2) In determining the practicability of the interviews under subdivision (1) of this subsection, the board may prioritize interviews with populations that have a documented higher rate of maternal death.

7. The board may contract with other entities consistent with the duties of the board.

[~~7.~~**]** 8. (1) Before June 30, 2020, and annually thereafter, the board shall submit to the Director of the Centers for Disease Control and Prevention, the director of the department, the governor, and the general assembly a report on maternal mortality in the state based on data collected through ongoing comprehensive, multidisciplinary reviews of all maternal deaths, and any other projects or efforts funded by the board. The data shall be collected using best practices to reliably determine and include all maternal deaths, regardless of the outcome of the pregnancy and shall include data, findings, and recommendations of the committee, and, as applicable, information on the implementation during such year of any recommendations submitted by the board in a previous year.

(2) The report shall be made available to the public on the department's website and the director shall disseminate the report to all health care providers and facilities that provide women's health services in the state.

[~~8.~~**]** 9. The director of the department, or his or her designee, shall provide the board with the copy of the death certificate and any linked birth or fetal death certificate for any maternal death occurring within the state.

[~~9.~~**]** 10. Upon request by the department, health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, law enforcement agencies, driver's license bureaus, other state agencies, and facilities licensed by the department shall provide to the department data related to maternal deaths from sources such as medical records, autopsy reports, medical examiner's reports, coroner's reports, law enforcement reports, motor vehicle records, social services records, and other sources as appropriate. Such data requests shall be limited to maternal deaths which have occurred within the previous twenty-four months. No entity shall be held liable for civil damages or be subject to any criminal or disciplinary action when complying in good faith with a request from the department for information under the provisions of this subsection.

[~~10.~~**]** 11. (1) The board shall protect the privacy and confidentiality of all patients, decedents, providers, hospitals, or any other participants involved in any maternal deaths or any cases of severe maternal morbidity. In no case shall any individually identifiable health information be provided to the public or submitted to an information clearinghouse.

(2) Nothing in this subsection shall prohibit the board or department from publishing statistical compilations and research reports that:

(a) Are based on confidential information relating to mortality reviews under this section; and

(b) Do not contain identifying information or any other information that could be used to ultimately identify the individuals concerned.

(3) Information, records, reports, statements, notes, memoranda, or other data collected under this section shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency, or person. Such information, records, reports, notes, memoranda, data obtained by the department or any other person, statements, notes, memoranda, or other data shall not be exhibited nor their contents disclosed in any way, in whole or in part, by any officer or representative of the department or any other person. No person participating in such review shall disclose, in any manner, the information so obtained except in strict conformity with such review project. Such information shall not be subject to disclosure under chapter 610.

(4) All information, records of interviews, written reports, statements, notes, memoranda, or other data obtained by the department, the board, and other persons, agencies, or organizations so authorized by the department under this section shall be confidential.

(5) All proceedings and activities of the board, opinions of members of such board formed as a result of such proceedings and activities, and records obtained, created, or maintained under this section, including records of interviews, written reports, statements, notes,

memoranda, or other data obtained by the department or any other person, agency, or organization acting jointly or under contract with the department in connection with the requirements of this section, shall be confidential and shall not be subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding; provided, however, that nothing in this section shall be construed to limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another source and entirely independent of the board's proceedings.

(6) Members of the board shall not be questioned in any civil or criminal proceeding regarding the information presented in or opinions formed as a result of a meeting or communication of the board; provided, however, that nothing in this section shall be construed to prevent a member of the board from testifying to information obtained independently of the board or which is public information.

[~~11.~~**]** 12. The department may use grant program funds to support the efforts of the board and may apply for additional federal government and private foundation grants as needed. The department may also accept private, foundation, city, county, or federal moneys to implement the provisions of this section.

192.1005. Sections 192.1005 to 192.1020 shall be known and may be cited as the "Missouri Dignity in Pregnancy and Childbirth Act".

