SECOND REGULAR SESSION

SENATE BILL NO. 847

97TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SCHAAF.

Read 1st time February 10, 2014, and ordered printed.

TERRY L. SPIELER, Secretary.

5245L.02I

AN ACT

To repeal sections 105.711, 197.305, 197.310, 197.315, 197.330, 208.010, 208.166, 208.325, 208.955, 334.035, 334.104, 334.735, 354.535, and 538.220, RSMo, and to enact in lieu thereof forty-five new sections relating to the provision of health care, with a penalty provision.

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

Section A. Sections 105.711, 197.305, 197.310, 197.315, 197.330, 208.010, 208.166, 208.325, 208.955, 334.035, 334.104, 334.735, 354.535, and 538.220, RSMo, are repealed and forty-five new sections enacted in lieu thereof, to be known as sections 105.711, 173.228, 191.875, 197.170, 197.173, 197.305, 197.310, 197.315, 197.330, 197.710, 208.010, 208.166, 208.187, 208.188, 208.325, 208.440, 334.035, 334.036, 334.104, 334.735, 354.535, 376.387, 376.393, 376.444, 376.1425, 376.2020, 431.205, 484.400, 484.402, 484.404, 484.406, 484.408, 484.410, 484.412, 484.414, 484.416, 484.418, 484.420, 484.422, 484.424, 484.426, 484.428, 484.430, 538.220, and 1, to read as follows:

105.711. 1. There is hereby created a "State Legal Expense Fund" which shall consist of moneys appropriated to the fund by the general assembly and moneys otherwise credited to such fund pursuant to section 105.716.

2. Moneys in the state legal expense fund shall be available for the payment of any claim or any amount required by any final judgment rendered by a court of competent jurisdiction against:

(1) The state of Missouri, or any agency of the state, pursuant to section 536.050 or 536.087 or section 537.600;

(2) Any officer or employee of the state of Missouri or any agency of the state, including, without limitation, elected officials, appointees, members of state

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

boards or commissions, and members of the Missouri National Guard upon conduct of such officer or employee arising out of and performed in connection with his or her official duties on behalf of the state, or any agency of the state, provided that moneys in this fund shall not be available for payment of claims made under chapter 287;

(3) (a) Any physician, psychiatrist, pharmacist, podiatrist, dentist, nurse, or other health care provider licensed to practice in Missouri under the provisions of chapter 330, 332, 334, 335, 336, 337 or 338 who is employed by the state of Missouri or any agency of the state under formal contract to conduct disability reviews on behalf of the department of elementary and secondary education or provide services to patients or inmates of state correctional facilities on a part-time basis, and any physician, psychiatrist, pharmacist, podiatrist, dentist, nurse, or other health care provider licensed to practice in Missouri under the provisions of chapter 330, 332, 334, 335, 336, 337, or 338 who is under formal contract to provide services to patients or inmates at a county jail on a part-time basis;

(b) Any physician licensed to practice medicine in Missouri under the provisions of chapter 334 and his **or her** professional corporation organized pursuant to chapter 356 who is employed by or under contract with a city or county health department organized under chapter 192 or chapter 205, or a city health department operating under a city charter, or a combined city-county health department to provide services to patients for medical care caused by pregnancy, delivery, and child care, if such medical services are provided by the physician pursuant to the contract without compensation or the physician is paid from no other source than a governmental agency except for patient co-payments required by federal or state law or local ordinance;

(c) Any physician licensed to practice medicine in Missouri under the provisions of chapter 334 who is employed by or under contract with a federally funded community health center organized under Section 315, 329, 330 or 340 of the Public Health Services Act (42 U.S.C. 216, 254c) to provide services to patients for medical care caused by pregnancy, delivery, and child care, if such medical services are provided by the physician pursuant to the contract or employment agreement without compensation or the physician is paid from no other source than a governmental agency or such a federally funded community health center except for patient co-payments required by federal or state law or local ordinance. In the case of any claim or judgment that arises under this

paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of one million dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause against any such physician, and shall not exceed one million dollars for any one claimant;

(d) Any physician licensed pursuant to chapter 334 who is affiliated with and receives no compensation from a nonprofit entity qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, which offers a free health screening in any setting or any physician, **chiropractor,** nurse, physician assistant, dental hygienist, dentist, or other health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338 who provides health care services within the scope of his or her license or registration at a city or county health department organized under chapter 192 or chapter 205, a city health department operating under a city charter, or a combined city-county health department, or a nonprofit community health center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, if such services are restricted to primary care and preventive health services, provided that such services shall not include the performance of an abortion, and if such health services are provided by the health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338 without compensation. MO HealthNet or Medicare payments for primary care and preventive health services provided by a health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338 who volunteers at a free health clinic is not compensation for the purpose of this section if the total payment is assigned to the free health clinic. For the purposes of the section, "free health clinic" means a nonprofit community health center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1987, as amended, that provides primary care and preventive health services to people without health insurance coverage for the services provided without charge. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars, for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars. Liability or malpractice insurance obtained and maintained in force by or on behalf of any

health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338 shall not be considered available to pay that portion of a judgment or claim for which the state legal expense fund is liable under this paragraph;

(e) Any physician, nurse, physician assistant, dental hygienist, or dentist licensed or registered to practice medicine, nursing, or dentistry or to act as a physician assistant or dental hygienist in Missouri under the provisions of chapter 332, 334, or 335, or lawfully practicing, who provides medical, nursing, or dental treatment within the scope of his license or registration to students of a school whether a public, private, or parochial elementary or secondary school or summer camp, if such physician's treatment is restricted to primary care and preventive health services and if such medical, dental, or nursing services are provided by the physician, dentist, physician assistant, dental hygienist, or nurse without compensation. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars, for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars; or

(f) Any physician licensed under chapter 334, or dentist licensed under chapter 332, providing medical care without compensation to an individual referred to his or her care by a city or county health department organized under chapter 192 or 205, a city health department operating under a city charter, or a combined city-county health department, or nonprofit health center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or a federally funded community health center organized under Section 315, 329, 330, or 340 of the Public Health Services Act, 42 U.S.C. Section 216, 254c; provided that such treatment shall not include the performance of an abortion. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of one million dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed one million dollars for any one claimant, and insurance policies purchased under the provisions of section 105.721 shall be limited to one million dollars. Liability or malpractice insurance obtained and maintained in

force by or on behalf of any physician licensed under chapter 334, or any dentist licensed under chapter 332, shall not be considered available to pay that portion of a judgment or claim for which the state legal expense fund is liable under this paragraph;

(g) Any physician licensed under chapter 334 who is under contract to provide medical care to participants in the MO HealthNet pilot project established under section 208.188. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased under the provisions of section 105.721 shall be limited to five hundred thousand dollars. Liability or malpractice insurance obtained and maintained in force by or on behalf of any physician licensed under chapter 334 shall not be considered available to pay that portion of a judgment or claim for which the state legal expense fund is liable under this paragraph;

(4) Staff employed by the juvenile division of any judicial circuit;

(5) Any attorney licensed to practice law in the state of Missouri who practices law at or through a nonprofit community social services center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or through any agency of any federal, state, or local government, if such legal practice is provided by the attorney without compensation. In the case of any claim or judgment that arises under this subdivision, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars;

(6) Any social welfare board created under section 205.770 and the members and officers thereof upon conduct of such officer or employee while acting in his or her capacity as a board member or officer, and any physician, nurse, physician assistant, dental hygienist, dentist, or other health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336,

337, or 338 who is referred to provide medical care without compensation by the board and who provides health care services within the scope of his or her license or registration as prescribed by the board; or

(7) Any person who is selected or appointed by the state director of revenue under subsection 2 of section 136.055 to act as an agent of the department of revenue, to the extent that such agent's actions or inactions upon which such claim or judgment is based were performed in the course of the person's official duties as an agent of the department of revenue and in the manner required by state law or department of revenue rules.

3. The department of health and senior services shall promulgate rules regarding contract procedures and the documentation of care provided under paragraphs (b), (c), (d), (e), **[**and**]** (f)**, and (g)** of subdivision (3) of subsection 2 of this section. The limitation on payments from the state legal expense fund or any policy of insurance procured pursuant to the provisions of section 105.721, provided in subsection 7 of this section, shall not apply to any claim or judgment arising under paragraph (a), (b), (c), (d), (e), **[**or**]** (f)**, or (g)** of subdivision (3) of subsection 2 of this section. Any claim or judgment arising under paragraph (a), (b), (c), (d), (e), **[**or**]** (f)**, or (g)** of subdivision (3) of subsection 2 of this section shall be paid by the state legal expense fund or any policy of insurance procured pursuant to section 105.721, to the extent damages are allowed under sections 538.205 to 538.235. Liability or malpractice insurance obtained and maintained in force by any health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338 for coverage concerning his or her private practice and assets shall not be considered available under subsection 7 of this section to pay that portion of a judgment or claim for which the state legal expense fund is liable under paragraph (a), (b), (c), (d), (e), **[**or**]** (f)**, or (g)** of subdivision (3) of subsection 2 of this section. However, a health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338 may purchase liability or malpractice insurance for coverage of liability claims or judgments based upon care rendered under paragraphs (c), (d), (e), **[**and**]** (f)**, and (g)** of subdivision (3) of subsection 2 of this section which exceed the amount of liability coverage provided by the state legal expense fund under those paragraphs. Even if paragraph (a), (b), (c), (d), (e), **[**or**]** (f)**, or (g)** of subdivision (3) of subsection 2 of this section is repealed or modified, the state legal expense fund shall be available for damages which occur while the pertinent paragraph (a), (b), (c), (d), (e), **[**or**]** (f)**, or (g)** of subdivision (3) of subsection 2 of this section

is in effect.

4. The attorney general shall promulgate rules regarding contract procedures and the documentation of legal practice provided under subdivision (5) of subsection 2 of this section. The limitation on payments from the state legal expense fund or any policy of insurance procured pursuant to section 105.721 as provided in subsection 7 of this section shall not apply to any claim or judgment arising under subdivision (5) of subsection 2 of this section. Any claim or judgment arising under subdivision (5) of subsection 2 of this section shall be paid by the state legal expense fund or any policy of insurance procured pursuant to section 105.721 to the extent damages are allowed under sections 538.205 to 538.235. Liability or malpractice insurance otherwise obtained and maintained in force shall not be considered available under subsection 7 of this section to pay that portion of a judgment or claim for which the state legal expense fund is liable under subdivision (5) of subsection 2 of this section. However, an attorney may obtain liability or malpractice insurance for coverage of liability claims or judgments based upon legal practice rendered under subdivision (5) of subsection 2 of this section that exceed the amount of liability coverage provided by the state legal expense fund under subdivision (5) of subsection 2 of this section. Even if subdivision (5) of subsection 2 of this section is repealed or amended, the state legal expense fund shall be available for damages that occur while the pertinent subdivision (5) of subsection 2 of this section is in effect.

5. All payments shall be made from the state legal expense fund by the commissioner of administration with the approval of the attorney general. Payment from the state legal expense fund of a claim or final judgment award against a health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, described in paragraph (a), (b), (c), (d), (e), **[**or**]** (f)**, or (g)** of subdivision (3) of subsection 2 of this section, or against an attorney in subdivision (5) of subsection 2 of this section, shall only be made for services rendered in accordance with the conditions of such paragraphs. In the case of any claim or judgment against an officer or employee of the state or any agency of the state based upon conduct of such officer or employee arising out of and performed in connection with his or her official duties on behalf of the state or any agency of the state that would give rise to a cause of action under section 537.600, the state legal expense fund shall be liable, excluding punitive damages, for:

(1) Economic damages to any one claimant; and

(2) Up to three hundred fifty thousand dollars for noneconomic damages. The state legal expense fund shall be the exclusive remedy and shall preclude any other civil actions or proceedings for money damages arising out of or relating to the same subject matter against the state officer or employee, or the officer's or employee's estate. No officer or employee of the state or any agency of the state shall be individually liable in his or her personal capacity for conduct of such officer or employee arising out of and performed in connection with his or her official duties on behalf of the state or any agency of the state. The provisions of this subsection shall not apply to any defendant who is not an officer or employee of the state or any agency of the state in any proceeding against an officer or employee of the state or any agency of the state. Nothing in this subsection shall limit the rights and remedies otherwise available to a claimant under state law or common law in proceedings where one or more defendants is not an officer or employee of the state or any agency of the state.

6. The limitation on awards for noneconomic damages provided for in this subsection shall be increased or decreased on an annual basis effective January first of each year in accordance with the Implicit Price Deflator for Personal Consumption Expenditures as published by the Bureau of Economic Analysis of the United States Department of Commerce. The current value of the limitation shall be calculated by the director of the department of insurance, financial institutions and professional registration, who shall furnish that value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021.

7. Except as provided in subsection 3 of this section, in the case of any claim or judgment that arises under sections 537.600 and 537.610 against the state of Missouri, or an agency of the state, the aggregate of payments from the state legal expense fund and from any policy of insurance procured pursuant to the provisions of section 105.721 shall not exceed the limits of liability as provided in sections 537.600 to 537.610. No payment shall be made from the state legal expense fund or any policy of insurance procured with state funds pursuant to section 105.721 unless and until the benefits provided to pay the claim by any other policy of liability insurance have been exhausted.

8. The provisions of section 33.080 notwithstanding, any moneys remaining to the credit of the state legal expense fund at the end of an

appropriation period shall not be transferred to general revenue.

9. Any rule or portion of a rule, as that term is defined in section 536.010, that is promulgated under the authority delegated in sections 105.711 to 105.726 shall become effective only if it has been promulgated pursuant to the provisions of chapter 536. Nothing in this section shall be interpreted to repeal or affect the validity of any rule filed or adopted prior to August 28, 1999, if it fully complied with the provisions of chapter 536. 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, 1999, shall be invalid and void.

173.228. 1. There is hereby created within the department of higher education the "Board of Medical Scholarship Awards", which shall establish scholarships and loans to provide for the medical training of qualified applicants for admission, or students in the University of Missouri School of Medicine or any other accredited or provisionally accredited school of medicine in this state. The recipients of loan awards shall enter into a valid agreement with the board to practice the profession of medicine in those areas and localities of Missouri as may be determined by the board for a number of years to be stipulated in the agreement. The board shall collaborate with the Lester R. Bryant Pre-Admissions Program established within the University of Missouri School of Medicine to participate in the scholarships and loans provided under this section, including the flexibility to provide financial incentives, such as forgiveness or repayment of all or a portion of educational loans.

2. The board of medical scholarship awards shall be composed of:

(1) Two members of the board of directors of the Missouri State Medical Association, appointed by the president of the Missouri State Medical Association;

(2) One member of the board of trustees for the Missouri Association of Osteopathic Physicians and Surgeons, appointed by the president of the board;

(3) The dean of each school of osteopathic or allopathic medicine in this state, or the dean's designee;

(4) The chair of the admissions committee of each school of osteopathic or allopathic medicine in this state; and

(5) One member of the senate appointed by the president pro tem of the senate; and

(6) One member of the house of representatives appointed by the speaker of the house.

3. (1) The members of the Missouri State Medical Association and the Missouri Association of Osteopathic Physicians and Surgeons shall serve four-year terms. The terms of the legislative members shall be four years for the senate member and two years for the house member, concurrent with their legislative terms. All appointed members of the board may be reappointed.

(2) The chair of the board shall be selected from the members appointed from the Missouri Medical Association and the Missouri Association of Osteopathic Physicians and Surgeons.

4. (1) The board shall make a careful and thorough investigation of the ability, character, and qualifications of each applicant, and award scholarships and loans according to the judgment of the board. Preference in granting loans shall be given to applicants who sign agreements to practice in those areas in greatest need of medical service for periods of time stipulated by the board.

