FIRST REGULAR SESSION

[P E R F E C T E D**]**

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILLS NOS. 70 & 128

100TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR HOUGH.

Offered April 23, 2019.

Senate Substitute adopted April 23, 2019.

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ADRIANE D. CROUSE, Secretary.

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AN ACT

To repeal sections 192.007, 192.667, 198.082, 208.909, 208.918, 208.924, 344.030, and 376.690, RSMo, and to enact in lieu thereof fourteen new sections relating to the administration of health care services, with existing penalty provisions, with an emergency clause for a certain section.

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

Section A. Sections 192.007, 192.667, 198.082, 208.909, 208.918, 208.924,
2 344.030, and 376.690, RSMo, are repealed and fourteen new sections enacted in
3 lieu thereof, to be known as sections 192.007, 192.667, 197.108, 198.082, 208.909,
4 208.918, 208.924, 208.935, 217.930, 221.125, 344.030, 376.690, 376.1212, and
5 376.1260, to read as follows:

192.007. 1. The director of the department of health and senior services
2 shall be appointed by the governor by and with the advice and consent of the
3 senate. The director shall serve at the pleasure of the governor and the director's
4 salary shall not exceed appropriations made for that purpose.

5 2. The director shall be a person of recognized character, integrity and
6 executive ability, **[**shall be a graduate of an institution of higher education
7 approved by recognized accrediting agencies, and shall have had the
8 administrative experience necessary to enable him to successfully perform the
9 duties of his office. He shall have experience in public health management and

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

10 agency operation and management] **and shall have, at a minimum, the**
11 **following qualifications:**
12 **(1) A medical doctor or a doctor of osteopathy degree; or**
13 **(2) A Ph.D. in a health-related field, which may include nursing,**
14 **public health, health policy, environmental health, community health,**
15 **or health education or a master's degree in public health or an**
16 **equivalent academic degree from an institution of higher education**
17 **approved by recognized accrediting agencies.**

192.667. 1. All health care providers shall at least annually provide to
2 the department charge data as required by the department. All hospitals shall
3 at least annually provide patient abstract data and financial data as required by
4 the department. Hospitals as defined in section 197.020 shall report patient
5 abstract data for outpatients and inpatients. Ambulatory surgical centers and
6 abortion facilities as defined in section 197.200 shall provide patient abstract
7 data to the department. The department shall specify by rule the types of
8 information which shall be submitted and the method of submission.
9 2. The department shall collect data on the incidence of health
10 care-associated infections from hospitals, ambulatory surgical centers, abortion
11 facilities, and other facilities as necessary to generate the reports required by this
12 section. Hospitals, ambulatory surgical centers, abortion facilities, and other
13 facilities shall provide such data in compliance with this section. **In order to**
14 **streamline government and to eliminate duplicative reporting**
15 **requirements, if the Centers for Medicare and Medicaid Services, or its**
16 **successor entity, requires hospitals to submit health care-associated**
17 **infection data, then hospitals and the department shall not be required**
18 **to comply with the health care-associated infection data reporting**
19 **requirements of subsections 2 to 17 of this section applicable to**
20 **hospitals, except that the department shall post a link on its website to**
21 **publicly reported data by hospitals on the Centers for Medicare and**
22 **Medicaid Services' Hospital Compare website, or its successor.**
23 3. The department shall promulgate rules specifying the standards and
24 procedures for the collection, analysis, risk adjustment, and reporting of the
25 incidence of health care-associated infections and the types of infections and
26 procedures to be monitored pursuant to subsection 13 of this section. In
27 promulgating such rules, the department shall:
28 (1) Use methodologies and systems for data collection established by the

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29 federal Centers for Disease Control and Prevention's National Healthcare Safety
30 Network, or its successor; and
31 (2) Consider the findings and recommendations of the infection control
32 advisory panel established pursuant to section 197.165.
33 4. By January 1, 2017, the infection control advisory panel created by
34 section 197.165 shall make recommendations to the department regarding the
35 Centers for Medicare and Medicaid Services' health care-associated infection data
36 collection, analysis, and public reporting requirements for hospitals, ambulatory
37 surgical centers, and other facilities in the federal Centers for Disease Control
38 and Prevention's National Healthcare Safety Network, or its successor, in lieu of
39 all or part of the data collection, analysis, and public reporting requirements of
40 this section. The advisory panel recommendations shall address which hospitals
41 shall be required as a condition of licensure to use the National Healthcare Safety
42 Network for data collection; the use of the National Healthcare Safety Network
43 for risk adjustment and analysis of hospital submitted data; and the use of the
44 Centers for Medicare and Medicaid Services' Hospital Compare website, or its
45 successor, for public reporting of the incidence of health care-associated infection
46 metrics. The advisory panel shall consider the following factors in developing its
47 recommendation:
48 (1) Whether the public is afforded the same or greater access to
49 facility-specific infection control indicators and metrics;
50 (2) Whether the data provided to the public is subject to the same or
51 greater accuracy of risk adjustment;
52 (3) Whether the public is provided with the same or greater specificity of
53 reporting of infections by type of facility infections and procedures;
54 (4) Whether the data is subject to the same or greater level of
55 confidentiality of the identity of an individual patient;
56 (5) Whether the National Healthcare Safety Network, or its successor, has
57 the capacity to receive, analyze, and report the required data for all facilities;
58 (6) Whether the cost to implement the National Healthcare Safety
59 Network infection data collection and reporting system is the same or less.
60 5. After considering the recommendations of the infection control advisory
61 panel, and provided that the requirements of subsection 13 of this section can be
62 met, the department shall implement guidelines from the federal Centers for
63 Disease Control and Prevention's National Healthcare Safety Network, or its
64 successor. It shall be a condition of licensure for hospitals that meet the

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65 minimum public reporting requirements of the National Healthcare Safety
66 Network and the Centers for Medicare and Medicaid Services to participate in the
67 National Healthcare Safety Network, or its successor. Such hospitals shall
68 permit the National Healthcare Safety Network, or its successor, to disclose
69 facility-specific infection data to the department as required under this section,
70 and as necessary to provide the public reports required by the department. It
71 shall be a condition of licensure for any ambulatory surgical center or abortion
72 facility which does not voluntarily participate in the National Healthcare Safety
73 Network, or its successor, to submit facility-specific data to the department as
74 required under this section, and as necessary to provide the public reports
75 required by the department.