192.1010. For purposes of sections 192.1005 to 192.1020, the following terms mean:

(1) "Implicit bias", a bias in judgment or behavior that results from subtle cognitive processes, including implicit prejudice and implicit stereotypes that often operate at a level below conscious awareness and without intentional control;

(2) "Implicit prejudice", prejudicial negative feelings or beliefs about a group that a person holds without being aware of such feelings or beliefs;

(3) "Implicit stereotypes", the unconscious attributions of particular qualities to a member of a certain social group. Implicit stereotypes are influenced by experience and are based on learning associations between various qualities and social categories, including race and gender;

(4) "Perinatal care", the provision of care during pregnancy, labor, delivery, and postpartum and neonatal periods;

(5) "Pregnancy-related death", the death of a person while pregnant or within three hundred sixty-five days of the end of a pregnancy, regardless of the duration or site of the pregnancy, from any cause related to, or aggravated by, the pregnancy or its management, but not from accidental or incidental causes.

192.1015. 1. Any hospital, clinic, or other health care facility that provides perinatal care shall implement an evidence-based implicit bias program for all health care providers involved in the perinatal care of patients within that facility.

2. An implicit bias program implemented under subsection 1 of this section shall include all of the following:

(1) Identification of previous or current unconscious biases and misinformation;

(2) Identification of personal, interpersonal, institutional, structural, and cultural barriers to inclusion;

(3) Corrective measures to decrease implicit bias at the interpersonal and institutional levels, including ongoing policies and practices for that purpose;

(4) Information on the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of minority communities;

(5) Information about cultural identity across racial or ethnic groups;

(6) Information about communicating more effectively across identities, including racial, ethnic, religious, and gender identities;

(7) Discussion on power dynamics and organizational decision-making;

(8) Discussion on health inequities within the perinatal care field, including information on how implicit bias impacts maternal and infant health outcomes;

(9) Perspectives of diverse, local constituency groups and experts on particular racial, identity, cultural, and provider-community relations issues in the community; and

(10) Information on reproductive justice.

3. (1) A health care provider described in subsection 1 of this section shall complete initial basic training through the implicit bias program based on the components described in subsection 2 of this section.

(2) Upon completion of the initial basic training, a health care provider shall complete a refresher course under the implicit bias program every two years thereafter, or on a more frequent basis if deemed necessary by the facility, in order to keep current with changing racial, identity, and cultural trends and best practices in decreasing interpersonal and institutional implicit bias.

4. A facility described in subsection 1 of this section shall provide a certificate of training completion to another facility or a training attendee upon request. A facility may accept a certificate of completion from another facility described in subsection 1 of this section to satisfy the training requirement described in subsection 3 of this section for a health care provider who works in more than one facility.

5. Notwithstanding subsections 1 to 4 of this section, if a physician involved in the perinatal care of patients is not directly employed by a facility, the facility shall offer the training to the physician.

192.1020. 1. The department of health and senior services shall track data on severe maternal morbidity including, but not limited to, all of the following health conditions:

(1) Obstetric hemorrhage;

(2) Hypertension;

(3) Preeclampsia and eclampsia;

(4) Venous thromboembolism;

(5) Sepsis;

(6) Cerebrovascular accident; and

(7) Amniotic fluid embolism.

2. The data on severe maternal morbidity collected under subsection 1 of this section shall be published at least once every three years after all of the following have occurred:

(1) The data has been aggregated by state regions as defined by the department of health and senior services to ensure data reflects how regionalized care systems are or should be collaborating to improve maternal health outcomes or other smaller regional sorting based on standard statistical methods for accurate dissemination of public health data without risking a confidentiality or other disclosure breach; and

(2) The data has been disaggregated by racial and ethnic identity.

3. The department of health and senior services shall track data on pregnancy-related deaths including, but not limited to, all of the conditions listed in subsection 1 of this section, indirect obstetric deaths, and other maternal disorders predominantly related to pregnancy and complications predominantly related to the puerperium.

4. The data on pregnancy-related deaths collected under subsection 3 of this section shall be published, at least once every three years, after all of the following have occurred:

(1) The data has been aggregated by state regions as defined by the department of health and senior services to ensure data reflects how regionalized care systems are or should be collaborating to improve maternal health outcomes or other smaller regional sorting based on standard statistical methods for accurate dissemination of public health data without risking a confidentiality or other disclosure breach; and

(2) The data has been disaggregated by racial and ethnic identity.