(2) The board shall make reasonable rules for implementing and administering the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

5. The board shall make two types of awards as follows:

(1) Loans. A number of loans equal in number to twenty percent of the student body of the medical schools in the state of Missouri, each in an amount of up to the average cost of tuition, fees, and living expenses, as set forth in the current catalogs of the University of

Missouri School of Medicine or other school of medicine in this state, for the year of each enrollment. Such loans shall be available to any resident of Missouri of good character who has been accepted for matriculation by one of the medical schools in Missouri, with preference given to those applicants who can demonstrate an economic need and who commit in writing to practice in a rural area of generalists specialty as determined by the board. The board may, in its discretion, permit students to apply for a loan under this subdivision in any scholastic year and for any previously completed scholastic year of medical education. Such loans shall be repaid following graduation, under the terms of a contract to practice clinical medicine in an area of Missouri identified by the board as medically underserved for a term of years, as hereinafter set forth;

(2) Merit scholarships. A number of merit scholarships equal in number to five percent of the student body of the medical schools in the state of Missouri, each in an amount not to exceed five thousand dollars per annum or twenty thousand dollars over a four-year period shall be granted to students with high scholastic achievement and excellent character who will attend one of the medical schools in the state of Missouri. The students to whom merit scholarships are granted shall not be obligated to repay the amount of the scholarship award.

6. Any recipient who fails for any reason to continue his or her medical education may, at the discretion of the board, be required to repay all loan amounts immediately with simple interest of eight percent annually from the date of his or her departure or removal from medical school.

7. The loan or any portion thereof shall be repaid by engaging in full-time clinical practice, as defined in rule of the board, in one of the following ways, in accordance with a contract approved by the board:

(1) Practice for a period equal to one year of practice for each year the individual received a loan in a community of less than five thousand population which is in an area within Missouri identified by the board as medically underserved;

(2) Practice for a period equal to one and one-quarter years of practice for each year the individual received a loan in a community of between five thousand and fifteen thousand population which is in an area within Missouri identified by the board as medically

underserved;

(3) Practice for a period equal to one and one-half years of practice for each year the individual received a loan in a community of between fifteen thousand and fifty thousand population which is in an area of Missouri identified by the board as medically underserved.

8. (1) Each recipient of a loan under this section shall enter into an agreement with the board whereby the recipient agrees to practice in an area described in subsection 6 of this section. In the event of a default or other breach of contract by the recipient of loans provided under this section, or other termination of contract prior to the completion of the period of medical education and training, the individual shall be liable for immediate repayment of the total principal loan amount plus interest at the rate of eight percent accruing from the date of default or termination and an additional penalty as specified:

(a) For default or termination of a loan for one scholastic year, a penalty equal to twenty percent of the total principal amount of the loan;

(b) For default or termination of a loan for two scholastic years, a penalty equal to thirty percent of the total principal amount of the loan;

(c) For default or termination of a loan for three scholastic years, a penalty equal to forty percent of the total principal amount of the loan;

(d) For default or termination of a loan for four scholastic years, a penalty equal to fifty percent of the total principal amount of the loan;

(e) If default or termination occurs after the fourth year but prior to the completion of an accredited residency training program in a generalists specialty as determined by the board, a penalty equal to one hundred percent of the total principal amount of the loan; and

(f) If default or termination occurs after completion of an accredited residency training program but prior to completion of the repayment obligation under subsection 7 of this section, a penalty equal to two hundred percent of the total principal amount of the loan.

(2) The attorney general, upon request of the board, shall institute proceedings in the name of the state for the purpose of

recovering any amount due the state under this section. Any moneys recovered under this section from loan recipients or paid by recipients to the board shall be retained by the board for funding of future scholarships.

(3) In the event of death of a recipient or upon the recipient's becoming permanently disabled to an extent that he or she is no longer able to engage in the practice of medicine, repayment of the loan may be excused by the board.

9. The failure of a recipient of a loan to perform his or her agreement with the board or to pay the amount he or she is liable for under this section shall constitute a ground for the revocation of his or her license to practice medicine.

10. Any incorporated or unincorporated municipality or locality in this state having a population of less than fifteen thousand inhabitants, desiring additional physicians and wishing to be designated as a locality needing additional physicians, may apply to the board to be placed on a list of localities in need of additional physicians, which shall be maintained by the board. Such applications may be made either by the governing body of the municipality or by a petition signed by at least one twentieth of the qualified voters of the municipality or locality. If the board determines that such locality is in need of physicians, the board shall place such locality on the list of localities in need of physicians from which recipients of scholarships may, after graduation, select an area in which to practice. In compiling and maintaining the list, the board may place any locality thereon which, in its opinion, needs additional physicians.

11. (1) There is hereby created in the state treasury the "Board of Medical Scholarship Awards Fund", which shall consist of money collected under this section, any state appropriations, and all gifts, bequests, grants, or donations from any source whatsoever, including but not limited to grants from the Missouri Foundation for Health. 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, money in the fund shall be used solely for the administration of 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.

191.875. 1. By January 1, 2015, any patient or consumer of health care services who requests an estimate of the cost of health care services from a health care provider or the insurance costs from such patient's or consumer's health carrier shall be provided such estimate of cost or insurance costs prior to the provision of such services, if feasible, but in no event later than three business days after such request. The provisions of this subsection shall not apply to emergency health care services.

2. As used in this section, the following terms shall mean:

(1) "Ambulatory surgical center", any ambulatory surgical center as defined in section 197.200;

(2) "Estimate of cost", an estimate based on the information entered and assumptions about typical utilization and costs for health care services. Such estimate of cost shall include the following:

(a) The amount that will be charged to a patient for the health services if all charges are paid in full without a public or private third party paying for any portion of the charges;

(b) The average negotiated settlement on the amount that will be charged to a patient required to be provided in paragraph (a) of this subdivision;

(c) The amount of any MO HealthNet reimbursement for the health care services, including claims and pro rata supplemental payments, if known;

(d) The amount of any Medicare reimbursement for the medical services, if known; and

(e) The amount of any insurance co-payments for the health benefit plan of the patient, if known;

(3) "Health care provider", any hospital, ambulatory surgical center, physician, dentist, clinical psychologist, pharmacist, optometrist, podiatrist, registered nurse, physician assistant, chiropractor, physical therapist, nurse anesthetist, anesthetist, long-term care facility, or other licensed health care facility or professional

providing health care services in this state;

(4) "Health carrier", an entity as such term is defined under section 376.1350;

(5) "Insurance costs", an estimate of costs of covered services provided by a health carrier based on a specific insured's coverage and health care services to be provided. Such insurance cost shall include:

(a) The reimbursement amount to any health care provider;

(b) Any deductibles, co-payments, or co-insurance amounts; and

(c) Any amounts not covered under the health benefit plan;

(6) "Public or private third party", the state, the federal government, employers, health carriers, third-party administrators, and managed care organizations.

3. (1) Health care providers shall include with any estimate of costs the following: "Your estimated cost is based on the information entered and assumptions about typical utilization and costs. The actual amount billed to you may be different from the estimate of costs provided to you. Many factors affect the actual bill you will receive, and this estimate of costs does not account for all of them. Additionally, the estimate of costs is not a guarantee of insurance coverage. You will be billed at the provider's charge for any service provided to you that is not a covered benefit under your plan. Please check with your insurance company if you need help understanding your benefits for the service chosen.".

(2) Health carriers shall include with any insurance costs the following: "Your insurance costs are based on the information entered and assumptions about typical utilization and costs. The actual amount of insurance costs and the amount billed to you may be different from the insurance costs provided to you. Many factors affect the actual insurance costs, and this insurance costs does not account for all of them. Additionally, the insurance costs provided is limited to the specific information provided and is not a guarantee of insurance coverage for additional services. You will be billed at the provider's charge for any service provided to you that is not a covered benefit under your plan. You may contact us if you need further assistance in understanding your benefits for the service chosen.".

4. Each health care provider shall also make available the percentage or amount of any discounts for cash payment of any charges

incurred by a posting on the provider's website and by making it available at the provider's location.

5. Nothing in this section shall be construed as violating any provider contract provisions with a health carrier that prohibit disclosure of the provider's fee schedule with a health carrier to third parties.

6. The department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

197.170. 1. This section and section 197.173 shall be known as the "Health Care Cost Reduction and Transparency Act".

2. As used in this section and section 197.173 the following terms shall mean:

(1) "Ambulatory surgical center", a health care facility as such term is defined under section 197.200;

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

(3) "DRG", diagnosis related group;

(4) "Health carrier", an entity as such term is defined under section 376.1350;

(5) "Hospital", a health care facility as such term is defined under section 197.020;

(6) "Public or private third party", includes the state, the federal government, employers, health carriers, third-party administrators, and managed care organizations.

3. The department of health and senior services shall make available to the public on its internet website the most current price information it receives from hospitals and ambulatory surgical centers under section 197.173. The department shall provide this information in a manner that is easily understood by the public and meets the

following minimum requirements:

(1) Information for each hospital shall be listed separately and hospitals shall be listed in groups by category as determined by the department in rules adopted under section 197.173;

(2) Information for each hospital outpatient department and each ambulatory surgical center shall be listed separately.

4. Any data disclosed to the department by a hospital or ambulatory surgical center under section 197.173 shall be the sole property of the hospital or center that submitted the data. Any data or product derived from the data disclosed under section 197.173, including a consolidation or analysis of the data, shall be the sole property of the state. The department shall not allow proprietary information it receives under section 197.173 to be used by any person or entity for commercial purposes.

197.173. 1. Beginning with the quarter ending June 30, 2015, and quarterly thereafter, each hospital shall provide to the department, in the manner and format determined by the department, the following information about the one hundred most frequently reported admissions by DRG for inpatients as established by the department:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges;

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection;

(3) The amount of Medicaid reimbursement for each DRG, including claims and pro rata supplemental payments;

(4) The amount of Medicare reimbursement for each DRG;

(5) For the five largest health carriers providing payment to the hospital on behalf of insureds and state employees, the range and the average of the amount of payment made for each DRG. Prior to providing this information to the department, each hospital shall redact the names of the health carrier and any other information that would otherwise identify the health carriers.

A hospital shall not be required to report the information required by this subsection for any of the one hundred most frequently reported admissions where the reporting of that information reasonably could

lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

2. Beginning with the quarter ending September 30, 2015, and quarterly thereafter, each hospital and ambulatory surgical center shall provide to the department, in a manner and format determined by the department, information on the total costs for the twenty most common surgical procedures and the twenty most common imaging procedures, by volume, performed in hospital outpatient settings or in ambulatory surgical centers, along with the related current procedural terminology ("CPT") and healthcare common procedure coding system ("HCPCS") codes. Hospitals and ambulatory surgical centers shall report this information in the same manner as required by subsection 1 of this section, provided that hospitals and ambulatory surgical centers shall not be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of HIPAA or other federal law.

3. Upon request of a patient for a particular DRG, imaging procedure, or surgery procedure reported in this section, a hospital or ambulatory surgical center shall provide the information required by subsection 1 or 2 of this section to the patient in writing, either electronically or by mail, within three business days after receiving the request.

4. (1) The department shall promulgate rules on or before March 1, 2015, to ensure that subsection 1 of this section is properly implemented and that hospitals report this information to the department in a uniform manner. The rules shall include all of the following:

(a) The one hundred most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection 1 of this section;

(b) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the department's internet website.

(2) The department shall promulgate rules on or before June 1, 2015, to ensure that subsection 2 of this section is properly

implemented and that hospitals and ambulatory surgical centers report this information to the department in a uniform manner. The rules shall include the list of the twenty most common surgical procedures and the twenty most common imaging procedures, by volume, performed in a hospital outpatient setting and those performed in an ambulatory surgical facility, along with the related CPT and HCPCS codes.

(3) 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, 2014, shall be invalid and void.

197.305. As used in sections 197.300 to **[**197.366**]** **197.367**, the following terms mean:

(1) "Affected persons", the person proposing the development of a new institutional health service, the public to be served, and health care facilities within **[**the service area in which**]** **a five-mile radius of** the proposed new health care service **[**is**]** to be developed;

(2) "Agency", the certificate of need program of the Missouri department of health and senior services;

(3) "Capital expenditure", an expenditure by or on behalf of a health care facility which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance;

(4) "Certificate of need", a written certificate issued by the committee setting forth the committee's affirmative finding that a proposed project sufficiently satisfies the criteria prescribed for such projects by sections 197.300 to **[**197.366**]** **197.367**;

(5) "Develop", to undertake those activities which on their completion will result in the offering of a new institutional health service or the incurring of a financial obligation in relation to the offering of such a service;

(6) "Expenditure minimum" shall mean:

(a) For beds in existing or proposed health care facilities licensed pursuant to chapter 198 and long-term care beds in a hospital as described in subdivision (3) of subsection 1 of section 198.012, **[**six hundred thousand**] one million** dollars in the case of capital expenditures, or **[**four hundred thousand**] two million** dollars in the case of major medical equipment, provided, however, that prior to January 1, 2003, the expenditure minimum for beds in such a facility and long-term care beds in a hospital described in section 198.012 shall be zero, subject to the provisions of subsection 7 of section 197.318;

(b) For beds or equipment in a long-term care hospital meeting the requirements described in 42 CFR, Section 412.23(e), the expenditure minimum shall be zero; and

(c) For health care facilities, new institutional health services or beds not described in paragraph (a) or (b) of this subdivision one million dollars in the case of capital expenditures, excluding major medical equipment, and one million dollars in the case of medical equipment;

(7) "Health service area", a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources, consisting of a population of not less than five hundred thousand or more than three million;

(8) "Major medical equipment", medical equipment used for the provision of medical and other health services;

(9) "New institutional health service":

(a) The development of a new health care facility costing in excess of the applicable expenditure minimum;

(b) The acquisition, including acquisition by lease, of any health care facility, or major medical equipment costing in excess of the expenditure minimum;

(c) Any capital expenditure by or on behalf of a health care facility in excess of the expenditure minimum;

(d) Predevelopment activities as defined in subdivision (12) **[**hereof**] of this section** costing in excess of one hundred fifty thousand dollars;

(e) Any change in licensed bed capacity of a health care facility which increases the total number of beds by more than ten or more than ten percent of total bed capacity, whichever is less, over a two-year period;

(f) Health services, excluding home health services, which are offered in a health care facility and which were not offered on a regular basis in such health

care facility within the twelve-month period prior to the time such services would be offered;

(g) A reallocation by an existing health care facility of licensed beds among major types of service or reallocation of licensed beds from one physical facility or site to another by more than ten beds or more than ten percent of total licensed bed capacity, whichever is less, over a two-year period;

(10) "Nonsubstantive projects", projects which do not involve the addition, replacement, modernization or conversion of beds or the provision of a new health service but which include a capital expenditure which exceeds the expenditure minimum and are due to an act of God or a normal consequence of maintaining health care services, facility or equipment;

(11) "Person", any individual, trust, estate, partnership, corporation, including associations and joint stock companies, state or political subdivision or instrumentality thereof, including a municipal corporation;

(12) "Predevelopment activities", expenditures for architectural designs, plans, working drawings and specifications, and any arrangement or commitment made for financing; but excluding submission of an application for a certificate of need.

197.310. 1. The "Missouri Health Facilities Review Committee" is hereby established. The agency shall provide clerical and administrative support to the committee. The committee may employ additional staff as it deems necessary.