76 6. The department shall not require the resubmission of data which has
77 been submitted to the department of health and senior services or the department
78 of social services under any other provision of law. The department of health and
79 senior services shall accept data submitted by associations or related
80 organizations on behalf of health care providers by entering into binding
81 agreements negotiated with such associations or related organizations to obtain
82 data required pursuant to section 192.665 and this section. A health care
83 provider shall submit the required information to the department of health and
84 senior services:

85 (1) If the provider does not submit the required data through such
86 associations or related organizations;

87 (2) If no binding agreement has been reached within ninety days of
88 August 28, 1992, between the department of health and senior services and such
89 associations or related organizations; or

90 (3) If a binding agreement has expired for more than ninety days.

91 7. Information obtained by the department under the provisions of section
92 192.665 and this section shall not be public information. Reports and studies
93 prepared by the department based upon such information shall be public
94 information and may identify individual health care providers. The department
95 of health and senior services may authorize the use of the data by other research
96 organizations pursuant to the provisions of section 192.067. The department
97 shall not use or release any information provided under section 192.665 and this
98 section which would enable any person to determine any health care provider's
99 negotiated discounts with specific preferred provider organizations or other
100 managed care organizations. The department shall not release data in a form

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101 which could be used to identify a patient. Any violation of this subsection is a
102 class A misdemeanor.

103 8. The department shall undertake a reasonable number of studies and
104 publish information, including at least an annual consumer guide, in
105 collaboration with health care providers, business coalitions and consumers based
106 upon the information obtained pursuant to the provisions of section 192.665 and
107 this section. The department shall allow all health care providers and
108 associations and related organizations who have submitted data which will be
109 used in any publication to review and comment on the publication prior to its
110 publication or release for general use. The publication shall be made available
111 to the public for a reasonable charge.

112 9. Any health care provider which continually and substantially, as these
113 terms are defined by rule, fails to comply with the provisions of this section shall
114 not be allowed to participate in any program administered by the state or to
115 receive any moneys from the state.

116 10. A hospital, as defined in section 197.020, aggrieved by the
117 department's determination of ineligibility for state moneys pursuant to
118 subsection 9 of this section may appeal as provided in section 197.071. An
119 ambulatory surgical center or abortion facility as defined in section 197.200
120 aggrieved by the department's determination of ineligibility for state moneys
121 pursuant to subsection 9 of this section may appeal as provided in section
122 197.221.

123 11. The department of health may promulgate rules providing for
124 collection of data and publication of the incidence of health care-associated
125 infections for other types of health facilities determined to be sources of
126 infections; except that, physicians' offices shall be exempt from reporting and
127 disclosure of such infections.

128 12. By January 1, 2017, the advisory panel shall recommend and the
129 department shall adopt in regulation with an effective date of no later than
130 January 1, 2018, the requirements for the reporting of the following types of
131 infections as specified in this subsection:

132 (1) Infections associated with a minimum of four surgical procedures for
133 hospitals and a minimum of two surgical procedures for ambulatory surgical
134 centers that meet the following criteria:

135 (a) Are usually associated with an elective surgical procedure. An
136 "elective surgical procedure" is a planned, nonemergency surgical procedure that

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137 may be either medically required such as a hip replacement or optional such as
138 breast augmentation;
139 (b) Demonstrate a high priority aspect such as affecting a large number
140 of patients, having a substantial impact for a smaller population, or being
141 associated with substantial cost, morbidity, or mortality; or
142 (c) Are infections for which reports are collected by the National
143 Healthcare Safety Network or its successor;
144 (2) Central line-related bloodstream infections;
145 (3) Health care-associated infections specified for reporting by hospitals,
146 ambulatory surgical centers, and other health care facilities by the rules of the
147 Centers for Medicare and Medicaid Services to the federal Centers for Disease
148 Control and Prevention's National Healthcare Safety Network, or its successor;
149 and
150 (4) Other categories of infections that may be established by rule by the
151 department.
152 The department, in consultation with the advisory panel, shall be authorized to
153 collect and report data on subsets of each type of infection described in this
154 subsection.
155 13. In consultation with the infection control advisory panel established
156 pursuant to section 197.165, the department shall develop and disseminate to the
157 public reports based on data compiled for a period of twelve months. Such
158 reports shall be updated quarterly and shall show for each hospital, ambulatory
159 surgical center, abortion facility, and other facility metrics on risk-adjusted
160 health care-associated infections under this section.
161 14. The types of infections under subsection 12 of this section to be
162 publicly reported shall be determined by the department by rule and shall be
163 consistent with the infections tracked by the National Healthcare Safety Network,
164 or its successor.
165 15. Reports published pursuant to subsection 13 of this section shall be
166 published and readily accessible on the department's internet website. The
167 reports shall be distributed at least annually to the governor and members of the
168 general assembly. The department shall make such reports available to the
169 public for a period of at least two years.
170 16. The Hospital Industry Data Institute shall publish a report of
171 Missouri hospitals', ambulatory surgical centers', and abortion facilities'
172 compliance with standardized quality of care measures established by the federal

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173 Centers for Medicare and Medicaid Services for prevention of infections related
174 to surgical procedures. If the Hospital Industry Data Institute fails to do so by
175 July 31, 2008, and annually thereafter, the department shall be authorized to
176 collect information from the Centers for Medicare and Medicaid Services or from
177 hospitals, ambulatory surgical centers, and abortion facilities and publish such
178 information in accordance with this section.