192.1030. 1. For purposes of this section, the following terms mean:

(1) "Certified nurse midwife", the same meaning given to the term in section 335.016;

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

(3) "Professional midwife", any midwife allowed to practice in this state in accordance with the provisions of section 376.1753;

(4) "Programs that train certified nurse midwives", a nurse-midwifery education program that is recognized by the state board of nursing as providing education necessary to become a certified nurse midwife;

(5) "Programs that train professional midwives", a midwifery education program that provides the education necessary to practice as a midwife in this state in accordance with the provisions of section 376.1753.

2. Subject to appropriation, the department shall establish a program to contract with programs that train certified nurse midwives and programs that train professional midwives in

accordance with the global standards for midwifery education and the international definition of the term "midwife" as established by the International Confederation of Midwives in order to increase the number of students receiving quality education and training as a certified nurse midwife or as a professional midwife.

3. The department shall contract only with programs that train certified nurse midwives and programs that train professional midwives that, at minimum, include, or that intend to create, a component of training designed for medically underserved multicultural communities, lower socioeconomic neighborhoods, or rural communities, and that are organized to prepare program graduates for service in those neighborhoods and communities, or that seek to recruit and retain racially and ethnically diverse students, underrepresented groups, or people from underserved or historically marginalized communities.

4. (1) The department may adopt standards and regulations necessary to carry out the provisions of this section. In adopting eligibility standards for programs that train certified nurse midwives and programs that train professional midwives in accordance with the standards set forth in subsections 2 and 3 of this section, the department may accept those educational standards and competencies established by the state board of nursing or by the provisions of section 376.1753. The department shall take care not to implement education or competency standards beyond what is required by the state board of nursing or the provisions of section 376.1753 that could inadvertently create an unnecessary barrier for training programs to obtain funding for the training of midwives in this state.

(2) 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, 2026, shall be invalid and void.

5. The department shall develop alternative strategies to provide long-term stability for, or expansion of, the training provided for under this section, such as through funding provided by private foundations and administered by the department for the purposes of carrying out this section.

6. Nothing in this section prevents the department from developing a protocol to contract with potential programs that train certified nurse midwives or potential programs that train professional midwives in order to support the initial startup of new training programs as long as the eligibility requirements of this section are met or can be met through an award of funds.

7. The department may pay contracted programs that train certified nurse midwives and programs that train professional midwives in an amount calculated based on a single per-student

capitation formula, or through another method, in order to cover the costs of innovative special projects or programs.

8. Funds appropriated to the department for purposes of this section and awarded by the department to eligible programs that train certified nurse midwives or programs that train professional midwives may be used by the training program to develop new initiatives, projects, or curricula, or to expand existing initiatives, projects, or curricula. Awarded funds may also be used for general support and sustainability of the overall training program, or to sustain specific components of the training program including, but not limited to, tuition assistance for students, support for preceptor recruitment, or support to sustain preceptor training sites for students.

9. (1) There is hereby created in the state treasury the "Midwifery Education Fund", which shall consist of moneys appropriated to it by the general assembly and any gifts, contributions, grants, or bequests received from federal, private, or other sources. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and, upon appropriation, moneys in this fund shall be used solely as provided in this section.

(2) Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund.

(3) The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

193.145. 1. A certificate of death for each death which occurs in this state shall be filed with the local registrar, or as otherwise directed by the state registrar, within five days after death and shall be registered if such certificate has been completed and filed pursuant to this section. All data providers in the death registration process, including, but not limited to, the state registrar, local registrars, the state medical examiner, county medical examiners, coroners, funeral directors or persons acting as such, embalmers, sheriffs, attending physicians and resident physicians, physician assistants, assistant physicians, advanced practice registered nurses, and the chief medical officers of licensed health care facilities, and other public or private institutions providing medical care, treatment, or confinement to persons, shall be required to use and utilize any electronic death registration system required and adopted under subsection 1 of section 193.265 within six months of the system being certified by the director of the department of health and senior services, or the director's designee, to be operational and available to all data providers in the death registration process.