2. The committee shall be composed of:

(1) **[**Two members of the senate appointed by the president pro tem, who shall be from different political parties**] One member who is professionally qualified in health insurance plan sales and administration**; **[**and**]**

(2) **[**Two members of the house of representatives appointed by the speaker, who shall be from different political parties**] One member who has professionally qualified experience in commercial development, financing, and lending**; **[**and**]**

(3) **[**Five members**] Two members with a doctorate of philosophy in economics;**

(4) Two members who are professionally qualified as medical doctors or doctors of osteopathy, but who are not employees of a hospital or consultants to a hospital;

(5) Two members who are professionally experienced in hospital administration, but are not employed by a hospital or as consultants to

a hospital; and

(6) One member who is a registered nurse, but who is not an employee of a hospital or a consultant to a hospital.

All members shall be appointed by the governor with the advice and consent of the senate, not more than **[**three**] five** of whom shall be from the same political party. **All members shall serve four-year terms.**

3. No business of this committee shall be performed without a majority of the full body.

4. **[**The members shall be appointed as soon as possible after September 28, 1979. One of the senate members, one of the house members and three of the members appointed by the governor shall serve until January 1, 1981, and the remaining members shall serve until January 1, 1982. All subsequent members shall be appointed in the manner provided in subsection 2 of this section and shall serve terms of two years.

5.**]** The committee shall elect a chairman at its first meeting which shall be called by the governor. The committee shall meet upon the call of the chairman or the governor.

[6.**] 5.** The committee shall review and approve or disapprove all applications for a certificate of need made under sections 197.300 to **[**197.366**] 197.367**. It shall issue reasonable rules and regulations governing the submission, review and disposition of applications.

[7.**] 6.** Members of the committee shall serve without compensation but shall be reimbursed for necessary expenses incurred in the performance of their duties.

[8.**] 7.** Notwithstanding the provisions of subsection 4 of section 610.025, the proceedings and records of the facilities review committee shall be subject to the provisions of chapter 610.

197.315. 1. Any person who proposes to develop or offer a new institutional health service within the state must obtain a certificate of need from the committee prior to the time such services are offered. **However, a certificate of need shall not be required for a proposed project which creates five or more new full-time jobs, or full-time equivalent jobs provided that such person proposing the project submit a letter of intent and a report of the number of jobs and such other information as may be required by the health facilities review committee to document the basis for not requiring a certificate of need. If the letter**

of intent and report document that five or more new full-time jobs or full-time equivalent jobs shall be created, the health facilities review committee shall respond within thirty days to such person with an approval of the non-applicability of a certificate of need. No job that was created prior to the approval of nonapplicability of a certificate of need shall be deemed a new job. For purposes of this subsection, a "full-time employee" means an employee of the person that is scheduled to work an average of at least thirty-five hours per week for a twelve-month period, and one for which the person offers health insurance and pays at least fifty-percent of such insurance premiums.

2. Only those new institutional health services which are found by the committee to be needed shall be granted a certificate of need. Only those new institutional health services which are granted certificates of need shall be offered or developed within the state. No expenditures for new institutional health services in excess of the applicable expenditure minimum shall be made by any person unless a certificate of need has been granted.

3. After October 1, 1980, no state agency charged by statute to license or certify health care facilities shall issue a license to or certify any such facility, or distinct part of such facility, that is developed without obtaining a certificate of need.

4. If any person proposes to develop any new institutional health care service without a certificate of need as required by sections 197.300 to **[**197.366**]** **197.367**, the committee shall notify the attorney general, and he shall apply for an injunction or other appropriate legal action in any court of this state against that person.

5. After October 1, 1980, no agency of state government may appropriate or grant funds to or make payment of any funds to any person or health care facility which has not first obtained every certificate of need required pursuant to sections 197.300 to **[**197.366**]** **197.367**.

6. A certificate of need shall be issued only for the premises and persons named in the application and is not transferable except by consent of the committee.

7. Project cost increases, due to changes in the project application as approved or due to project change orders, exceeding the initial estimate by more than ten percent shall not be incurred without consent of the committee.

8. Periodic reports to the committee shall be required of any applicant

who has been granted a certificate of need until the project has been completed. The committee may order the forfeiture of the certificate of need upon failure of the applicant to file any such report.

9. A certificate of need shall be subject to forfeiture for failure to incur a capital expenditure on any approved project within six months after the date of the order. The applicant may request an extension from the committee of not more than six additional months based upon substantial expenditure made.

10. Each application for a certificate of need **[**must**]** **shall** be accompanied by an application fee. The time of filing commences with the receipt of the application and the application fee. The application fee is one thousand dollars**[**, or one-tenth of one percent of the total cost of the proposed project, whichever is greater**]**. All application fees shall be deposited in the state treasury. Because of the loss of federal funds, the general assembly will appropriate funds to the Missouri health facilities review committee.

11. In determining whether a certificate of need should be granted, no consideration shall be given to the facilities or equipment of any other health care facility located more than a **[**fifteen-mile**]** **five-mile** radius from the applying facility.

12. When a nursing facility shifts from a skilled to an intermediate level of nursing care, it may return to the higher level of care if it meets the licensure requirements, without obtaining a certificate of need.

13. In no event shall a certificate of need be denied because the applicant refuses to provide abortion services or information.

14. A certificate of need shall not be required for the transfer of ownership of an existing and operational health facility in its entirety.

15. A certificate of need may be granted to a facility for an expansion, an addition of services, a new institutional service, or for a new hospital facility which provides for something less than that which was sought in the application.

16. The provisions of this section shall not apply to facilities operated by the state, and appropriation of funds to such facilities by the general assembly shall be deemed in compliance with this section, and such facilities shall be deemed to have received an appropriate certificate of need without payment of any fee or charge.

17. Notwithstanding other provisions of this section, a certificate of need may be issued after July 1, 1983, for an intermediate care facility operated exclusively for the **[**mentally retarded**]** **intellectually disabled**.

18. To assure the safe, appropriate, and cost-effective transfer of new medical technology throughout the state, a certificate of need shall not be required for the purchase and operation of research equipment that is to be used in a clinical trial that has received written approval from a duly constituted institutional review board of an accredited school of medicine or osteopathy located in Missouri to establish its safety and efficacy and does not increase the bed complement of the institution in which the equipment is to be located. After the clinical trial has been completed, a certificate of need must be obtained for continued use in such facility.

197.330. 1. The committee shall:

(1) Notify the applicant within fifteen days of the date of filing of an application as to the completeness of such application;

(2) Provide written notification to affected persons located within this state at the beginning of a review. This notification may be given through publication of the review schedule in all newspapers of general circulation in the area to be served;

(3) Hold public hearings on all applications when a request in writing is filed by any affected person within thirty days from the date of publication of the notification of review;

(4) Within one hundred days of the filing of any application for a certificate of need, issue in writing its findings of fact, conclusions of law, and its approval or denial of the certificate of need; provided, that the committee may grant an extension of not more than thirty days on its own initiative or upon the written request of any affected person;

(5) Cause to be served upon the applicant, the respective health system agency, and any affected person who has filed his prior request in writing, a copy of the aforesaid findings, conclusions and decisions;

(6) Consider the needs and circumstances of institutions providing training programs for health personnel;

(7) Provide for the availability, based on demonstrated need, of both medical and osteopathic facilities and services to protect the freedom of patient choice; and

(8) Establish by regulation procedures to review, or grant a waiver from review, nonsubstantive projects. The term "filed" or "filing" as used in this section shall mean delivery to the staff of the health facilities review committee the document or documents the applicant believes constitute an application.

2. Failure by the committee to issue a written decision on an application for a certificate of need within the time required by this section shall constitute approval of and final administrative action on the application, and is subject to appeal pursuant to section 197.335 only on the question of approval by operation of law.

3. For all hearings held by the committee, including all public hearings under subdivision (3) of subsection 1 of this section:

(1) All testimony and other evidence taken during such hearings shall be under oath and subject to the penalty of perjury;

(2) The committee may, upon a majority vote of the committee, subpoena witnesses, and compel the attendance of witnesses, the giving of testimony, and the production of records;

(3) All ex parte communications between members of the committee and any interested party or witness which are related to the subject matter of a hearing shall be prohibited at any time prior to, during, or after such hearing;

(4) The provisions of sections 105.452 to 105.458, regarding conflict of interest shall apply;

(5) In all hearings, there shall be a rebuttable presumption of the need for additional medical services and lower costs for such medical services in the affected region or community. Any party opposing the issuance of a certificate of need shall have the burden of proof to show by clear and convincing evidence that no such need exists or that the new facility will cause a substantial and continuing loss of medical services within the affected region or community;

(6) All hearings before the committee shall be governed by rules to be adopted and prescribed by the committee; except that, in all inquiries or hearings, the committee shall not be bound by the technical rules of evidence. No formality in any proceeding nor in the manner of taking testimony before the committee shall invalidate any decision made by the committee; and

(7) The committee shall have the authority, upon a majority vote of the committee, to assess the costs of court reporting transcription or the issuance of subpoenas to one or both of the parties to the proceedings.

197.710. 1. No hospital shall require a physician to agree to make referrals to that hospital or any hospital-affiliated facility as a

condition of receiving medical staff membership or medical staff privileges.

2. No hospital shall refuse to grant medical staff membership or privileges, condition or otherwise limit medical staff membership or privileges, or limit a physician's medical staff participation because the physician, or a partner, associate, employee, or family member of the physician, provides medical or health care services at, or has an ownership interest in, or occupies a leadership position on the medical staff of another hospital, hospital system, or health care facility.

3. No hospital or hospital system shall refuse to grant a physician, or a partner, associate, employee, or family member of the physician, participatory status in a hospital or hospital system health plan because the physician, or a partner, associate, employee, or family member of the physician, provides medical or health care services at, or has an ownership interest in, or occupies a leadership position on the medical staff of another hospital, hospital system, or health care facility.

4. No hospital shall refuse to grant a physician, or a partner, associate, employee, or family member of such physician, participatory status in a hospital or hospital system health plan because the physician, or a partner, associate, employee, or family member of the physician leases or offers for lease medical office, clinical, or other medical facility space in close proximity to or within the same geographic service area of such hospital.

5. The department of health and senior services may impose administration sanctions or otherwise sanction the license of a hospital in any case in which the department finds that there has been a substantial failure to comply with the requirements of this section.

208.010. 1. In determining the eligibility of a claimant for public assistance pursuant to this law, it shall be the duty of the family support division to consider and take into account all facts and circumstances surrounding the claimant, including his or her living conditions, earning capacity, income and resources, from whatever source received, and if from all the facts and circumstances the claimant is not found to be in need, assistance shall be denied. In determining the need of a claimant, the costs of providing medical treatment which may be furnished pursuant to sections 208.151 to 208.158 shall be disregarded. The amount of benefits, when added to all other income, resources,

support, and maintenance shall provide such persons with reasonable subsistence compatible with decency and health in accordance with the standards developed by the family support division; provided, when a husband and wife are living together, the combined income and resources of both shall be considered in determining the eligibility of either or both. "Living together" for the purpose of this chapter is defined as including a husband and wife separated for the purpose of obtaining medical care or nursing home care, except that the income of a husband or wife separated for such purpose shall be considered in determining the eligibility of his or her spouse, only to the extent that such income exceeds the amount necessary to meet the needs (as defined by rule or regulation of the division) of such husband or wife living separately. In determining the need of a claimant in federally aided programs there shall be disregarded such amounts per month of earned income in making such determination as shall be required for federal participation by the provisions of the federal Social Security Act (42 U.S.C.A. 301, et seq.), or any amendments thereto. When federal law or regulations require the exemption of other income or resources, the family support division may provide by rule or regulation the amount of income or resources to be disregarded.

2. Benefits shall not be payable to any claimant who:

(1) Has or whose spouse with whom he or she is living has, prior to July 1, 1989, given away or sold a resource within the time and in the manner specified in this subdivision. In determining the resources of an individual, unless prohibited by federal statutes or regulations, there shall be included (but subject to the exclusions pursuant to subdivisions (4) and (5) of this subsection, and subsection 5 of this section) any resource or interest therein owned by such individual or spouse within the twenty-four months preceding the initial investigation, or at any time during which benefits are being drawn, if such individual or spouse gave away or sold such resource or interest within such period of time at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits, including but not limited to benefits based on December, 1973, eligibility requirements, as follows:

(a) Any transaction described in this subdivision shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance pursuant to this chapter unless such individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose;

(b) The resource shall be considered in determining eligibility from the

date of the transfer for the number of months the uncompensated value of the disposed of resource is divisible by the average monthly grant paid or average Medicaid payment in the state at the time of the investigation to an individual or on his or her behalf under the program for which benefits are claimed, provided that:

a. When the uncompensated value is twelve thousand dollars or less, the resource shall not be used in determining eligibility for more than twenty-four months; or

b. When the uncompensated value exceeds twelve thousand dollars, the resource shall not be used in determining eligibility for more than sixty months;

(2) The provisions of subdivision (1) of this subsection shall not apply to a transfer, other than a transfer to claimant's spouse, made prior to March 26, 1981, when the claimant furnishes convincing evidence that the uncompensated value of the disposed of resource or any part thereof is no longer possessed or owned by the person to whom the resource was transferred;

(3) Has received, or whose spouse with whom he or she is living has received, benefits to which he or she was not entitled through misrepresentation or nondisclosure of material facts or failure to report any change in status or correct information with respect to property or income as required by section 208.210. A claimant ineligible pursuant to this subsection shall be ineligible for such period of time from the date of discovery as the family support division may deem proper; or in the case of overpayment of benefits, future benefits may be decreased, suspended or entirely withdrawn for such period of time as the division may deem proper;

(4) Owns or possesses resources in the sum of **[**one**]** **two** thousand dollars or more; provided, however, that if such person is married and living with spouse, he or she, or they, individually or jointly, may own resources not to exceed **[**two**]** **four** thousand dollars; and provided further, that in the case of a temporary assistance for needy families claimant, the provision of this subsection shall not apply;

(5) Prior to October 1, 1989, owns or possesses property of any kind or character, excluding amounts placed in an irrevocable prearranged funeral or burial contract under chapter 436, or has an interest in property, of which he or she is the record or beneficial owner, the value of such property, as determined by the family support division, less encumbrances of record, exceeds twenty-nine thousand dollars, or if married and actually living together with husband or wife,

if the value of his or her property, or the value of his or her interest in property, together with that of such husband and wife, exceeds such amount;

(6) In the case of temporary assistance for needy families, if the parent, stepparent, and child or children in the home owns or possesses property of any kind or character, or has an interest in property for which he or she is a record or beneficial owner, the value of such property, as determined by the family support division and as allowed by federal law or regulation, less encumbrances of record, exceeds **[**one**] two** thousand dollars, excluding the home occupied by the claimant, amounts placed in an irrevocable prearranged funeral or burial contract under chapter 436, one automobile which shall not exceed a value set forth by federal law or regulation and for a period not to exceed six months, such other real property which the family is making a good-faith effort to sell, if the family agrees in writing with the family support division to sell such property and from the net proceeds of the sale repay the amount of assistance received during such period. If the property has not been sold within six months, or if eligibility terminates for any other reason, the entire amount of assistance paid during such period shall be a debt due the state;

(7) Is an inmate of a public institution, except as a patient in a public medical institution.

3. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the income and resources of a relative or other person living in the home shall be taken into account to the extent the income, resources, support and maintenance are allowed by federal law or regulation to be considered.

4. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the value of burial lots or any amounts placed in an irrevocable prearranged funeral or burial contract under chapter 436 shall not be taken into account or considered an asset of the burial lot owner or the beneficiary of an irrevocable prearranged funeral or funeral contract. For purposes of this section, "burial lots" means any burial space as defined in section 214.270 and any memorial, monument, marker, tombstone or letter marking a burial space. If the beneficiary, as defined in chapter 436, of an irrevocable prearranged funeral or burial contract receives any public assistance benefits pursuant to this chapter and if the purchaser of such contract or his or her successors in interest transfer, amend, or take any other such actions regarding the contract so that any person will be entitled to a refund, such refund shall be

paid to the state of Missouri with any amount in excess of the public assistance benefits provided under this chapter to be refunded by the state of Missouri to the purchaser or his or her successors. In determining eligibility and the amount of benefits to be granted under federally aided programs, the value of any life insurance policy where a seller or provider is made the beneficiary or where the life insurance policy is assigned to a seller or provider, either being in consideration for an irrevocable prearranged funeral contract under chapter 436, shall not be taken into account or considered an asset of the beneficiary of the irrevocable prearranged funeral contract. In addition, the value of any funds, up to nine thousand nine hundred ninety-nine dollars, placed into an irrevocable personal funeral trust account, where the trustee of the irrevocable personal funeral trust account is a state or federally chartered financial institution authorized to exercise trust powers in the state of Missouri, shall not be taken into account or considered an asset of the person whose funds are so deposited if such funds are restricted to be used only for the burial, funeral, preparation of the body, or other final disposition of the person whose funds were deposited into said personal funeral trust account. No person or entity shall charge more than ten percent of the total amount deposited into a personal funeral trust in order to create or set up said personal funeral trust, and any fees charged for the maintenance of such a personal funeral trust shall not exceed three percent of the trust assets annually. Trustees may commingle funds from two or more such personal funeral trust accounts so long as accurate books and records are kept as to the value, deposits, and disbursements of each individual depositor's funds and trustees are to use the prudent investor standard as to the investment of any funds placed into a personal funeral trust. If the person whose funds are deposited into the personal funeral trust account receives any public assistance benefits pursuant to this chapter and any funds in the personal funeral trust account are, for any reason, not spent on the burial, funeral, preparation of the body, or other final disposition of the person whose funds were deposited into the trust account, such funds shall be paid to the state of Missouri with any amount in excess of the public assistance benefits provided under this chapter to be refunded by the state of Missouri to the person who received public assistance benefits or his or her successors. No contract with any cemetery, funeral establishment, or any provider or seller shall be required in regards to funds placed into a personal funeral trust account as set out in this subsection.

5. In determining the total property owned pursuant to subdivision (5) of

subsection 2 of this section, or resources, of any person claiming or for whom public assistance is claimed, there shall be disregarded any life insurance policy, or prearranged funeral or burial contract, or any two or more policies or contracts, or any combination of policies and contracts, which provides for the payment of one thousand five hundred dollars or less upon the death of any of the following:

(1) A claimant or person for whom benefits are claimed; or

(2) The spouse of a claimant or person for whom benefits are claimed with whom he or she is living.

If the value of such policies exceeds one thousand five hundred dollars, then the total value of such policies may be considered in determining resources; except that, in the case of temporary assistance for needy families, there shall be disregarded any prearranged funeral or burial contract, or any two or more contracts, which provides for the payment of one thousand five hundred dollars or less per family member.

6. Beginning September 30, 1989, when determining the eligibility of institutionalized spouses, as defined in 42 U.S.C. Section 1396r-5, for medical assistance benefits as provided for in section 208.151 and 42 U.S.C. Sections 1396a, et seq., the family support division shall comply with the provisions of the federal statutes and regulations. As necessary, the division shall by rule or regulation implement the federal law and regulations which shall include but not be limited to the establishment of income and resource standards and limitations. The division shall require:

(1) That at the beginning of a period of continuous institutionalization that is expected to last for thirty days or more, the institutionalized spouse, or the community spouse, may request an assessment by the family support division of total countable resources owned by either or both spouses;

(2) That the assessed resources of the institutionalized spouse and the community spouse may be allocated so that each receives an equal share;

(3) That upon an initial eligibility determination, if the community spouse's share does not equal at least twelve thousand dollars, the institutionalized spouse may transfer to the community spouse a resource allowance to increase the community spouse's share to twelve thousand dollars;

(4) That in the determination of initial eligibility of the institutionalized spouse, no resources attributed to the community spouse shall be used in determining the eligibility of the institutionalized spouse, except to the extent

that the resources attributed to the community spouse do exceed the community spouse's resource allowance as defined in 42 U.S.C. Section 1396r-5;

(5) That beginning in January, 1990, the amount specified in subdivision (3) of this subsection shall be increased by the percentage increase in the Consumer Price Index for All Urban Consumers between September, 1988, and the September before the calendar year involved; and

(6) That beginning the month after initial eligibility for the institutionalized spouse is determined, the resources of the community spouse shall not be considered available to the institutionalized spouse during that continuous period of institutionalization.

7. Beginning July 1, 1989, institutionalized individuals shall be ineligible for the periods required and for the reasons specified in 42 U.S.C. Section 1396p.

8. The hearings required by 42 U.S.C. Section 1396r-5 shall be conducted pursuant to the provisions of section 208.080.

9. Beginning October 1, 1989, when determining eligibility for assistance pursuant to this chapter there shall be disregarded unless otherwise provided by federal or state statutes the home of the applicant or recipient when the home is providing shelter to the applicant or recipient, or his or her spouse or dependent child. The family support division shall establish by rule or regulation in conformance with applicable federal statutes and regulations a definition of the home and when the home shall be considered a resource that shall be considered in determining eligibility.

10. Reimbursement for services provided by an enrolled Medicaid provider to a recipient who is duly entitled to Title XIX Medicaid and Title XVIII Medicare Part B, Supplementary Medical Insurance (SMI) shall include payment in full of deductible and coinsurance amounts as determined due pursuant to the applicable provisions of federal regulations pertaining to Title XVIII Medicare Part B, except for hospital outpatient services or the applicable Title XIX cost sharing.

11. A "community spouse" is defined as being the noninstitutionalized spouse.

12. An institutionalized spouse applying for Medicaid and having a spouse living in the community shall be required, to the maximum extent permitted by law, to divert income to such community spouse to raise the community spouse's income to the level of the minimum monthly needs allowance, as described in 42 U.S.C. Section 1396r-5. Such diversion of income shall occur before the

community spouse is allowed to retain assets in excess of the community spouse protected amount described in 42 U.S.C. Section 1396r-5.

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

(1) "Department", the Missouri department of social services;

(2) "Prepaid capitated", a mode of payment by which the department periodically reimburse a contracted health provider plan or primary care physician sponsor for delivering health care services for the duration of a contract to a maximum specified number of members based on a fixed rate per member, notwithstanding:

(a) The actual number of members who receive care from the provider; or

(b) The amount of health care services provided to any members;

(3) "Primary care case-management", a mode of payment by which the department reimburses a contracted primary care physician sponsor on a fee-for-service schedule plus a monthly fee to manage each recipient's case;

(4) "Primary care physician sponsor", a physician licensed pursuant to chapter 334 who is a family practitioner, general practitioner, pediatrician, general internist or an obstetrician or gynecologist;

(5) "Specialty physician services arrangement", an arrangement where the department may restrict recipients of specialty services to designated providers of such services, even in the absence of a primary care case-management system.

2. The department or its designated division shall maximize the use of prepaid health plans, where appropriate, and other alternative service delivery and reimbursement methodologies, including, but not limited to, individual primary care physician sponsors or specialty physician services arrangements, designed to facilitate the cost-effective purchase of comprehensive health care.

3. In order to provide comprehensive health care, the department or its designated division shall have authority to:

(1) Purchase medical services for recipients of public assistance from prepaid health plans, health maintenance organizations, health insuring organizations, preferred provider organizations, individual practice associations, local health units, community health centers, or primary care physician sponsors;

(2) Reimburse those health care plans or primary care physicians' sponsors who enter into direct contract with the department on a prepaid capitated or primary care case-management basis on the following conditions:

(a) That the department or its designated division shall ensure, whenever possible and consistent with quality of care and cost factors, that publicly

supported neighborhood and community-supported health clinics shall be utilized as providers;

(b) That the department or its designated division shall ensure reasonable access to medical services in geographic areas where managed or coordinated care programs are initiated; and

(c) That the department shall ensure full freedom of choice for prescription drugs at any Medicaid participating pharmacy;

(3) Limit providers of medical assistance benefits to those who demonstrate efficient and economic service delivery for the level of service they deliver, and provided that such limitation shall not limit recipients from reasonable access to such levels of service;

(4) Provide recipients of public assistance with alternative services as provided for in state law, subject to appropriation by the general assembly;

(5) Designate providers of medical assistance benefits to assure specifically defined medical assistance benefits at a reduced cost to the state, to assure reasonable access to all levels of health services and to assure maximization of federal financial participation in the delivery of health related services to Missouri citizens; provided, all qualified providers that deliver such specifically defined services shall be afforded an opportunity to compete to meet reasonable state criteria and to be so designated;

(6) Upon mutual agreement with any entity of local government, to elect to use local government funds as the matching share for Title XIX payments, as allowed by federal law or regulation;

(7) To elect not to offset local government contributions from the allowable costs under the Title XIX program, unless prohibited by federal law and regulation.

4. Nothing in this section shall be construed to authorize the department or its designated division to limit the recipient's freedom of selection among health care plans or primary care physician sponsors, as authorized in this section, who have entered into contract with the department or its designated division to provide a comprehensive range of health care services on a prepaid capitated or primary care case-management basis, except in those instances of overutilization of Medicaid services by the recipient.

5. The provisions of this section shall expire upon the statewide implementation of the MO HealthNet benefits delivery system established under section 208.187.

208.187. 1. This section shall be known and may be cited as the "MO HealthNet Patient-centered Care Act of 2014".

2. Beginning July 1, 2015, or upon termination of any current contracted health plans in the pilot project areas and subject to receipt of any necessary state plan amendments or waivers from the federal Department of Health and Human Services, the MO HealthNet division shall establish a pilot project which transfers current MO HealthNet recipients in the pilot project areas to an approved health plan arrangement as defined in this section, wherein recipients may purchase health services through individual health savings accounts.

3. As used in this section, the following terms shall mean:

(1) "Approved health plan arrangement", a MO HealthNet benefit arrangement, approved by the division and funded in accordance with this section, which is composed of individual health savings accounts from which a recipient purchases a high deductible health insurance plan and health care services provided by the following providers who shall be considered qualified providers by the division:

(a) An osteopathic (D.O.) or allopathic (M.D.) physician licensed in this state; or

(b) A physician assistant, advanced practice registered nurse, or assistant physician licensed in this state working under a collaborative practice arrangement with a physician licensed in this state;

(c) A health care provider licensed in this state to whom the patient is refereed by a physician licensed in this state as described in this section; or

(d) A dentist for eligible dental services under section 208.152. Such arrangement shall include a requirement that all costs for health care services described in this subdivision and incurred by a policyholder shall be considered a qualified medical expense for purposes of the deductible and any maximum out-of-pocket medical expense limits under a high-deductible health plan;

(2) "Division", the MO HealthNet division within the department of social services;

(3) "Fund", the MO HealthNet health savings account trust fund created under subsection 10 of this section;

(4) "Health information exchange" or "HIE", the electronic movement of health-related information among organizations in

accordance with nationally recognized standards, with the goal of facilitating access to and retrieval of clinical data to provide safer, timelier, efficient, effective, equitable, patient-centered care;

(5) "HIPAA", the federal Health Insurance Portability and Accountability Act;

(6) "MO HealthNet", the medical assistance program on behalf of needy persons, Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301, et seq. and administered by the department of social services.

4. The MO HealthNet division shall seek any necessary state plan amendments and waivers from the federal Department of Health and Human Services necessary to implement the provisions of this section. If such necessary amendments or waivers are not granted by the federal Department of Health and Human Services, the division shall not be required to implement the provisions of this section.

5. (1) The pilot project shall be supported by a health management and population analytics system that tracks and monitors health outcomes in traditionally challenging populations, such as mothers at risk for premature births, frequent utilizers of emergency departments, and those suffering from chronic pain conditions. The system shall implement clinically based predictive models and interventions to improve the care coordination for the targeted populations within the pilot area.

(2) The MO HealthNet division shall contract for a system that shall:

(a) Support an interoperable data analytics platform for analyzing clinical data for defined populations, such as mothers at risk of premature birth, frequent utilizers of emergency departments, and those suffering from chronic pain conditions. The system shall be able to leverage cloud-based technology and be hosted remotely by the vendor of the application services system with interoperability capabilities to connect with disparate systems;

(b) Have the ability to interoperate using accepted industry standards, collect and aggregate data from disparate systems, and include but not be limited to clinical data, electronic medical records, claims and eligibility databases, state-managed registries and health information exchanges;

(c) Provide a member portal to beneficiaries to view and manage their personal health information, wellness plans, and overall health, and a HIPAA-compliant provider portal that allows providers with access to patient information;

(d) Allow for real-time patient queries and present clinical information to providers for the purpose of avoiding duplicate tests and improving care coordination;

(e) Have the ability to create condition specific registries for managing populations and provide predictive modeling or alerting functionality which alerts providers of at-risk patients and is able to communicate between various systems to provide electronic medical record (EMR) workflow integration or similar tools to communicate with a health care provider's workflow; and

(f) Operate on a statewide, regional, or community-wide basis.

(3) The coverage area of the system shall comprise the pilot project area and any MO HealthNet recipient participating in the pilot project shall reside in the designated pilot project area.

(4) All MO HealthNet providers providing services to MO HealthNet recipients in the designated pilot project area shall be required to participate in the system described in this subsection for their MO HealthNet recipient patients.

(5) All firearms-related data fields contained in any system shall be redacted or otherwise made inaccessible to system users for all MO HealthNet participants in the pilot project.

6. (1) Under the pilot project, the eligible government assistance amount shall be determined annually based on a survey of the commercial health market in this state and establishing the average cost of an approved health plan arrangement which is composed of direct primary care services and a high-deductible insurance plan. Such average cost shall be the government assistance amount.

(2) Transfer savings is an amount equal to the current cost of MO HealthNet benefits for all MO HealthNet enrollees in the pilot project areas minus the average government assistance amount multiplied by the number of enrollees in the pilot project.

7. (1) A portion of the transfer savings described in subsection 6 of this section shall be deposited in the MO HealthNet health savings account trust fund created under subsection 9 of this section in an

amount not to exceed the amount necessary to pay the lesser of gap insurance or the average deductible under a high-deductible health insurance plan component of an approved health plan arrangement described in this section until an individual's health savings account balance is determined actuarially sufficient to cover the deductible of such high-deductible health insurance plan without moneys from the trust fund.

(2) In addition to the amounts deposited under subdivision (1) of this subsection, the division shall seek additional moneys from any sources which may be available for funding gap insurance and deductibles described in subdivision (1) of this subsection, including but not limited to moneys available through public or private health foundations and organizations, other nonprofit entities, and any federal or other governmental funding programs. The division shall also seek technical assistance from foundations and other nongovernmental resources to search and apply for available grant and funding opportunities.

8. For the purpose of maximizing available coverage choices for recipients, the division shall approve any health plan arrangement that meets all of the following requirements:

(1) Any insurance plan component is offered by a health insurer issuer as described in 42 U.S.C. Section 18021(a)(1)(C);

(2) The arrangement offers access to quality health care by providing coverage under a package of benefits that is at least equal to coverage required for a catastrophic plan under 42 U.S.C. Section 18022(e); except that, the age restriction for such catastrophic plan shall not apply. When making its determination under this section, the division shall consider the availability of all of the following in the benefits package:

(a) Benefits under a high-deductible health insurance option;

(b) Direct primary care services option;

(c) Fee-for-service option; and

(d) Any combination of the options described in paragraphs (a) to (c) of this subdivision.

9. (1) There is hereby created in the state treasury the "MO HealthNet Health Savings Account Trust Fund", which shall consist of moneys deposited in accordance with this section and other moneys

received from any source for deposit into the fund. 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, money in the fund shall be used solely for the administration of 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.