179 17. The data collected or published pursuant to this section shall be
180 available to the department for purposes of licensing hospitals, ambulatory
181 surgical centers, and abortion facilities pursuant to chapter 197.

182 18. The department shall promulgate rules to implement the provisions
183 of section 192.131 and sections 197.150 to 197.160. Any rule or portion of a rule,
184 as that term is defined in section 536.010, that is created under the authority
185 delegated in this section shall become effective only if it complies with and is
186 subject to all of the provisions of chapter 536 and, if applicable, section
187 536.028. This section and chapter 536 are nonseverable and if any of the powers
188 vested with the general assembly pursuant to chapter 536 to review, to delay the
189 effective date, or to disapprove and annul a rule are subsequently held
190 unconstitutional, then the grant of rulemaking authority and any rule proposed
191 or adopted after August 28, 2004, shall be invalid and void.

192 19. No later than August 28, 2017, each hospital, excluding mental health
193 facilities as defined in section 632.005, and each ambulatory surgical center and
194 abortion facility as defined in section 197.200, shall in consultation with its
195 medical staff establish an antimicrobial stewardship program for evaluating the
196 judicious use of antimicrobials, especially antibiotics that are the last line of
197 defense against resistant infections. The hospital's stewardship program and the
198 results of the program shall be monitored and evaluated by hospital quality
199 improvement departments and shall be available upon inspection to the
200 department. At a minimum, the antimicrobial stewardship program shall be
201 designed to evaluate that hospitalized patients receive, in accordance with
202 accepted medical standards of practice, the appropriate antimicrobial, at the
203 appropriate dose, at the appropriate time, and for the appropriate duration.

204 20. Hospitals described in subsection 19 of this section shall meet the
205 National Healthcare Safety Network requirements for reporting antimicrobial
206 usage or resistance by using the Centers for Disease Control and Prevention's
207 Antimicrobial Use and Resistance (AUR) Module when **[**regulations concerning
208 Stage 3 of the Medicare and Medicaid Electronic Health Records Incentive

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Programs promulgated by the Centers for Medicare and Medicaid Services that enable the electronic interface for such reporting are effective**] conditions of participation promulgated by the Centers for Medicare and Medicaid Services requiring the electronic reporting of antibiotic use or antibiotic resistance by hospitals become effective**. When such antimicrobial usage or resistance reporting takes effect, hospitals shall authorize the National Healthcare Safety Network, or its successor, to disclose to the department facility-specific information reported to the AUR Module. Facility-specific data on antibiotic usage and resistance collected under this subsection shall not be disclosed to the public, but the department may release case-specific information to other facilities, physicians, and the public if the department determines on a case-by-case basis that the release of such information is necessary to protect persons in a public health emergency. **Nothing in this section shall prohibit a hospital from voluntarily reporting antibiotic use or antibiotic resistance date through the National Healthcare Safety Network, or its successor, prior to the effective date of the conditions of participation requiring the reporting.**

21. The department shall make a report to the general assembly beginning January 1, 2018, and on every January first thereafter on the incidence, type, and distribution of antimicrobial-resistant infections identified in the state and within regions of the state.

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197.108. 1. The department of health and senior services shall not assign an individual to inspect or survey a hospital, for any purpose, if the inspector or surveyor was an employee of such hospital or another hospital within its organization or a competing hospital within fifty miles of the hospital to be inspected or surveyed in the preceding two years.

2. For any inspection or survey of a hospital, regardless of the purpose, the department shall require every newly hired inspector or surveyor at the time of hiring or any currently employed inspector or surveyor as of August 28, 2019, to disclose:

(1) The name of every hospital in which he or she has been employed in the last ten years and the approximate length of service and the job title at the hospital; and

(2) The name of any member of his or her immediate family who

15 **has been employed in the last ten years or is currently employed at a**
16 **hospital and the approximate length of service and the job title at the**
17 **hospital.**
18 **The disclosures under this subsection shall be made to the department**
19 **whenever the event giving rise to disclosure first occurs.**
20 **3. For purposes of this section, the phrase "immediate family**
21 **member" shall mean a husband, wife, natural or adoptive parent, child,**
22 **sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law,**
23 **mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law,**
24 **grandparent, or grandchild.**
25 **4. The information provided under subsection 2 of this section**
26 **shall be considered a public record under the provisions of section**
27 **610.010.**
28 **5. Any person may notify the department if facts exist that would**
29 **lead a reasonable person to conclude that any inspector or surveyor**
30 **has any personal or business affiliation that would result in a conflict**
31 **of interest in conducting an inspection or survey for a hospital. Upon**
32 **receiving such notice, the department, when assigning an inspector or**
33 **surveyor to inspect or survey a hospital, for any purpose, shall take**
34 **steps to verify the information and, if the department has reason to**
35 **believe that such information is correct, the department shall not**
36 **assign the inspector or surveyor to the hospital or any hospital within**
37 **its organization so as to avoid an appearance of prejudice or favor to**
38 **the hospital or bias on the part of the inspector or surveyor.**