2. If the place of death is unknown but the dead body is found in this state, the certificate of death shall be completed and filed pursuant to the provisions of this section. The place where the body is found shall be shown as the place of death. The date of death shall be the date on which the remains were found.

3. When death occurs in a moving conveyance in the United States and the body is first removed from the conveyance in this state, the death shall be registered in this state and the place where the body is first removed shall be considered the place of death. When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in this state, the death shall be registered in this state but the certificate shall show the actual place of death if such place may be determined.

4. The funeral director or person in charge of final disposition of the dead body shall file the certificate of death. The funeral director or person in charge of the final disposition of the dead body shall obtain or verify and enter into the electronic death registration system:

(1) The personal data from the next of kin or the best qualified person or source available;

(2) The medical certification from the person responsible for such certification if designated to do so under subsection 5 of this section; **[**~~and~~**]**

(3) Information indicating whether the decedent was pregnant at the time of death, or within a year prior to the death, if known, as determined by observation, autopsy, or review of the medical record. The electronic death registration system shall capture additional information regarding the pregnancy status of the decedent consistent with the data elements on the U.S. Standard Certificate of Death. This subdivision shall not be interpreted to require the performance of a pregnancy test on a decedent or to require a review of medical records in order to determine pregnancy; and

(4) Any other information or data that may be required to be placed on a death certificate or entered into the electronic death certificate system including, but not limited to, the name and license number of the embalmer.

5. The medical certification shall be completed, attested to its accuracy either by signature or an electronic process approved by the department, and returned to the funeral director or person in charge of final disposition within seventy-two hours after death by the physician, physician assistant, assistant physician, or advanced practice registered nurse in charge of the patient's care for the illness or condition which resulted in death. In the absence of the physician, physician assistant, assistant physician, or advanced practice registered nurse or with the physician's, physician assistant's, assistant physician's, or advanced practice registered nurse's approval the certificate may be completed and attested to its accuracy either by signature or an approved electronic process by the physician's associate physician, the chief medical officer of the institution in which death occurred, or the physician who performed an autopsy upon the decedent, provided such individual has access to the medical history of the case, views the deceased at or after death and death is due to natural causes. The person authorized to complete the medical certification may, in writing, designate any other person to enter the medical certification information into the electronic death registration system if the person

authorized to complete the medical certificate has physically or by electronic process signed a statement stating the cause of death. Any persons completing the medical certification or entering data into the electronic death registration system shall be immune from civil liability for such certification completion, data entry, or determination of the cause of death, absent gross negligence or willful misconduct. The state registrar may approve alternate methods of obtaining and processing the medical certification and filing the death certificate. The Social Security number of any individual who has died shall be placed in the records relating to the death and recorded on the death certificate.

6. When death occurs from natural causes more than thirty-six hours after the decedent was last treated by a physician, physician assistant, assistant physician, or advanced practice registered nurse, the case shall be referred to the county medical examiner or coroner or physician or local registrar for investigation to determine and certify the cause of death. If the death is determined to be of a natural cause, the medical examiner or coroner or local registrar shall refer the certificate of death to the attending physician, physician assistant, assistant physician, or advanced practice registered nurse for such certification. If the attending physician, physician assistant, assistant physician, or advanced practice registered nurse refuses or is otherwise unavailable, the medical examiner or coroner or local registrar shall attest to the accuracy of the certificate of death either by signature or an approved electronic process within thirty-six hours.

7. If the circumstances suggest that the death was caused by other than natural causes, the medical examiner or coroner shall determine the cause of death and shall, either by signature or an approved electronic process, complete and attest to the accuracy of the medical certification within seventy-two hours after taking charge of the case.

8. If the cause of death cannot be determined within seventy-two hours after death, the attending medical examiner, coroner, attending physician, physician assistant, assistant physician, advanced practice registered nurse, or local registrar shall give the funeral director, or person in charge of final disposition of the dead body, notice of the reason for the delay, and final disposition of the body shall not be made until authorized by the medical examiner, coroner, attending physician, physician assistant, assistant physician, advanced practice registered nurse, or local registrar.