10. If a state medical assistance program, including but not limited to the pilot project established under this section, is amended to provide that recipients of such program are transferred and enrolled in a health care delivery system that include a health savings account component and moneys saved from such transfer is deposited into the MO HealthNet health savings account trust fund, the division shall expend the amount of money deposited into the fund for the benefit of such recipients to pay any deductibles under high-deductible health insurance plan components of an approved health plan arrangement as triggered by the health care services needed by the recipients. The division shall continue to pay the deductibles for such recipients until such time as each recipient's individual health savings account balance is determined by the division to be actuarially sufficient to cover his or her deductibles.

11. The division shall prepare and submit the following reports to the governor and general assembly:

(1) Beginning with the first calendar quarter of the pilot project, a report detailing the number of participants, amount of government assistance, transfer savings, grant moneys, and all other moneys allocated to the pilot project, provider participation, any information relating to recipient usage, and any data analysis under subsection 5 of this section. Such reports shall be submitted until termination of the pilot project;

(2) Beginning September 1, 2016, and no later than September first of each subsequent year, an annual report specifically detailing the demographics, provider participation, recipient participation, costs

of the pilot project, any data analysis under subsection 5 of this section, and recommendations of the division regarding the feasibility of statewide implementation. Such report shall also include any additional information the division deems relevant.

12. Except as authorized under the MO HealthNet program, the disclosure of any information provided to or obtained by a provider, business, or vendor under the pilot project within the MO HealthNet program as established in this section is prohibited. Such provider, business, or vendor shall not use or sell such information and shall not divulge the information without a court order. Violation of this subsection is a class A misdemeanor.

13. The MO HealthNet division shall promulgate rules necessary to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

14. Beginning July 1, 2017, unless the provisions of this section are repealed by an act of the general assembly, the pilot project described in this section shall automatically be implemented on a statewide basis for all MO HealthNet recipients who are eligible to receive MO HealthNet benefits under this section in accordance with federal law and state plan amendments and waivers.

208.188. 1. Beginning July 1, 2015, subject to appropriations and subject to receipt of waivers from the Department of Health and Human Services, the MO HealthNet division shall establish a pilot project which implements a electronic benefit transfer (EBT) payment system for receipt of MO HealthNet services by participating recipients. The provisions of this section shall not apply to aged, blind, and disabled recipients. Such system shall:

(1) Allow participating recipients to receive MO HealthNet services from providers selected by the recipients through direct pay

to the provider, a health insurance plan, managed care plan, health services plan, or any other available health care product providing benefits and payment for services in an approved health plan arrangement;

(2) Require the use of electronic benefit transfer (EBT) cards issued to participating recipients to pay for MO HealthNet services;

(3) Require recipients to receive an annual examination within six months of enrollment;

(4) Provide educational opportunities for recipients relating to budgeting, planning, and appropriate use of health care options;

(5) Provide incentives for recipients to seek health care services as needed, while retaining a portion of any savings achieved from efficient use of their EBT cards;

(6) Provide additional moneys to recipients for health savings accounts, payment of health insurance premiums, and other health-related costs to recipients not covered under the MO HealthNet program;

(7) Provide reimbursement of any willing providers licensed in this state and eligible to provide services under the terms of the pilot project at a rate of one hundred percent of the Medicare reimbursement rate for the same or similar services provided; and

(8) Provide demographic and cost efficiency information to determine feasibility of statewide implementation of the EBT payment system.

2. The department of social services shall seek all waivers from the Department of Health and Human Services necessary to implement the provisions of this section. If such waivers are not granted by the Department of Health and Human Services, the department shall not be required to implement the provisions of this section.

3. (1) The MO HealthNet division shall establish a minimum of three, but not more than six, pilot project areas in this state which shall include at least ten percent of the total MO HealthNet recipient population, excluding the aged, blind, and disabled population, in the first two years of the pilot project. In the third year of the pilot project, the division may increase the total number of pilot project areas to not more than ten and shall increase the number of participants to at least twenty percent of the total MO HealthNet

recipient population, excluding the aged, blind, and disabled population. If the pilot project is automatically implemented on a statewide basis in accordance with subsection 14 of this section, the EBT payment system shall apply to every MO HealthNet recipient, excluding the aged, blind, and disabled population. To ensure an accurate sampling of MO HealthNet recipients, the demographics of the pilot project population shall reflect, to the extent practicable within the geographic area served by the system described in subsection 5 of section 208.187, the current percentages of recipients in the MO HealthNet program population regarding age, gender, socioeconomic status, healthy versus chronically ill populations, urban versus rural populations, and other relevant demographics as determined by the division. Nothing in this subsection shall be construed as requiring the division to obtain the exact and precise demographics of the current MO HealthNet recipient population in the pilot project or to include or exclude recipients based solely on the pilot project demographic requirements contained in this subsection.

(2) The division shall compile and include a summary of the demographic information for the pilot project and the current MO HealthNet program in the reports required under subsection 9 of this section.

4. The division shall permit MO HealthNet recipients in the pilot project areas to volunteer to participate in the pilot project. In order to obtain the necessary demographics of the pilot project, the division may require all or a portion of recipients in a pilot project area to participate.

5. Any willing provider eligible to provide services under the terms of the pilot project shall be reimbursed for services provided to pilot project recipients at a rate of one hundred percent of the Medicare reimbursement rate for the same or similar services provided. Physicians participating in the pilot project shall have moneys available from the legal expense fund under section 105.711 for payment of any claim or final judgment rendered against such physician for service provided under the pilot program.

6. (1) Pilot project recipients shall receive a prepaid EBT card to pay for MO HealthNet services received, whether through direct pay to the provider, a health insurance plan, managed care plan, health

services plan, health savings account, or any other available health care product providing benefits and payment for services approved by the division. The division shall determine the amount credited to such EBT card for each recipient on a risk adjusted basis and for currently enrolled recipients on historical usage of benefits based on an assessment of the estimated health care costs for services required and the method selected for delivery of such services. For current MO HealthNet recipients, the division shall determine such amount based on prior history of health care usage of recipients. For new MO HealthNet recipients, the division shall determine such amount based on available information obtained in the application process regarding medical history, lifestyle choices, age, preexisting conditions, and other relevant factors as determined by the division by rule.

(2) Participating recipients shall be permitted to designate a third party to act on behalf of the participating recipient in case of incapacity, incompetence, or other physical or mental condition as determined by rule of the division which necessitates a designee to act on behalf of the participating recipient. If no designee is selected by a participating recipient, the division shall act on behalf of the participating recipient.

7. Providers in the MO HealthNet pilot project shall be required to swipe a recipient's EBT card for every visit or service received, regardless of the balance on the recipient's EBT card. Subject to any federal and state laws, the division shall maintain a record of every visit or service received by a recipient, regardless of whether payment was obtained from a recipient's EBT card. Participating recipients shall be required to permit, and if required sign a waiver for, disclosure of the information required in this subsection to the division. Nothing in this subsection shall be construed as requiring the division to maintain specific medical records of recipients. The disclosure required under this section shall be limited to name of the provider, date, and general nature of the visit or service.

8. Any remaining balance on a recipient's EBT card at the end of the benefit year shall be apportioned as follows:

(1) To the recipient:

(a) For a recipient who does not receive the mandatory health services under subdivision (3) of subsection 1 of this section, no

apportionment to the recipient of the remaining amount and the remaining balance shall revert to the division in accordance with subdivision (2) of this subsection;

(b) For a recipient who receives the mandatory health services under subdivision (3) of subsection 1 of this section, the recipient shall receive any remaining EBT card balance not to exceed twenty-five percent of the total amount credited to the EBT card at the beginning of the benefit year;

(c) Any remaining balance apportioned to a recipient shall only be carried over to the following benefit year or credited as a benefit under another public assistance program for which the recipient is eligible, including but not limited to temporary assistance for needy families (TANF), women, infants and children (WIC), early periodic screening diagnosis and treatment (EPSDT), supplemental nutrition assistance program (SNAP), supplemental security income (SSI), child care subsidies, and other public assistance programs as determined by the division;

(2) Any balance not apportioned to the recipient under subdivision (1) of this subsection shall revert to the division. The division shall apportion any amounts reverting to the division as follows:

(a) Any reverted amounts which, in the aggregate, total twenty-five percent or less of the total amounts credited on all EBT cards under the pilot project shall be deposited in the MO HealthNet EBT payment system fund created under subsection 12 of this section;

(b) All remaining reverted amounts shall be used in the MO HealthNet program for recipients not participating in the pilot project. The division shall reassess the amount of MO HealthNet moneys allocated for the pilot project based on the amounts reverting to the division under this subsection.

9. The division shall prepare and submit the following reports to the governor and general assembly:

(1) Beginning with the first calendar quarter of the pilot project, a report detailing the number of participants, amount of MO HealthNet moneys allocated to the pilot project, provider participation, and any information relating to recipient usage. Such reports shall be submitted until termination of the pilot project;

(2) No later than September first of each year, an annual report specifically detailing the demographics, provider participation, recipient participation, costs of the pilot project, and recommendations of the division regarding the feasibility of statewide implementation. Such report shall also include any additional information the division deems relevant.

10. Except as authorized under the MO HealthNet program, the disclosure of any information provided to or obtained by a provider, business, or vendor under the pilot project within the MO HealthNet program as established in this section is prohibited. Such provider, business, or vendor shall not use or sell such information and shall not divulge the information without a court order. Violation of this subsection is a class A misdemeanor.

11. The MO HealthNet division shall promulgate rules necessary to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

12. (1) There is hereby created in the state treasury the "MO HealthNet EBT Payment System Fund", which shall consist of moneys reverting to the division under paragraph (a) of subdivision (2) of subsection 8 of this section and any moneys received under subsection 13 of this section. 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, money in the fund shall be used to provide pilot project MO HealthNet recipients with:

(a) Additional benefits for health services costs incurred by recipients due to unanticipated health conditions not covered by the catastrophic plan, such as a diagnosis of cancer or other serious medical condition, heart attack, or stroke. The department shall by

rule determine the unanticipated health conditions which are eligible for fund expenditures; and

(b) Additional assistance for health savings accounts, health insurance premiums, and other health-related costs not covered under the MO HealthNet program.

(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.

13. The division shall seek additional moneys from sources, including but not limited to foundations, corporations, and federal and other governmental funding programs. The division shall also seek technical assistance from foundations and other nongovernmental resources to search and apply for available grant and funding opportunities.

14. Beginning July 1, 2018, unless the provisions of this section are repealed by an act of the general assembly, the pilot project described in this section shall automatically be implemented on a statewide basis for all MO HealthNet recipients.

15. For purposes of this section, the pilot project established and implemented under this section includes the EBT payment system implemented from July 1, 2015, to June 30, 2018, and the EBT payment system automatically implemented on a statewide basis under subsection 14 of this section on and after July 1, 2018.

208.325. 1. Beginning October 1, 1994, the department of social services shall enroll AFDC recipients in the self-sufficiency program established by this section. The department may target AFDC households which meet at least one of the following criteria:

(1) Received AFDC benefits in at least eighteen out of the last thirty-six months; or

(2) Are parents under twenty-four years of age without a high school diploma or a high school equivalency certificate and have a limited work history; or

(3) Whose youngest child is sixteen years of age, or older; or

(4) Are currently eligible to receive benefits pursuant to section 208.041,

an assistance program for unemployed married parents.

2. The department shall, subject to appropriation, enroll in self-sufficiency pacts by July 1, 1996, the following AFDC households:

(1) Not fewer than fifteen percent of AFDC households who are required to participate in the FUTURES program under sections 208.405 and 208.410, and who are currently participating in the FUTURES program;

(2) Not fewer than five percent of AFDC households who are required to participate in the FUTURES program under sections 208.405 and 208.410, but who are currently not participating in the FUTURES program; and

(3) By October 1, 1997, not fewer than twenty-five percent of aid to families with dependent children recipients, excluding recipients who meet the following criteria and are exempt from mandatory participation in the family self-sufficiency program:

(a) Disabled individuals who meet the criteria for coverage under the federal Americans with Disabilities Act, P.L. 101-336, and are assessed as lacking the capacity to engage in full-time or part-time subsidized employment;

(b) Parents who are exclusively responsible for the full-time care of disabled children; and

(c) Other families excluded from mandatory participation in FUTURES by federal guidelines.

3. Upon enrollment in the family self-sufficiency program, a household shall receive an initial assessment of the family's educational, child care, employment, medical and other supportive needs. There shall also be assessment of the recipient's skills, education and work experience and a review of other relevant circumstances. Each assessment shall be completed in consultation with the recipient and, if appropriate, each child whose needs are being assessed.

4. Family assessments shall be used to complete a family self-sufficiency pact in negotiation with the family. The family self-sufficiency pact shall identify a specific point in time, no longer than twenty-four months after the family enrolls in the self-sufficiency pact, when the family's primary self-sufficiency pact shall conclude. The self-sufficiency pact is subject to reassessment and may be extended for up to an additional twenty-four months, but the maximum term of any self-sufficiency pact shall not exceed a total of forty-eight months. Family self-sufficiency pacts should be completed and entered into within three months of the initial assessment.

5. The division of family services shall complete family self-sufficiency

pact assessments and/or may contract with other agencies for this purpose, subject to appropriation.

6. Family self-sufficiency assessments shall be used to develop a family self-sufficiency pact after a meeting. The meeting participants shall include:

(1) A representative of the division of family services, who may be a case manager or other specially designated, trained and qualified person authorized to negotiate the family self-sufficiency pact and follow-up with the family and responsible state agencies to ensure that the self-sufficiency pact is reviewed at least annually and, if necessary, revised as further assessments, experience, circumstances and resources require;

(2) The recipient and, if appropriate, another family member, assessment personnel or an individual interested in the family's welfare.

7. The family self-sufficiency pact shall:

(1) Be in writing and establish mutual state and family member obligations as part of a plan containing goals, objectives and timelines tailored to the needs of the family and leading to self-sufficiency;

(2) Identify available support services such as subsidized child care, medical services and transportation benefits during a transition period, to help ensure that the family will be less likely to return to public assistance.

8. The family self-sufficiency pact shall include a parent and child development plan to develop the skills and knowledge of adults in their role as parents to their children and partners of their spouses. Such plan shall include school participation records. The department of social services shall, in cooperation with the department of health and senior services, the department of mental health, and the "Parents as Teachers" program in the department of elementary and secondary education, develop or make available existing programs to be presented to persons enrolled in a family self-sufficiency pact.

9. A family enrolled in a family self-sufficiency pact may own or possess property as described in subdivision (6) of subsection 2 of section 208.010 with a value of five thousand dollars instead of the **[**one**]** **two** thousand dollars as set forth in subdivision (6) of subsection 2 of section 208.010.

10. A family receiving AFDC may own one automobile, which shall not be subject to property value limitations provided in section 208.010.

11. Subject to appropriations and necessary waivers, the department of social services may disregard from one-half to two-thirds of a recipient's gross earned income for job-related and other expenses necessary for a family to make

the transition to self-sufficiency.

12. A recipient may request a review by the director of the division of family services, or his designee, of the family self-sufficiency pact or any of its provisions that the recipient objects to because it is inappropriate. After receiving an informal review, a recipient who is still aggrieved may appeal the results of that review under the procedures in section 208.080.

13. The term of the family self-sufficiency pact may only be extended due to circumstances creating barriers to self-sufficiency and the family self-sufficiency pact may be updated and adjusted to identify and address the removal of these barriers to self-sufficiency.

14. Where the capacity of services does not meet the demand for the services, limited services may be substituted and the pact completion date extended until the necessary services become available for the participant. The pact shall be modified appropriately if the services are not delivered as a result of waiting lists or other delays.