198.082. 1. Each **certified** nursing assistant hired to work in a skilled
2 nursing or intermediate care facility after January 1, 1980, shall have
3 successfully completed a nursing assistant training program approved by the
4 department or shall enroll in and begin the first available approved training
5 program which is scheduled to commence within ninety days of the date of the
6 **certified** nursing assistant's employment and which shall be completed within
7 four months of employment. Training programs shall be offered at any facility
8 licensed **[**or approved**]** by the department of health and senior services**; any**
9 **skilled nursing or intermediate care unit in a Missouri veterans home,**
10 **as defined in section 42.002; or any hospital, as defined in section**
11 **197.020. Training programs shall be [**which is most**]** reasonably accessible
12 to the enrollees in each class. The program may be established by **[**the**] a** skilled
13 nursing or intermediate care facility, **unit, or hospital;** by a professional

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14 organization**[**,**];** or by the department, and training shall be given by the
15 personnel of the facility, **unit, or hospital;** by a professional organization**[**,**];** by
16 the department**[**,**];** by any community college**;** or by the vocational education
17 department of any high school.

18 2. As used in this section the term "**certified** nursing assistant" means
19 an employee**[**,**] who has completed the training required under subsection**
20 **1 of this section, who has passed the certification exam, and [**including
21 a nurse's aide or an orderly,**]** who is assigned by a skilled nursing or intermediate
22 care facility**, unit, or hospital** to provide or assist in the provision of direct
23 resident health care services under the supervision of a nurse licensed under the
24 nursing practice law, chapter 335.

25 **3.** This section shall not apply to any person otherwise **regulated or**
26 licensed to perform health care services under the laws of this state. It shall not
27 apply to volunteers or to members of religious or fraternal orders which operate
28 and administer the facility, if such volunteers or members work without
29 compensation.

30 **[**3.**] 4.** The training program **[**after January 1, 1989, shall consist of at
31 least the following:

32 (1) A training program consisting**] requirements shall be defined in**
33 **regulation by the department and shall require [**of**]** at least seventy-five
34 classroom hours of training **[**on basic nursing skills, clinical practice, resident
35 safety and rights, the social and psychological problems of residents, and the
36 methods of handling and caring for mentally confused residents such as those
37 with Alzheimer's disease and related disorders,**]** and one hundred hours
38 supervised and on-the-job training. **On-the-job training sites shall include**
39 **supervised practical training in a laboratory or other setting in which**
40 **the trainee demonstrates knowledge while performing tasks on an**
41 **individual under the direct supervision of a registered nurse or a**
42 **licensed practical nurse.** The **[**one hundred hours**] training** shall be
43 completed within four months of employment and may consist of normal
44 employment as nurse assistants **or hospital nursing support staff** under the
45 supervision of a licensed nurse**[**; and

46 (2) Continuing in-service training to assure continuing competency in
47 existing and new nursing skills. All nursing assistants trained prior to January
48 1, 1989, shall attend, by August 31, 1989, an entire special retraining program
49 established by rule or regulation of the department which shall contain

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50 information on methods of handling mentally confused residents and which may
51 be offered on premises by the employing facility**]**.

52 **[**4.**]** **5. Certified nursing** **[**Nursing**]** assistants who have not
53 successfully completed the nursing assistant training program prior to
54 employment may begin duties as a **certified** nursing assistant **[**only after
55 completing an initial twelve hours of basic orientation approved by the
56 department**]** and may provide direct resident care only if under the **[**general**]**
57 **direct** supervision of a licensed nurse prior to completion of the seventy-five
58 classroom hours of the training program.

59 **6. The competency evaluation shall be performed in a facility, as**
60 **defined in 42 CFR 483.5, or laboratory setting comparable to the setting**
61 **in which the individual shall function as a certified nursing assistant.**

62 **7. Persons completing the training requirements of unlicensed**
63 **assistive personnel under 19 CSR 30-20.125 or its successor regulation,**
64 **and who have completed the competency evaluation, shall be allowed**
65 **to sit for the certified nursing assistant examination and be deemed to**
66 **have fulfilled the classroom and clinical standards for designation as**
67 **a certified nursing assistant.**

68 **8. The department of health and senior services may offer**
69 **additional training programs and certifications to students who are**
70 **already certified as nursing assistants according to regulations**
71 **promulgated by the department and curriculum approved by the board.**

208.909. 1. Consumers receiving personal care assistance services shall
2 be responsible for:

3 (1) Supervising their personal care attendant;

4 (2) Verifying wages to be paid to the personal care attendant;

5 (3) Preparing and submitting time sheets, signed by both the consumer
6 and personal care attendant, to the vendor on a biweekly basis;

7 (4) Promptly notifying the department within ten days of any changes in
8 circumstances affecting the personal care assistance services plan or in the
9 consumer's place of residence;

10 (5) Reporting any problems resulting from the quality of services rendered
11 by the personal care attendant to the vendor. If the consumer is unable to resolve
12 any problems resulting from the quality of service rendered by the personal care
13 attendant with the vendor, the consumer shall report the situation to the
14 department; **[**and**]**