9. When a death is presumed to have occurred within this state but the body cannot be located, a death certificate may be prepared by the state registrar upon receipt of an order of a court of competent jurisdiction which shall include the finding of facts required to complete the death certificate. Such a death certificate shall be marked "Presumptive", show on its face the date of registration, and identify the court and the date of decree.

10. (1) The department of health and senior services shall notify all physicians, physician assistants, assistant physicians, and advanced practice registered nurses licensed under

chapters 334 and 335 of the requirements regarding the use of the electronic vital records system provided for in this section.

(2) On or before August 30, 2015, the department of health and senior services, division of community and public health shall create a working group comprised of representation from the Missouri electronic vital records system users and recipients of death certificates used for professional purposes to evaluate the Missouri electronic vital records system, develop recommendations to improve the efficiency and usability of the system, and to report such findings and recommendations to the general assembly no later than January 1, 2016.

11. Notwithstanding any provision of law to the contrary, if a coroner or deputy coroner is not current with or is without the approved training under chapter 58, the department of health and senior services shall prohibit such coroner from attesting to the accuracy of a certificate of death. No person elected or appointed to the office of coroner can assume such elected office until the training required under section 58.030 has been completed and a certificate of completion has been issued. In the event a coroner cannot fulfill his or her duties or is no longer qualified to attest to the accuracy of a death certificate, the sheriff of the county shall appoint a medical professional to attest death certificates until such time as the coroner can resume his or her duties or another coroner is appointed or elected to the office."; and

Further amend said bill, Page 15, Section 196.990, Line 89, by inserting after said section and line the following:

"197.178. 1. Each hospital shall provide each patient, upon admission or as soon thereafter as reasonably practicable, written information regarding the following rights of the patient:

(1) The right to be informed of continuing health care requirements following discharge from the hospital;

(2) The right to be informed that, if the patient so authorizes, a friend or family member may be provided information about the patient's continuing health care requirements following discharge from the hospital;

(3) The right to participate actively in decisions regarding medical care. To the extent permitted by law, participation shall include the right to refuse treatment;

(4) The right to appropriate pain assessment and treatment;

(5) The right to be free of discrimination on the basis of any protected status as set forth in chapter 213; and

(6) The right to information on how to file a complaint with the following:

(a) The department of health and senior services;

(b) The Missouri commission on human rights; and

(c) The state board of registration for the healing arts.

2. A hospital may include the information required by this section with other notices to the patient regarding patient rights. If a hospital chooses to include this information along with existing notices to the patient regarding patient rights, any newly required information shall be provided when the hospital exhausts its existing inventory of written materials and prints new written materials."; and

Further amend said bill, Page 20, Section 208.149, Line 32, by inserting after said section and line the following:

"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 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 or her 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 or she 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.~~**]** Pub. L. 101-239 (42 U.S.C. Sections 1396a and 1396d), as amended, 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 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) Childbirth education classes for pregnant women and a support person;

(27) 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, 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 an 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.

16. The department of social services shall study the impact that the childbirth education classes provided under subdivision (26) of subsection 1 of this section have on infant and maternal mortality among pregnant women of color. The department of social services shall submit a report to the general assembly with the results of the study before January 1, 2029."; and

Further amend said bill, Page 52, Section 376.1017, Line 10, by inserting after said section and line the following:

"376.1213. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law, and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2027, and providing for maternity benefits, shall provide coverage for childbirth education classes."; and

Further amend said bill, Page 54, Section 376.1280, Line 26, by inserting after said section and line the following:

"376.1285. 1. As used in this section, the terms "health carrier" and "health benefit plan" shall have the same meanings given to the terms in section 376.1350.

2. Each health carrier or health benefit plan that offers or issues health benefit plans that are delivered, issued for delivery, continued, or renewed in this state on or after August 28, 2026, shall provide coverage for annual kidney function screening services designed to identify patients at risk for chronic kidney disease. Coverage for such screening services shall include,

but is not limited to, glomerular filtration rate testing, basic metabolic panel testing, and urine testing for screening albumin and creatinine levels.

3. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months' or less duration, or any other supplemental policy as determined by the director of the department of commerce and insurance."; and

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