15. The division of family services shall establish a training program for self-sufficiency pact case managers which shall include but not be limited to:

(1) Knowledge of public and private programs available to assist recipients to achieve self-sufficiency;

(2) Skills in facilitating recipient access to public and private programs; and

(3) Skills in motivating and in observing, listening and communicating.

16. The division of family services shall ensure that families enrolled in the family self-sufficiency program make full use of the federal earned income tax credit.

17. Failure to comply with any of the provisions of a self-sufficiency pact developed pursuant to this section shall result in a recalculation of the AFDC cash grant for the household without considering the needs of the caretaker recipient.

18. If a suspension of caretaker benefits is imposed, the recipient shall have the right to a review by the director of the division of family services or his designee.

19. After completing the family self-sufficiency program, should a recipient who has previously received thirty-six months of aid to families with dependent children benefits again become eligible for aid to families with dependent children benefits, the cash grant amount shall be calculated without

considering the needs of caretaker recipients. The limitations of this subsection shall not apply to any applicant who starts a self-sufficiency pact on or before July 1, 1997, or to any applicant who has become disabled or is receiving or has received unemployment benefits since completion of a self-sufficiency program.

20. There shall be conducted a comprehensive evaluation of the family self-sufficiency program contained in the provisions of this act and the job opportunities and basic skills training program ("JOBS" or "FUTURES") as authorized by the provisions of sections 208.400 to 208.425. The evaluation shall be conducted by a competitively chosen independent and impartial contractor selected by the commissioner of the office of administration. The evaluation shall be based on specific, measurable data relating to those who participate successfully and unsuccessfully in these programs and a control group, factors which contributed to such success or failures, the structure of such programs and other areas. The evaluation shall include recommendations on whether such programs should be continued and suggested improvements in such programs. The first such evaluation shall be completed and reported to the governor and the general assembly by September 1, 1997. Future evaluations shall be completed every three years thereafter. In addition, in 1997, and every three years thereafter, the oversight division of the committee on legislative research shall complete an evaluation on general relief, child care and development block grants and social services block grants.

21. The director of the department of social services may promulgate rules and regulations, pursuant to section 660.017, and chapter 536 governing the use of family self-sufficiency pacts in this program and in other programs, including programs for noncustodial parents of children receiving assistance.

22. The director of the department of social services shall apply to the United States Secretary of Health and Human Services for all waivers of requirements under federal law necessary to implement the provisions of this section with full federal participation. The provisions of this section shall be implemented, subject to appropriation, as waivers necessary to ensure continued federal participation are received.

208.440. 1. By December 31, 2014, and updated once per-calendar quarter, each MO HealthNet managed care organization, as defined in section 208.431, shall provide to the MO HealthNet division all utilization, access, and spending data for the cost of care to each MO HealthNet participant covered under the organization. Such data shall:

(1) Be in the form of all payments made to health care providers, as defined in section 376.1350, for services rendered to MO HealthNet participants;

(2) Identify claim-specific data for each patient service or procedure; and

(3) Include any other information the MO HealthNet division may require by rule to meet the requirements of this section.

2. The department of social services shall promulgate rules to develop and implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

334.035. **Except as otherwise provided in section 334.036,** every applicant for a permanent license as a physician and surgeon shall provide the board with satisfactory evidence of having successfully completed such postgraduate training in hospitals or medical or osteopathic colleges as the board may prescribe by rule.

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

(1) "Assistant physician", any medical school graduate who:

(a) Is a resident and citizen of the United States or is a legal resident alien;

(b) Has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination or the equivalent of such steps of any other board-approved medical licensing examination within the eighteen-month period immediately preceding application for licensure as an assistant physician; and

(c) Has not entered into postgraduate residency training prescribed by rule of the board under section 334.035;

(d) Has proficiency in the English language;

(2) "Assistant physician collaborative practice arrangement", an

agreement between a physician and an assistant physician which meets the requirements of this section and section 334.104;

(3) "Medical school graduate", any person who has graduated from a medical college or osteopathic medical college described in section 334.031.

2. (1) An assistant physician collaborative practice arrangement shall limit the assistant physician to providing only primary care services and only in medically underserved rural or urban areas of this state.

(2) For a physician-assistant physician team working in a rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended:

(a) An assistant physician shall be considered a physician assistant for purposes of regulations of the Centers for Medicare and Medicaid Services (CMS); and

(b) No supervision requirements in addition to the minimum federal law shall be required.

3. (1) For purposes of this section, the licensure of assistant physicians shall take place within processes established by rules of the state board of registration for the healing arts. The board of healing arts is authorized to establish rules under chapter 536 establishing licensure and renewal procedures, supervision, collaborative practice arrangements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensure may be denied or the licensure of an assistant physician may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule.

(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, 2014, shall

be invalid and void.

4. An assistant physician shall clearly identify himself or herself as an assistant physician and shall be permitted to use the terms "doctor", "Dr." or "doc". No assistant physician shall practice or attempt to practice without an assistant physician collaborative practice arrangement, except as otherwise provided in this section and in an emergency situation.

5. The collaborating physician is responsible at all times for the oversight of the activities of, and accepts responsibility for, primary care services rendered by the assistant physician.

6. The provisions of section 334.104 shall apply to all assistant physician collaborative practice arrangements. To be eligible to practice as an assistant physician, a licensed assistant physician shall enter into an assistant physician collaborative practice arrangement within six months of his or her initial licensure and shall not have more than a six-month time period between collaborative practice arrangements during his or her licensure period. Any renewal of licensure under this section shall include verification of actual practice under a collaborative practice arrangement in accordance with this subsection during the immediately preceding licensure period.

334.104. 1. A physician may enter into collaborative practice arrangements with **assistant physicians, physician assistants, or** registered professional nurses. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which shall be in writing, may delegate to **[**a**] an assistant physician, physician assistant, or** registered professional nurse the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the **assistant physician, physician assistant, or** registered professional nurse and is consistent with that **assistant physician's, physician assistant's or** nurse's skill, training and competence **and the skill and training of the collaborating physician**.

2. Collaborative practice arrangements, which shall be in writing, may delegate to**:**

(1) An assistant physician or physician assistant the authority to dispense or prescribe drugs and provide treatment to the extent

permitted within the assistant physician's or physician assistant's scope of practice and licensure;

(2) A registered professional nurse the authority to administer, dispense or prescribe drugs and provide treatment if the registered professional nurse is an advanced practice registered nurse as defined in subdivision (2) of section 335.016. Collaborative practice arrangements may delegate to an advanced practice registered nurse, as defined in section 335.016, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017; except that, the collaborative practice arrangement shall not delegate the authority to administer any controlled substances listed in Schedules III, IV, and V of section 195.017 for the purpose of inducing sedation or general anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic controlled substance prescriptions shall be limited to a one hundred twenty-hour supply without refill.

Such collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols or standing orders for the delivery of health care services.

3. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the **assistant physician, physician assistant, or** advanced practice registered nurse;

(2) A list of all other offices or locations besides those listed in subdivision (1) of this subsection where the collaborating physician authorized the **assistant physician, physician assistant, or** advanced practice registered nurse to prescribe;

(3) A requirement that there shall be posted at every office where the **assistant physician, physician assistant, or** advanced practice registered nurse is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by an **assistant physician, physician assistant, or** advanced practice registered nurse and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the **assistant physician, physician assistant, or** advanced practice registered nurse;

(5) The manner of collaboration between the collaborating physician and

the **assistant physician, physician assistant, or** advanced practice registered nurse, including how the collaborating physician and the **assistant physician, physician assistant, or** advanced practice registered nurse will:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity, except the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar year for rural health clinics as defined by P.L. 95-210, as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. This exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics where the provider is a critical access hospital as provided in 42 U.S.C. 1395i-4, and provider-based rural health clinics where the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician is required to maintain documentation related to this requirement and to present it to the state board of registration for the healing arts when requested; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(6) A description of the **assistant physician's, physician assistant's, or** advanced practice registered nurse's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the **assistant physician, physician assistant, or** nurse to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(7) A list of all other written practice agreements of the collaborating physician and the **assistant physician, physician assistant, or** advanced practice registered nurse;

(8) The duration of the written practice agreement between the collaborating physician and the **assistant physician, physician assistant, or** advanced practice registered nurse;

(9) A description of the time and manner of the collaborating physician's review of the **assistant physician's, physician assistant's, or** advanced practice registered nurse's delivery of health care services. The description shall include provisions that the **assistant physician, physician assistant, or** advanced practice registered nurse shall submit a minimum of ten percent of the

charts documenting the **assistant physician's, physician assistant's, or** advanced practice registered nurse's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days; and

(10) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the **assistant physician, physician assistant, or** advanced practice registered nurse prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (9) of this subsection.

4. The state board of registration for the healing arts pursuant to section 334.125 **[**and**], in consultation with** the board of nursing **[**pursuant to section 335.036 may jointly**] shall** promulgate rules regulating the use of collaborative practice arrangements **for assistant physicians, physician assistants, and nurses**. Such rules shall **[**be limited to specifying**] specify** geographic areas to be covered, the methods of treatment that may be covered by collaborative practice arrangements**, the development and implementation of proficiency benchmarks and periodic skills assessment,** and the requirements for review of services provided pursuant to collaborative practice arrangements**,** including delegating authority to prescribe controlled substances. Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. Any rules relating to dispensing or distribution of controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the department of health and senior services and the state board of pharmacy. **[**In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither the state board of registration for the healing arts nor the board of nursing may separately promulgate rules relating to collaborative practice arrangements. Such jointly promulgated rules shall be consistent with guidelines for federally funded clinics**]. The state board of registration for the healing arts shall promulgate one set of rules applicable to all three licensure categories, and shall not promulgate separate rules applicable to only one licensure category. Such promulgated rules shall be consistent with guidelines for federally funded clinics**.

The rulemaking authority granted in this subsection shall not extend to collaborative practice arrangements of hospital employees providing inpatient care within hospitals as defined pursuant to chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

5. The state board of registration for the healing arts shall not deny, revoke, suspend or otherwise take disciplinary action against a physician for health care services delegated to **[**a**]** **an assistant physician, physician assistant, or** registered professional nurse provided the provisions of this section and the rules promulgated thereunder are satisfied. Upon the written request of a physician subject to a disciplinary action imposed as a result of an agreement between a physician and **[**a**]** **an assistant physician, physician assistant, or** registered professional nurse **[**or registered physician assistant**]**, whether written or not, prior to August 28, 1993, all records of such disciplinary licensure action and all records pertaining to the filing, investigation or review of an alleged violation of this chapter incurred as a result of such an agreement shall be removed from the records of the state board of registration for the healing arts and the division of professional registration and shall not be disclosed to any public or private entity seeking such information from the board or the division. The state board of registration for the healing arts shall take action to correct reports of alleged violations and disciplinary actions as described in this section which have been submitted to the National Practitioner Data Bank. In subsequent applications or representations relating to his **or her** medical practice, a physician completing forms or documents shall not be required to report any actions of the state board of registration for the healing arts for which the records are subject to removal under this section.

6. Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice agreement, including collaborative practice agreements delegating the authority to prescribe controlled substances, **[**or physician assistant agreement**]** and also report to the board the name of each licensed professional with whom the physician has entered into such agreement. The board may make this information available to the public. The board shall track the reported information and may routinely conduct random reviews of such agreements to ensure that agreements are carried out for compliance under this chapter.

7. Notwithstanding any law to the contrary, a certified registered nurse

anesthetist as defined in subdivision (8) of section 335.016 shall be permitted to provide anesthesia services without a collaborative practice arrangement provided that he or she is under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed. Nothing in this subsection shall be construed to prohibit or prevent a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016 from entering into a collaborative practice arrangement under this section, except that the collaborative practice arrangement **[**may**]** **shall** not delegate the authority to prescribe any controlled substances listed in Schedules III, IV, and V of section 195.017.

8. A collaborating physician shall not enter into a collaborative practice arrangement with more than three full-time equivalent **assistant physicians, physician assistants, or** advanced practice registered nurses. **Such limitation may include any three full-time equivalent combination of assistant physician, physician assistant, and advanced practice registered nurse, but shall not exceed a total of three full-time equivalents for all three categories combined.** This limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

9. It is the responsibility of the collaborating physician to determine and document the completion of at least a one-month period of time during which the **assistant physician, physician assistant, or** advanced practice registered nurse shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. This limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

10. No agreement made under this section shall supersede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital as defined in section 197.020 if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

11. No contract or other agreement shall require a physician to act as a collaborating physician for an **assistant physician, physician assistant, or**

advanced practice registered nurse against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular **assistant physician, physician assistant, or** advanced practice registered nurse. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any **assistant physician, physician assistant, or** advanced practice registered nurse, but this requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by hospital's medical staff.

12. No contract or other agreement shall require any **assistant physician, physician assistant, or** advanced practice registered nurse to serve as a collaborating advanced practice registered nurse for any collaborating physician against the **assistant physician's, physician assistant's, or** advanced practice registered nurse's will. An **assistant physician, physician assistant, or** advanced practice registered nurse shall have the right to refuse to collaborate, without penalty, with a particular physician.

13. All assistant physicians, physician assistants, and advanced practice registered nurses in collaborative practice arrangements shall wear identification badges while acting within the scope of their collaborative practice agreement. The identification badges shall prominently display the licensure status of such assistant physicians, physician assistants, and advanced practice registered nurses.

334.735. 1. As used in sections 334.735 to 334.749, the following terms mean:

(1) "Applicant", any individual who seeks to become licensed as a physician assistant;

(2) "Certification" or "registration", a process by a certifying entity that grants recognition to applicants meeting predetermined qualifications specified by such certifying entity;

(3) "Certifying entity", the nongovernmental agency or association which certifies or registers individuals who have completed academic and training requirements;

(4) "Department", the department of insurance, financial institutions and professional registration or a designated agency thereof;

(5) "License", a document issued to an applicant by the board

acknowledging that the applicant is entitled to practice as a physician assistant;

(6) "Physician assistant", a person who has graduated from a physician assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency, who has passed the certifying examination administered by the National Commission on Certification of Physician Assistants and has active certification by the National Commission on Certification of Physician Assistants who provides health care services delegated by a licensed physician. A person who has been employed as a physician assistant for three years prior to August 28, 1989, who has passed the National Commission on Certification of Physician Assistants examination, and has active certification of the National Commission on Certification of Physician Assistants;

(7) **"Physician assistant collaborative practice arrangement", an agreement between a physician and a physician assistant which meets the requirements of this section and section 334.104;**

(8) "Recognition", the formal process of becoming a certifying entity as required by the provisions of sections 334.735 to 334.749**[**;

(8) "Supervision", control exercised over a physician assistant working with a supervising physician and oversight of the activities of and accepting responsibility for the physician assistant's delivery of care. The physician assistant shall only practice at a location where the physician routinely provides patient care, except existing patients of the supervising physician in the patient's home and correctional facilities. The supervising physician must be immediately available in person or via telecommunication during the time the physician assistant is providing patient care. Prior to commencing practice, the supervising physician and physician assistant shall attest on a form provided by the board that the physician shall provide supervision appropriate to the physician assistant's training and that the physician assistant shall not practice beyond the physician assistant's training and experience. Appropriate supervision shall require the supervising physician to be working within the same facility as the physician assistant for at least four hours within one calendar day for every fourteen days on which the physician assistant provides patient care as described in subsection 3 of this section. Only days in which the physician assistant provides patient care as described in subsection 3 of this section shall be counted toward the fourteen-day period. The requirement of appropriate supervision shall be applied so that no more than thirteen calendar days in which a physician

assistant provides patient care shall pass between the physician's four hours working within the same facility. The board shall promulgate rules pursuant to chapter 536 for documentation of joint review of the physician assistant activity by the supervising physician and the physician assistant**]**.