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15 (6) Providing the vendor with all necessary information to complete
16 required paperwork for establishing the employer identification number**; and**
17 **(7) Allowing the vendor to comply with its quality assurance and**
18 **supervision process, which shall include, but not be limited to, bi-**
19 **annual face-to-face home visits and monthly case management**
20 **activities**.
21 2. Participating vendors shall be responsible for:
22 (1) Collecting time sheets or reviewing reports of delivered services and
23 certifying the accuracy thereof;
24 (2) The Medicaid reimbursement process, including the filing of claims
25 and reporting data to the department as required by rule;
26 (3) Transmitting the individual payment directly to the personal care
27 attendant on behalf of the consumer;
28 (4) Monitoring the performance of the personal care assistance services
29 plan. **Such monitoring shall occur during the bi-annual face-to-face**
30 **home visits under section 208.918. The vendor shall document whether**
31 **the attendant was present and if services are being provided to the**
32 **consumer as set forth in the plan of care. If the attendant was not**
33 **present or not providing services, the vendor shall notify the**
34 **department and the department may suspend services to the consumer.**
35 3. No state or federal financial assistance shall be authorized or expended
36 to pay for services provided to a consumer under sections 208.900 to 208.927, if
37 the primary benefit of the services is to the household unit, or is a household task
38 that the members of the consumer's household may reasonably be expected to
39 share or do for one another when they live in the same household, unless such
40 service is above and beyond typical activities household members may reasonably
41 provide for another household member without a disability.
42 4. No state or federal financial assistance shall be authorized or expended
43 to pay for personal care assistance services provided by a personal care attendant
44 who has not undergone the background screening process under section 192.2495.
45 If the personal care attendant has a disqualifying finding under section 192.2495,
46 no state or federal assistance shall be made, unless a good cause waiver is first
47 obtained from the department in accordance with section 192.2495.
48 5. (1) All vendors shall, by July 1, 2015, have, maintain, and use a
49 telephone tracking system for the purpose of reporting and verifying the delivery
50 of consumer-directed services as authorized by the department of health and

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51 senior services or its designee. **[**Use of such a system prior to July 1, 2015, shall
52 be voluntary.**]** The telephone tracking system shall be used to process payroll for
53 employees and for submitting claims for reimbursement to the MO HealthNet
54 division. At a minimum, the telephone tracking system shall:
55 (a) Record the exact date services are delivered;
56 (b) Record the exact time the services begin and exact time the services
57 end;
58 (c) Verify the telephone number from which the services are registered;
59 (d) Verify that the number from which the call is placed is a telephone
60 number unique to the client;
61 (e) Require a personal identification number unique to each personal care
62 attendant;
63 (f) Be capable of producing reports of services delivered, tasks performed,
64 client identity, beginning and ending times of service and date of service in
65 summary fashion that constitute adequate documentation of service; and
66 (g) Be capable of producing reimbursement requests for consumer
67 approval that assures accuracy and compliance with program expectations for
68 both the consumer and vendor.
69 (2) **[**The department of health and senior services, in collaboration with
70 other appropriate agencies, including centers for independent living, shall
71 establish telephone tracking system pilot projects, implemented in two regions of
72 the state, with one in an urban area and one in a rural area. Each pilot project
73 shall meet the requirements of this section and section 208.918. The department
74 of health and senior services shall, by December 31, 2013, submit a report to the
75 governor and general assembly detailing the outcomes of these pilot projects. The
76 report shall take into consideration the impact of a telephone tracking system on
77 the quality of the services delivered to the consumer and the principles of
78 self-directed care.
79 (3)**]** As new technology becomes available, the department may allow use
80 of a more advanced tracking system, provided that such system is at least as
81 capable of meeting the requirements of this subsection.
82 **[**(4)**]** **(3)** The department of health and senior services shall promulgate
83 by rule the minimum necessary criteria of the telephone tracking system. Any
84 rule or portion of a rule, as that term is defined in section 536.010, that is created
85 under the authority delegated in this section shall become effective only if it
86 complies with and is subject to all of the provisions of chapter 536 and, if

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87 applicable, section 536.028. This section and chapter 536 are nonseverable and
88 if any of the powers vested with the general assembly pursuant to chapter 536 to
89 review, to delay the effective date, or to disapprove and annul a rule are
90 subsequently held unconstitutional, then the grant of rulemaking authority and
91 any rule proposed or adopted after August 28, 2010, shall be invalid and void.

92 **[**6. In the event that a consensus between centers for independent living
93 and representatives from the executive branch cannot be reached, the telephony
94 report issued to the general assembly and governor shall include a minority
95 report which shall detail those elements of substantial dissent from the main
96 report.

97 7. No interested party, including a center for independent living, shall be
98 required to contract with any particular vendor or provider of telephony services
99 nor bear the full cost of the pilot program.**]**

208.918. 1. In order to qualify for an agreement with the department, the
2 vendor shall have a philosophy that promotes the consumer's ability to live
3 independently in the most integrated setting or the maximum community
4 inclusion of persons with physical disabilities, and shall demonstrate the ability
5 to provide, directly or through contract, the following services:

6 (1) Orientation of consumers concerning the responsibilities of being an
7 employer**[**,**] and** supervision of personal care attendants including the
8 preparation and verification of time sheets**. Such orientation shall include
9 notifying customers that falsification of attendant visit verification
10 records shall be considered fraud and shall be reported to the
11 department. Such orientation shall take place in the presence of the
12 personal care attendant, to the fullest extent possible**;

13 (2) Training for consumers about the recruitment and training of personal
14 care attendants;

15 (3) Maintenance of a list of persons eligible to be a personal care
16 attendant;

17 (4) Processing of inquiries and problems received from consumers and
18 personal care attendants;

19 (5) Ensuring the personal care attendants are registered with the family
20 care safety registry as provided in sections 210.900 to **[**210.937**] 210.936**; and

21 (6) The capacity to provide fiscal conduit services through a telephone
22 tracking system by the date required under section 208.909.

23 2. In order to maintain its agreement with the department, a vendor shall

24 comply with the provisions of subsection 1 of this section and shall:
25 (1) Demonstrate sound fiscal management as evidenced on accurate
26 quarterly financial reports and **an** annual **financial statement** audit **[**submitted
27 to the department**]** **performed by a certified public accountant if the**
28 **vendor's annual gross revenue is one hundred thousand dollars or more**
29 **or, if the vendor's annual gross revenue is less than one hundred**
30 **thousand dollars, an annual financial statement audit or annual**
31 **financial statement review performed by a certified public**
32 **accountant. Such reports, audits, and reviews shall be completed and**
33 **made available upon request to the department**; **[**and**]**
34 (2) Demonstrate a positive impact on consumer outcomes regarding the
35 provision of personal care assistance services as evidenced on accurate quarterly
36 and annual service reports submitted to the department;
37 (3) Implement a quality assurance and supervision process that ensures
38 program compliance and accuracy of records**:**
39 **(a) The department of health and senior services shall**
40 **promulgate by rule a consumer-directed services division provider**
41 **certification manager course**; and
42 **(b) The vendor shall perform with the consumer at least bi-**
43 **annual face-to-face home visits to provide ongoing monitoring of the**
44 **provision of services in the plan of care and assess the quality of care**
45 **being delivered. The bi-annual face-to-face home visits do not preclude**
46 **the vendor's responsibility from its ongoing diligence of case**
47 **management activity oversight;**
48 (4) Comply with all provisions of sections 208.900 to 208.927, and the
49 regulations promulgated thereunder**; and**
50 **(5) Maintain a business location which shall comply with any and**
51 **all applicable city, county, state, and federal requirements, verified by**
52 **the Missouri Medicaid audit and compliance unit.**
53 **3. No state or federal funds shall be authorized or expended if**
54 **the owner, primary operator, certified manager, or any direct employee**
55 **of the consumer-directed services vendor is also the personal care**
56 **attendant, unless such person provides services solely on a temporary**
57 **basis for no more than three days in a thirty-day period**.

208.924. A consumer's personal care assistance services may be
2 discontinued under circumstances such as the following:

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3 (1) The department learns of circumstances that require closure of a
4 consumer's case, including one or more of the following: death, admission into a
5 long-term care facility, no longer needing service, or inability of the consumer to
6 consumer-direct personal care assistance service;
7 (2) The consumer has falsified records**; provided false information of**
8 **his or her condition, functional capacity, or level of care needs;** or
9 committed fraud;
10 (3) The consumer is noncompliant with the plan of care. Noncompliance
11 requires persistent actions by the consumer which negate the services provided
12 in the plan of care;
13 (4) The consumer or member of the consumer's household threatens or
14 abuses the personal care attendant or vendor to the point where their welfare is
15 in jeopardy and corrective action has failed;
16 (5) The maintenance needs of a consumer are unable to continue to be met
17 because the plan of care hours exceed availability; and
18 (6) The personal care attendant is not providing services as set forth in
19 the personal care assistance services plan and attempts to remedy the situation
20 have been unsuccessful.

208.935. Subject to appropriations, the department of health and
2 **senior services shall develop, or contract with a state agency or third**
3 **party to develop, an interactive assessment tool, which may include**
4 **mobile as well as centralized functionality, for utilization when**
5 **implementing the assessment and authorization process for MO**
6 **HealthNet home and community-based services authorized by the**
7 **division of senior and disability services.**

217.930. 1. (1) Medical assistance under MO HealthNet shall be
2 **suspended, rather than canceled or terminated, for a person who is an**
3 **offender in a correctional center if:**
4 **(a) The department of social services is notified of the person's**
5 **entry into the correctional center;**
6 **(b) On the date of entry, the person was enrolled in the MO**
7 **HealthNet program; and**
8 **(c) The person is eligible for MO HealthNet except for**
9 **institutional status.**
10 **(2) A suspension under this subsection shall end on the date the**
11 **person is no longer an offender in a correctional center.**

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(3) Upon release from incarceration, such person shall continue to be eligible for receipt of MO HealthNet benefits until such time as the person is otherwise determined to no longer be eligible for the program.

2. The department of corrections shall notify the department of social services:

(1) Within twenty days after receiving information that a person receiving benefits under MO HealthNet is or will be an offender in a correctional center; and

(2) Within forty-five days prior to the release of a person who is qualified for suspension under subsection 1 of this section.

221.125. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than canceled or terminated, for a person who is an offender in a county jail, a city jail, or a private jail if:

(a) The department of social services is notified of the person's entry into the jail;

(b) On the date of entry, the person was enrolled in the MO HealthNet program; and

(c) The person is eligible for MO HealthNet except for institutional status.

(2) A suspension under this subsection shall end on the date the person is no longer an offender in a jail.

(3) Upon release from incarceration, such person shall continue to be eligible for receipt of MO HealthNet benefits until such time as the person is otherwise determined to no longer be eligible for the program.

2. City, county, and private jails shall notify the department of social services within ten days after receiving information that a person receiving medical assistance under MO HealthNet is or will be an offender in the jail.

344.030. 1. An applicant for an initial license shall file a completed application with the board on a form provided by the board, accompanied by an application fee as provided by rule payable to the department of health and senior services. Information provided in the application shall be attested by signature to be true and correct to the best of the applicant's knowledge and belief.