2. (1) A supervision agreement shall limit the physician assistant to practice only **[**at locations described in subdivision (8) of subsection 1 of this section, where the supervising physician is no further than fifty miles by road using the most direct route available and where the location is not so situated as to create an impediment to effective intervention and supervision of patient care or adequate review of services**] in accordance with this section and section 334.104**.

(2) For a physician-physician assistant team working in a rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended, no supervision requirements in addition to the minimum federal law shall be required.

3. The scope of practice of a physician assistant shall consist only of the following services and procedures:

(1) Taking patient histories;

(2) Performing physical examinations of a patient;

(3) Performing or assisting in the performance of routine office laboratory and patient screening procedures;

(4) Performing routine therapeutic procedures;

(5) Recording diagnostic impressions and evaluating situations calling for attention of a physician to institute treatment procedures;

(6) Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by a licensed physician;

(7) Assisting the **[**supervising**] collaborating** physician in institutional settings, including reviewing of treatment plans, ordering of tests and diagnostic laboratory and radiological services, and ordering of therapies, using procedures reviewed and approved by a licensed physician;

(8) Assisting in surgery; **and**

(9) Performing such other tasks not prohibited by law under the supervision of a licensed physician as the physician's assistant has been trained and is proficient to perform**[**; and

(10)**].**

Physician assistants shall not perform or prescribe abortions.

4. Physician assistants shall not prescribe nor dispense any drug, medicine, device or therapy unless pursuant to a physician **[**supervision agreement**]** **collaborative practice arrangement** in accordance with the law, nor prescribe lenses, prisms or contact lenses for the aid, relief or correction of vision or the measurement of visual power or visual efficiency of the human eye, nor administer or monitor general or regional block anesthesia during diagnostic tests, surgery or obstetric procedures. Prescribing and dispensing of drugs, medications, devices or therapies by a physician assistant shall be pursuant to a physician assistant **[**supervision agreement**]** **collaborative practice arrangement** which is specific to the clinical conditions treated by the **[**supervising**]** **collaborating** physician and the physician assistant shall be subject to the following:

(1) A physician assistant shall only prescribe controlled substances in accordance with section 334.747;

(2) The types of drugs, medications, devices or therapies prescribed or dispensed by a physician assistant shall be consistent with the scopes of practice of the physician assistant and the **[**supervising**]** **collaborating** physician;

(3) All prescriptions shall conform with state and federal laws and regulations and shall include the name, address and telephone number of the physician assistant and the **[**supervising**]** **collaborating** physician;

(4) A physician assistant, or advanced practice registered nurse as defined in section 335.016 may request, receive and sign for noncontrolled professional samples and may distribute professional samples to patients;

(5) A physician assistant shall not prescribe any drugs, medicines, devices or therapies the supervising physician is not qualified or authorized to prescribe; and

(6) A physician assistant may only dispense starter doses of medication to cover a period of time for seventy-two hours or less.

5. A physician assistant shall clearly identify himself or herself as a physician assistant and shall not use or permit to be used in the physician assistant's behalf the terms "doctor", "Dr." or "doc" nor hold himself or herself out in any way to be a physician or surgeon. No physician assistant shall practice or attempt to practice without physician supervision or in any location where the **[**supervising**]** **collaborating** physician is not immediately available for consultation, assistance and intervention, except as otherwise provided in this section, and in an emergency situation, nor shall any physician assistant bill a

patient independently or directly for any services or procedure by the physician assistant.

6. For purposes of this section, the licensing of physician assistants shall take place within processes established by the state board of registration for the healing arts through rule and regulation. The board of healing arts is authorized to establish rules pursuant to chapter 536 establishing licensing and renewal procedures, supervision, **[**supervision agreements**]** **collaborative practice arrangements**, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensing may be denied or the license of a physician assistant may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule or regulation. Persons licensed pursuant to the provisions of chapter 335 shall not be required to be licensed as physician assistants. All applicants for physician assistant licensure who complete a physician assistant training program after January 1, 2008, shall have a master's degree from a physician assistant program.

7. **[**"Physician assistant supervision agreement" means a written agreement, jointly agreed-upon protocols or standing order between a supervising physician and a physician assistant, which provides for the delegation of health care services from a supervising physician to a physician assistant and the review of such services. The agreement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, telephone numbers, and state license numbers of the supervising physician and the physician assistant;

(2) A list of all offices or locations where the physician routinely provides patient care, and in which of such offices or locations the supervising physician has authorized the physician assistant to practice;

(3) All specialty or board certifications of the supervising physician;

(4) The manner of supervision between the supervising physician and the physician assistant, including how the supervising physician and the physician assistant shall:

(a) Attest on a form provided by the board that the physician shall provide supervision appropriate to the physician assistant's training and experience and that the physician assistant shall not practice beyond the scope of the physician assistant's training and experience nor the supervising physician's capabilities

and training; and

(b) Provide coverage during absence, incapacity, infirmity, or emergency by the supervising physician;

(5) The duration of the supervision agreement between the supervising physician and physician assistant; and

(6) A description of the time and manner of the supervising physician's review of the physician assistant's delivery of health care services. Such description shall include provisions that the supervising physician, or a designated supervising physician listed in the supervision agreement review a minimum of ten percent of the charts of the physician assistant's delivery of health care services every fourteen days**] The provisions of section 334.104 shall apply to all physician assistant collaborative practice arrangements**.

8. When a physician assistant supervision agreement is utilized to provide health care services for conditions other than acute self-limited or well-defined problems, the supervising physician or other physician designated in the supervision agreement shall see the patient for evaluation and approve or formulate the plan of treatment for new or significantly changed conditions as soon as practical, but in no case more than two weeks after the patient has been seen by the physician assistant.

9. At all times the physician is responsible for the oversight of the activities of, and accepts responsibility for, health care services rendered by the physician assistant.

10. It is the responsibility of the **[**supervising**] collaborating** physician to determine and document the completion of at least a one-month period of time during which the licensed physician assistant shall practice with a **[**supervising**] collaborating** physician continuously present before practicing in a setting where a **[**supervising**] collaborating** physician is not continuously present.

[11. No contract or other agreement shall require a physician to act as a supervising physician for a physician assistant against the physician's will. A physician shall have the right to refuse to act as a supervising physician, without penalty, for a particular physician assistant. No contract or other agreement shall limit the supervising physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any physician assistant, but this requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for

safe medical practice established by the hospital's medical staff.

12. Physician assistants shall file with the board a copy of their supervising physician form.

13. No physician shall be designated to serve as supervising physician for more than three full-time equivalent licensed physician assistants. This limitation shall not apply to physician assistant agreements of hospital employees providing inpatient care service in hospitals as defined in chapter 197.**]**

354.535. 1. If a pharmacy, operated by or contracted with by a health maintenance organization, is closed or is unable to provide health care services to an enrollee in an emergency, a pharmacist may take an assignment of such enrollee's right to reimbursement, if the policy or contract provides for such reimbursement, for those goods or services provided to an enrollee of a health maintenance organization. No health maintenance organization shall refuse to pay the pharmacist any payment due the enrollee under the terms of the policy or contract.

2. No health maintenance organization, conducting business in the state of Missouri, shall contract with a pharmacy, pharmacy distributor or wholesale drug distributor, nonresident or otherwise, unless such pharmacy or distributor has been granted a permit or license from the Missouri board of pharmacy to operate in this state.

3. Every health maintenance organization shall apply the same coinsurance, co-payment and deductible factors to all drug prescriptions filled by a pharmacy provider who participates in the health maintenance organization's network if the provider meets the contract's explicit product cost determination. If any such contract is rejected by any pharmacy provider, the health maintenance organization may offer other contracts necessary to comply with any network adequacy provisions of this act. However, nothing in this section shall be construed to prohibit the health maintenance organization from applying different coinsurance, co-payment and deductible factors between generic and brand name drugs.

4. **If the co-payment applied by a health maintenance organization exceeds the usual and customary retail price of the prescription drug, enrollees shall only be required to pay the usual and customary retail price of the prescription drug, and no further charge to the enrollee or plan sponsor shall be incurred on such prescription.**

5. Health maintenance organizations shall not set a limit on the quantity

of drugs which an enrollee may obtain at any one time with a prescription, unless such limit is applied uniformly to all pharmacy providers in the health maintenance organization's network.

[5.**]** **6.** Health maintenance organizations shall not insist or mandate any physician or other licensed health care practitioner to change an enrollee's maintenance drug unless the provider and enrollee agree to such change. For the purposes of this provision, a maintenance drug shall mean a drug prescribed by a practitioner who is licensed to prescribe drugs, used to treat a medical condition for a period greater than thirty days. Violations of this provision shall be subject to the penalties provided in section 354.444. Notwithstanding other provisions of law to the contrary, health maintenance organizations that change an enrollee's maintenance drug without the consent of the provider and enrollee shall be liable for any damages resulting from such change. Nothing in this subsection, however, shall apply to the dispensing of generically equivalent products for prescribed brand name maintenance drugs as set forth in section 338.056.

376.387. If the co-payment for prescription drugs applied by a health insurer or health carrier, as defined in section 376.1350, exceeds the usual and customary retail price of the prescription drug, enrollees shall only be required to pay the usual and customary retail price of the prescription drug, and no further charge to the enrollee or plan sponsor shall be incurred on such prescription.

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

(1) "Health carrier", the same meaning as such term is defined in section 376.1350;

(2) "Provider", the same meaning as such term is defined in section 376.1350, and in addition, orthotic and prosthetic services and rehabilitative centers.

2. Each health carrier shall provide each contracted provider with access to the health carrier's standard fee schedule, specific to the provider's geographic area, through a secure website. Such fee schedule shall reflect the current payment rates for all goods and services pertinent to the provider's practice or business, defined by procedure codes, diagnosis related groups, or defined by another payment mechanism. All contracted providers in such geographic area

shall be paid for the goods and services provided at such rates, unless different rates have been specifically agreed upon contractually with an individual provider. In no case shall the standard fee schedule include a rate for a specific good or service that is less than the lowest rate individually contracted for by the providers of such good or service in the applicable geographic area if all the providers in such area have individually contracted to be paid at different rates for such good or service.

3. No health carrier, or any of its subsidiaries, networks, contractors, or subcontractors, shall refuse to contract with any Missouri provider who is located within the geographic coverage area of a health benefit plan and who is willing to meet the terms and conditions for provider participation established for such health benefit plan, including the MO HealthNet and Medicare programs, if such provider is willing, as a term of such contract, to be paid at rates equal to the standard rates provided under subsection 2 of this section.

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

(1) "Health carrier", shall have the same meaning ascribed to it as in section 376.1350;

(2) "Provider", shall have the same meaning ascribed to it as in section 376.1350 and shall include licensed pharmacies and home health agencies.

2. An agreement between a health carrier and a participating provider under this chapter or chapter 354 shall not contain a provision that:

(1) Prohibits, or grants the health carrier an option to prohibit, the participating provider from contracting with another health carrier to provide health care services at a lower price than the payment specified in the agreement;

(2) Requires, or grants the health carrier an option to require, the participating provider to accept a lower payment from the health carrier if the participating provider agrees to provide health care services to another health carrier at a lower price;

(3) Requires, or grants the health carrier an option to require, termination or renegotiation of the existing agreement in the event the participating provider agrees to provide health care services to any

other health carrier at a lower price; or

(4) Requires the participating provider to disclose the participating provider's contractual reimbursement rates with other health carriers.

3. Any contract provision that violates any provision of this section shall be void and unenforceable.

376.1425. 1. No referral by a provider or selection of facility by a patient shall be required or otherwise restricted by a health carrier or health benefit plan, as defined in section 376.1350, if the medical facility referred to and selected by a patient is in the provider network and is medically appropriate for the health care service to be provided.

2. No health carrier or health benefit plan shall discriminate between medically appropriate facilities within the provider network regarding benefit coverage or reimbursement for provider services for the same health care service.

3. Any health care provider, health carrier, or health benefit plan shall be subject to licensure sanction for failure to comply with the provisions of this section.

376.2020. 1. For purposes of this section, the following terms shall mean:

(1) "Enrollee", shall have the same meaning ascribed to it in section 376.1350;

(2) "Health care provider", shall have the same meaning ascribed to it in section 376.1350;

(3) "Health care service", shall have the same meaning ascribed to it in section 376.1350;

(4) "Health carrier", shall have the same meaning ascribed to it in section 376.1350.

2. No provision in a contract in existence or entered into, amended, or renewed on or after August 28, 2014, between a health carrier and a health care provider shall be enforceable if such contractual provision prohibits, conditions, or in any way restricts any party to such contract from disclosing to an enrollee, patient, potential patient, or such person's parent or legal guardian, the contractual payment amount for a health care service if such payment amount is less than the health care provider's usual charge for the health care service, and if such contractual provision prevents the determination

of the potential out-of-pocket cost for the health care service by the enrollee, patient, potential patient, parent or legal guardian.

431.205. Notwithstanding section 431.202 to the contrary, any contract or agreement which creates or establishes the terms of a partnership, employment, or any other form of professional relationship between a nonprofit organization or entity and a physician licensed to practice in this state under chapter 334, which includes any restriction of the right of such physician to practice medicine in any geographic area for any period of time after the termination of such partnership, employment, or professional relationship shall be void and unenforceable with respect to said restriction; provided, however, that nothing under this section shall render void or unenforceable the remaining provisions of any such contract or agreement.

484.400. 1. The general assembly finds and declares that contingency fees play a useful and often critical role in ensuring access to counsel and the courts on the part of those persons who would otherwise be unable to afford such access, but that:

(1) Personal injury claimants are often subjected to unnecessary costs, delays, and inefficiencies in processing their compensation claims;

(2) Virtually all such claimants who are represented by attorneys are charged contingent fees;

(3) The ethical and legal validity of a contingent fee is dependent upon an attorney undertaking risk in exchange for sharing proportionately in the proceeds of a claim;

(4) The perverse incentives of the existing system often encourage and reward defendants who take intransigent settlement positions and otherwise unethically add to the costs and delays of settling meritorious claims for, among other reasons, the purpose of reducing the marginal rates of compensation received by claimants' counsel;

(5) Many deserving claimants receive inequitable compensation because:

(a) Such claimants are required to pay attorneys approximately one-third or more of any recovery even when there is little or no issue of liability or damages and therefore little or no assumption of risk by the attorney; and

(b) When a defendant or a defendant's insurer has made a substantial settlement offer before the attorney's retention or shortly thereafter and the attorney has added little or nothing to the value of the claim to that point, payment of a substantial contingent fee is nonetheless generally required;

(6) The current compensation system often fails to provide sufficient financial incentives to effectuate prompt and adequate compensation to deserving claimants resulting in:

(a) Delays in adjudications and case settlements often caused by intransigent defendant conduct that the present system perversely rewards and thereby deprives claimants of prompt compensation;

(b) A substantial burden on federal and state courts contributing to very high case backlogs; and

(c) Regressive costs burdens and substantial avoidable costs imposed on all parties resulting from the long delays in resolving many claims;

(7) The current tort compensation system which results in delays in resolving claims and which effectively provides for increased noneconomic damages and, therefore, increased legal fees as medical care costs increase provides perverse financial incentives for both more intensive and unnecessary use of medical care providers and the fraudulent incurrence of medical care expenses, thereby adding materially to our state and the nation's health care costs and burdens;

(8) Delays in resolving claims often result in more intensive and unnecessary use of medical care providers, thereby adding to our state and nation's health care burden;

(9) The claims process gives rise to substantial avoidable transaction costs because of the lack of adequate incentives for defendants and their insurers to offer prompt and equitable settlements to meritorious claimants and because claimants' attorneys exact a significant share of any settlement even when their efforts do not generate or augment the settlement offer;

(10) Contingency fee practices, as described in the preceding subdivisions, expose a clear and impermissible gap between the ethical standards established and promulgated by courts and professed by the legal bar, and the actual practices of the legal bar;

(11) Contingency fee practices, as described in the preceding

subdivisions, bring substantial disrepute to the legal bar and the legal system as a whole and loss of confidence in the rule of law itself, not the least because they create and expose broad gaps between the stated ethical principles of the legal profession and its real world practices;

(12) The inability of the legal bar and the courts to curb contingency fee abuses has led to higher settlement costs, lowered compensation to injured persons, excessive medical care costs, and delayed claims processing; and

(13) There is a need for adopting a procedure to implement appropriate ethical and legal standards and to resolve personal injury claims more fairly and promptly.