2. No initial license shall be issued to a person as a nursing home administrator unless:

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8 (1) The applicant provides the board satisfactory proof that the applicant
9 is of good moral character and a high school graduate or equivalent; **and**
10 (2) The applicant provides the board satisfactory proof that the applicant
11 has had a minimum of three years' experience in health care administration**,** or
12 two years of postsecondary education in health care administration**, or has an**
13 **associate degree or higher from an accredited academic institution,** or
14 has satisfactorily completed a course of instruction and training prescribed by the
15 board, which includes instruction in the needs properly to be served by nursing
16 homes, the protection of the interests of residents therein, and the elements of
17 good nursing home administration, or has presented evidence satisfactory to the
18 board of sufficient education, training, or experience in the foregoing fields to
19 administer, supervise and manage a nursing home; and
20 (3) The applicant passes the examinations administered by the board. If
21 an applicant fails to make a passing grade on either of the examinations such
22 applicant may make application for reexamination on a form furnished by the
23 board and may be retested. If an applicant fails either of the examinations a
24 third time, the applicant shall be required to complete a course of instruction
25 prescribed and approved by the board. After completion of the board-prescribed
26 course of instruction, the applicant may reapply for examination. With regard to
27 the national examination required for licensure, no examination scores from other
28 states shall be recognized by the board after the applicant has failed his or her
29 third attempt at the national examination. There shall be a separate,
30 nonrefundable fee for each examination. The board shall set the amount of the
31 fee for examination by rules and regulations promulgated pursuant to section
32 536.021. The fee shall be set at a level to produce revenue which shall not
33 substantially exceed the cost and expense of administering the examination.
34 3. Nothing in **[**sections 344.010 to 344.108**] this chapter**, or the rules or
35 regulations thereunder shall be construed to require an applicant for a license as
36 a nursing home administrator, who is employed by an institution listed and
37 certified by the Commission for Accreditation of Christian Science Nursing
38 Organizations/Facilities, Inc., to administer institutions certified by such
39 commission for the care and treatment of the sick in accordance with the creed
40 or tenets of a recognized church or religious denomination, to demonstrate
41 proficiency in any techniques or to meet any educational qualifications or
42 standards not in accord with the remedial care and treatment provided in such
43 institutions. The applicant's license shall be endorsed to confine the applicant's

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44 practice to such institutions.
45 4. The board may issue a temporary emergency license for a period not to
46 exceed [ninety] **one hundred and twenty** days to a person [twenty-one]
47 **eighteen** years of age or over, of good moral character and a high school
48 graduate or equivalent to serve as an acting nursing home administrator,
49 provided such person is replacing a licensed nursing home administrator who has
50 died, has been removed or has vacated the nursing home administrator's position.
51 No temporary emergency license may be issued to a person who has had a
52 nursing home administrator's license denied, suspended or revoked. [A
53 temporary emergency license may be renewed for one additional ninety-day period
54 upon a showing that the person seeking the renewal of a temporary emergency
55 license meets the qualifications for licensure and has filed an application for a
56 regular license, accompanied by the application fee, and the applicant has taken
57 the examination or examinations but the results have not been received by the
58 board. No temporary emergency license may be renewed more than one time.]
376.690. 1. As used in this section, the following terms shall mean:
2 (1) "Emergency medical condition", the same meaning given to such term
3 in section 376.1350;
4 (2) "Facility", the same meaning given to such term in section 376.1350;
5 (3) "Health care professional", the same meaning given to such term in
6 section 376.1350;
7 (4) "Health carrier", the same meaning given to such term in section
8 376.1350;
9 (5) "Unanticipated out-of-network care", health care services received by
10 a patient in an in-network facility from an out-of-network health care professional
11 from the time the patient presents with an emergency medical condition until the
12 time the patient is discharged.
13 2. (1) Health care professionals [may] **shall** send any claim for charges
14 incurred for unanticipated out-of-network care to the patient's health carrier
15 within one hundred eighty days of the delivery of the unanticipated
16 out-of-network care on a U.S. Centers of Medicare and Medicaid Services Form
17 1500, or its successor form, or electronically using the 837 HIPAA format, or its
18 successor.
19 (2) Within forty-five processing days, as defined in section 376.383, of
20 receiving the health care professional's claim, the health carrier shall offer to pay
21 the health care professional a reasonable reimbursement for unanticipated

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22 out-of-network care based on the health care professional's services. If the health
23 care professional participates in one or more of the carrier's commercial networks,
24 the offer of reimbursement for unanticipated out-of-network care shall be the
25 amount from the network which has the highest reimbursement.

26 (3) If the health care professional declines the health carrier's initial offer
27 of reimbursement, the health carrier and health care professional shall have sixty
28 days from the date of the initial offer of reimbursement to negotiate in good faith
29 to attempt to determine the reimbursement for the unanticipated out-of-network
30 care.

31 (4) If the health carrier and health care professional do not agree to a
32 reimbursement amount by the end of the sixty-day negotiation period, the dispute
33 shall be resolved through an arbitration process as specified in subsection 4 of
34 this section.

35 (5) To initiate arbitration proceedings, either the health carrier or health
36 care professional must provide written notification to the director and the other
37 party within one hundred twenty days of the end of the negotiation period,
38 indicating their intent to arbitrate the matter and notifying the director of the
39 billed amount and the date and amount of the final offer by each party. A claim
40 for unanticipated out-of-network care may be resolved between the parties at any
41 point prior to the commencement of the arbitration proceedings. Claims may be
42 combined for purposes of arbitration, but only to the extent the claims represent
43 similar circumstances and services provided by the same health care professional,
44 and the parties attempted to resolve the dispute in accordance with subdivisions
45 (3) to (5) of this subsection.

46 (6) No health care professional who sends a claim to a health carrier
47 under subsection 2 of this section shall send a bill to the patient for any
48 difference between the reimbursement rate as determined under this subsection
49 and the health care professional's billed charge.

50 3. (1) When unanticipated out-of-network care is provided, the health
51 care professional who sends a claim to a health carrier under subsection 2 of this
52 section may bill a patient for no more than the cost-sharing requirements
53 described under this section.

54 (2) Cost-sharing requirements shall be based on the reimbursement
55 amount as determined under subsection 2 of this section.

56 (3) The patient's health carrier shall inform the health care professional
57 of its enrollee's cost-sharing requirements within forty-five processing days of

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58 receiving a claim from the health care professional for services provided.
59 (4) The in-network deductible and out-of-pocket maximum cost-sharing
60 requirements shall apply to the claim for the unanticipated out-of-network care.
61 4. The director shall ensure access to an external arbitration process when
62 a health care professional and health carrier cannot agree to a reimbursement
63 under subdivision (3) of subsection 2 of this section. In order to ensure access,
64 when notified of a parties' intent to arbitrate, the director shall randomly select
65 an arbitrator for each case from the department's approved list of arbitrators or
66 entities that provide binding arbitration. The director shall specify the criteria
67 for an approved arbitrator or entity by rule. The costs of arbitration shall be
68 shared equally between and will be directly billed to the health care professional
69 and health carrier. These costs will include, but are not limited to, reasonable
70 time necessary for the arbitrator to review materials in preparation for the
71 arbitration, travel expenses and reasonable time following the arbitration for
72 drafting of the final decision.
73 5. At the conclusion of such arbitration process, the arbitrator shall issue
74 a final decision, which shall be binding on all parties. The arbitrator shall
75 provide a copy of the final decision to the director. The initial request for
76 arbitration, all correspondence and documents received by the department and
77 the final arbitration decision shall be considered a closed record under section
78 374.071. However, the director may release aggregated summary data regarding
79 the arbitration process. The decision of the arbitrator shall not be considered an
80 agency decision nor shall it be considered a contested case within the meaning of
81 section 536.010.
82 6. The arbitrator shall determine a dollar amount due under subsection
83 2 of this section between one hundred twenty percent of the Medicare-allowed
84 amount and the seventieth percentile of the usual and customary rate for the
85 unanticipated out-of-network care, as determined by benchmarks from
86 independent nonprofit organizations that are not affiliated with insurance
87 carriers or provider organizations.
88 7. When determining a reasonable reimbursement rate, the arbitrator
89 shall consider the following factors if the health care professional believes the
90 payment offered for the unanticipated out-of-network care does not properly
91 recognize:
92 (1) The health care professional's training, education, or experience;
93 (2) The nature of the service provided;

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94 (3) The health care professional's usual charge for comparable services
95 provided;
96 (4) The circumstances and complexity of the particular case, including the
97 time and place the services were provided; and
98 (5) The average contracted rate for comparable services provided in the
99 same geographic area.
100 8. The enrollee shall not be required to participate in the arbitration
101 process. The health care professional and health carrier shall execute a
102 nondisclosure agreement prior to engaging in an arbitration under this section.
103 9. **[**This section shall take effect on January 1, 2019.
104 10.**]** The department of insurance, financial institutions and professional
105 registration may promulgate rules and fees as necessary to implement the
106 provisions of this section, including but not limited to procedural requirements
107 for arbitration. Any rule or portion of a rule, as that term is defined in section
108 536.010, that is created under the authority delegated in this section shall
109 become effective only if it complies with and is subject to all of the provisions of
110 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
111 nonseverable and if any of the powers vested with the general assembly pursuant
112 to chapter 536 to review, to delay the effective date, or to disapprove and annul
113 a rule are subsequently held unconstitutional, then the grant of rulemaking
114 authority and any rule proposed or adopted after August 28, 2018, shall be
115 invalid and void.

376.1212. 1. This section shall apply to any health benefit plan,
2 **as defined in section 376.1350, which is delivered, issued for delivery,**
3 **continued, or renewed on or after January 1, 2020, which is written**
4 **inside the state of Missouri or written outside the state of Missouri but**
5 **covering Missouri residents, and in which a person may only enroll in**
6 **such plan during an initial, open, or special enrollment period.**
7 **2. Notwithstanding any other provision of law to the contrary,**
8 **such health benefit plan shall permit enrollment of a pregnant person**
9 **at any time after the commencement of her pregnancy, if such person**
10 **would be otherwise eligible to enroll in such plan during such initial,**
11 **open, or special enrollment period.**
12 **3. Such health benefit plan may require that such pregnancy be**
13 **certified by a health care practitioner licensed in this state and acting**
14 **within the scope of his or her practice.**

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15 **4. Coverage shall be effective as of the first day of the month**
16 **such pregnancy was certified, or if no certification is required, as of**
17 **the first day of the month self-attestation of pregnancy was made by the**
18 **person.**

376.1260. 1. (1) As used in this section, unless the context clearly
2 **requires otherwise, terms shall have the same meaning as ascribed to**
3 **them in section 376.1350.**
4 **(2) As used in this section, the term "off-label usage" shall mean**
5 **when a Food and Drug Administration-approved drug is used for the**
6 **practice of medicine in a manner that differs from the approved drug**
7 **label, including but not limited to:**
8 **(a) Used for a different disease or medical condition;**
9 **(b) Administered in a different manner; or**
10 **(c) Administered in a different dose.**
11 **2. Each health benefit plan delivered, issued for delivery,**
12 **continued, or renewed in the state shall provide coverage for an**
13 **enrollee's off-label usage of drugs for purposes of cancer treatment**
14 **when the drug has been prescribed or recommended to the enrollee by**
15 **at least two licensed oncologists who attest the drug may extend the**
16 **enrollee's life.**

Section B. Because of the need for timely and affordable access to medical
2 treatments, the enactment of section 376.1260 of this act is deemed necessary for
3 the immediate preservation of the public health, welfare, peace and safety, and
4 is hereby declared to be an emergency act within the meaning of the constitution,
5 and the enactment of section 376.1260 of this act shall be in full force and effect
6 upon its passage and approval.

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