2. The purpose of sections 484.400 to 484.430 are to:

(1) Enforce more efficiently and effectively ethical standards governing the reasonableness of attorneys' fees and correspondingly to implement the stricter scrutiny that courts are obliged to apply to contingent fees;

(2) Reverse systemic incentives now in effect so as to reward, and not to penalize, defendants who make substantial early settlement offers;

(3) Compensate claimants' attorneys more rationally by calculating their compensation in relation to the value of services rendered and risks undertaken;

(4) Compensate more fairly those seeking redress for injuries by giving them a larger share of promptly achieved settlements;

(5) Further enhance the likelihood of early settlement of claims by preserving a larger share of early settlement offers for claimants;

(6) Lower the costs of the personal injury tort compensation system, including unnecessary medical and defense costs;

(7) Remove the burdensome interstate commerce and our state's and the nation's health care programs that are imposed by the current tort compensation system;

(8) Create a simple self-enforcing system controlled by the parties which forms an early basis for establishing the sums and issues that are in dispute;

(9) Reduce unworkable burdens now placed on courts and legal bar grievance boards presently charged with enforcing ethical standards through ex post facto case-by-case fact finding processes that

pose difficult burdens of proof and impose disproportionate transaction costs on both parties and fact finders; and

(10) Provide alternatives to across-the-board fee cap reforms, which often provide defendants with unearned advantages and further encourage many defendants in unethical protraction of settlement or meritorious claims.

484.402. As used in sections 484.400 to 484.430, the following terms shall mean:

(1) "Allegedly responsible party", a person, partnership, corporation, and an insurer thereof alleged by a claimant to be responsible for at least some portion of a personal injury alleged by a claimant;

(2) "Claim", an assertion of entitlement to compensation for personal injury from an allegedly responsible party and, to the extent subject to a contingent fee agreement, to all other related claims arising from such injury;

(3) "Claimant", an individual who in his or her own right or vicariously as otherwise permitted by law is seeking compensation for personal injury;

(4) "Contingent fee", the fee negotiated in a contingent fee agreement that is payable in fact or in effect only from the proceeds of any recovery on behalf of a claimant;

(5) "Contingent fee agreement", a fee agreement between an attorney and a claimant wherein the attorney agrees to bear the risk of no or inadequate compensation in exchange for a proportionate share of any recovery by settlement of a verdict obtained for a claimant;

(6) "Contingent fee attorney", an attorney who agrees to represent a claimant in exchange for a contingent fee;

(7) "Fixed fee", an agreement between an attorney and a claimant whereby the attorney agrees to perform a specific legal task in exchange for a specified sum to be paid by a claimant;

(8) "Hourly rate fee", the fee generated by an agreement or otherwise by operation of law between an attorney and a claimant providing that a claimant pay the attorney a fee determined by multiplying the hourly rate negotiated or otherwise set by law between the attorney and a claimant by the number of hours that the attorney

has worked on behalf of a claimant in furtherance of a claimant's interest. An hourly rate fee may also be a contingent fee to the extent it is only payable in fact or in effect from the proceeds of any recovery on behalf of a claimant;

(9) "Injury", personal injury;

(10) "Personal injury", an occurrence resulting from any act giving rise to a tort claim, including without limitation, bodily injury, sickness, disease, death, or property damage accompanying bodily injury;

(11) "Post-retention offer", an offer of settlement in response to a demand for compensation made within the time constraints, and conforming to the provisions of sections 484.400 to 484.430 made to a claimant who is represented by a contingent fee attorney;

(12) "Preretention offer", an offer to settle a claim for compensation made to a claimant not represented by an attorney at the time of the offer;

(13) "Response", a written communication by a claimant or an allegedly responsible party, or the attorney for either, deposited into the United States mail and sent certified mail or delivered by an overnight delivery service;

(14) "Settlement offer", a written offer of settlement set forth in a response within the time limits set forth in sections 484.400 to 484.430.

484.404. For purposes of sections 484.400 to 484.430, a fiduciary relationship commences when a claimant consults a contingent fee attorney to seek professional services.

484.406. Contingent fee agreements for the representation of parties with claims shall also include alternate hourly rate fees. If a contingent fee attorney has not entered into a written agreement with a claimant at the time of retention setting forth the attorney's hourly rate, a reasonable hourly rate is payable, subject to the limitations set forth in sections 484.400 to 484.430.

484.408. 1. At any time after retention, a contingent fee attorney pursuing a claim shall send a demand for compensation by certified mail to an allegedly responsible party which shall set forth the material facts relevant to the claim, including:

(1) The name, address, age, marital status, and occupation of a

claimant. For purposes of this section, claimant includes the injured party if a claimant is operating in a representative capacity;

(2) A brief description of how the injury occurred;

(3) The names and, if known, the addresses, telephone numbers, and occupations of all known witnesses to the injury;

(4) Copies of photographs in a claimant's possession that relate to the injury;

(5) The basis for claiming that the party to whom the claim is addressed is at least partially responsible for causing the injury;

(6) A description of the nature of the injury, the names and addresses of all physicians, other health care providers, and hospitals, clinics, or other medical service entities that provided medical care to a claimant or the injured party, including the date and nature of the service;

(7) Medical records relating to the injury and those involving a prior injury or preexisting medical condition which an allegedly responsible party would be able to introduce into evidence in a trial or, in lieu of either or both, executed releases authorizing the allegedly responsible party to obtain such records directly from health care providers that produced or possess them; and

(8) Relevant documentation, including records of earnings if a claimant is self-employed and employer records of earnings if a claimant is employed, or any medical expenses, wages lost, or other pertinent damages suffered as a consequence of the injury.

2. At the time of the mailing of the demand for compensation, a claimant's attorney shall mail copies of each such demand to the claimant and every other allegedly responsible party.

3. A fee received by or contracted for by a contingent fee attorney that exceeds ten percent of any settlement or judgment received by his or her client after reasonable expenses have been deducted is unreasonable and excessive if the attorney has sent a timely demand for compensation but has omitted information of a material nature that is required by this section which he or she had in his or her possession or which was readily available to him or her at the time of filing.

484.410. 1. To qualify its response as a post-retention offer under sections 484.400 to 484.430, an allegedly responsible party shall:

(1) Issue a response stating a settlement offer within sixty days from receipt of a demand for compensation;

(2) Send the response to the claimant's attorney with a copy to the claimant;

(3) State that the offer is open for acceptance for a minimum of thirty days from the time of its receipt by the claimant's attorney and further state whether it expires at the end of such period or remains open for acceptance for a longer period or until a notice of withdrawal is given; and

(4) Include with the offer copies of materials in its or its attorney's possession concerning the alleged injury upon which the allegedly responsible party relied in making the settlement offer except material that such party or its attorney believes in good faith would not be discoverable by a claimant during the course of litigation. If reproduction costs under this subdivision would be significant relative to the size of the offer, the allegedly responsible party may, in the alternative, offer other forms of access to the materials convenient and at reasonable costs to a claimant's attorney.

2. If within thirty days of receipt of a claimant's demand for compensation an allegedly responsible party notifies an unrepresented claimant or a claimant's attorney that it seeks to have a medical examination of the claimant, and the claimant is not made available for such examination within ten days of receipt of the request, the time provided for issuing a response is extended by one day for each day that the request is not honored after the expiration of ten days from the date of the request. Any such extension also includes a further period of ten days from the date of the completion of the medical examination.

3. The settlement offer may be increased during the sixty-day period set for in subdivision (1) of subsection 1 of this section by issuing an additional offer stating that the time for acceptance is ten days after receipt of the additional offer by the claimant's attorney or thirty days from receipt of the initial response, whichever is longer, unless the additional response specifies a longer period of time for acceptance as set for in subdivision (3) of subsection 1 of this section.

484.412. 1. If an allegedly responsible party or its attorney willfully fails to include the material required in subdivision (4) of

subsection 1 of section 484.410 with a response stating a settlement offer or does not otherwise make such material available:

(1) A claimant may revoke its acceptance of such settlement offer within two years of having accepted it; and

(2) Any fees and costs reasonably incurred by a claimant in revoking its acceptance of such settlement offer and reinstating its claim is recoverable from the allegedly responsible party, including the losses suffered by a claimant who is precluded from reinstating its claim by operation of a statute of limitations.

2. Willful failure of an attorney for an allegedly responsible party to comply with subdivision (4) of subsection 1 of section 484.410 shall subject such party to the sanctions applicable to a party who fails to comply with requests for the production of documents.

3. Willful failure of an attorney for an allegedly responsible party to comply with subdivision (4) of subsection 1 of section 484.410 shall subject such attorney to the same sanctions applicable to attorneys who improperly counsel their clients not to produce documents for which there has been discovery request.

484.414. 1. Nothing in sections 484.400 to 484.430 shall be construed as imposing on an allegedly responsible party an obligation to issue a response to a demand for compensation.

2. Demands for compensation, early settlement offers, or the failure of an allegedly responsible party to issue the same are admissible in any subsequent litigation, proceeding, or arbitration to the extent that evidence of settlement negotiations is inadmissible in the jurisdiction where the case is brought.

484.416. A settlement offer to an injured party represented by a contingent fee counsel made before receipt of a demand for compensation, which is open for acceptance for sixty days or more from the time of its receipt, is deemed a post-retention offer and has the same effect under sections 484.400 to 484.430 as if it were a response to a demand for compensation.

484.418. 1. It is a violation of sections 484.400 to 484.430 for an attorney retained after claimant has received a pre-retention offer to enter into an agreement with a claimant to receive a contingent fee based upon or payable from the proceeds of the pre-retention offer, provided that the pre-retention offer remains in effect or is renewed

until the time has elapsed for issuing a response containing a settlement offer as described in section 484.410.

2. An attorney entering into a fee agreement that would effectively result in payment of a percentage of a pre-retention offer to a claimant has charged an unreasonable and excessive fee.

3. An attorney who contracts with a claimant for a reasonable hourly rate or a reasonable fixed fee, or who is paid such a fee for advising a claimant regarding the fairness of the pre-retention offer, has charged a presumptively reasonable fee.

484.420. 1. A fee paid or contracted to be paid to a contingent fee attorney by a claimant who has rejected a preretention offer and who later accepts a post-retention offer of a greater amount is an unreasonable and excessive fee unless it is an hourly rate fee that does not exceed twenty-five percent of the excess of the post-retention offer over the preretention offer.

2. If the accepted post-retention offer is less than the preretention offer, a total fee for all services rendered that is greater than ten percent of the first one hundred thousand dollars of the post-retention offer plus five percent of any amount that exceeds one hundred thousand dollars after all reasonable expenses have been deducted is an unreasonable and excessive fee.

484.422. A fee paid or contracted to be paid to a contingent fee attorney by a claimant who has not received a preretention offer and who has accepted a post-retention offer is unreasonable and excessive unless it is an hourly rate fee that does not exceed ten percent of the first one hundred thousand dollars of the offer plus five percent of any amount that exceeds one hundred thousand dollars after all reasonable expenses have been deducted.

484.424. Irrespective of any preretention offer, the provisions of section 484.422 regarding maximum allowable fees remain in effect if a post-retention offer is not accepted by a claimant within the time provided in sections 484.400 to 484.430. Contingent fees are unreasonable and excessive unless charged against the difference between an unaccepted post-retention offer and the judgment or settlement ultimately obtained by a claimant. When such judgment or settlement is lower than the unaccepted offer, the fee limitations of section 484.422 apply against the judgment or settlement.

484.426. Upon receipt of any settlement or judgment and prior to the disbursement thereof, a contingent fee attorney shall provide a claimant with a written statement detailing how the proceeds are to be distributed, including the amount of the expenses paid out or to be paid out of the proceeds, the amount of the fee, how the fee amount is calculated, and the amount due a claimant.

484.428. 1. A contingent fee attorney who charges a fee that contravenes sections 484.400 to 484.430 has charged an unreasonable and excessive fee.

2. If the fee violates subsection 1 of this section, it is also excessive and unreasonable to the extent that it has not been reduced by any reasonable fees and costs incurred by a claimant in establishing that the fee agreement contravened sections 484.400 to 484.430.

3. Fee agreements between claimants and contingent fee attorneys who have charged fees described in sections 484.400 to 484.430 as unreasonable or excessive are illegal and unenforceable except to the extent provided under sections 484.400 to 484.430.

484.430. 1. Except for the provisions of section 484.406, nothing in sections 484.400 to 484.430 applies to an agreement between a claimant and an attorney to retain the attorney:

(1) On an hourly rate fee or fixed fee basis solely to evaluate a preretention offer;

(2) To collect overdue amounts from an accepted preretention or post-retention settlement offer.

2. The provisions of sections 484.400 to 484.430 prohibiting the charging of contingency fees in the absence of assuming meaningful risk and defining reasonable and unreasonable fees shall have no effect on contingent fee agreements in cases in which neither a preretention nor a post-retention offer of settlement is made.

3. Sections 484.400 to 484.430 shall not apply to accidental bodily injury caused by the operation or use of a motor vehicle in claims in which an uninsured motorist or personal protection insured is involved. For purposes of this subsection, "operation or use":

(1) Means operation or use of a motor vehicle as a motor vehicle, including, incident to its operation or use as a vehicle, the occupation of the vehicle;

(2) Does not cover conduct within the course of a business of

manufacturing, selling, or maintaining a motor vehicle, including repairing, servicing, washing, loading, or unloading; and

(3) Does not include such conduct not within the course of such a business unless such conduct occurs while occupying a motor vehicle.

538.220. 1. In any action against a health care provider for damages for personal injury or death arising out of the rendering of or the failure to render health care services, past damages shall be payable in a lump sum.

2. At the request of any party to such action made prior to the entry of judgment, the court shall include in the judgment a requirement that future damages be paid in whole or in part in periodic or installment payments if the total award of damages in the action exceeds one hundred thousand dollars. Any judgment ordering such periodic or installment payments shall specify a future medical periodic payment schedule, which shall include the recipient, the amount of each payment, the interval between payments, and the number of payments. The duration of the future medical payment schedule shall be for a period of time equal to the life expectancy of the person to whom such services were rendered, as determined by the court, based solely on the evidence of such life expectancy presented by the plaintiff at trial. The amount of each of the future medical periodic payments shall be determined by dividing the total amount of future medical damages by the number of future medical periodic payments. The court shall apply interest on such future periodic payments at a per annum interest rate no greater than the coupon issue yield equivalent, as determined by the Federal Reserve Board, of the average accepted auction price for the last auction of fifty-two-week United States Treasury bills settled immediately prior to the date of the judgment. The judgment shall state the applicable interest rate. The parties shall be afforded the opportunity to agree on the manner of payment of future damages, including the rate of interest, if any, to be applied, subject to court approval. However, in the event the parties cannot agree, the unresolved issues shall be submitted to the court for resolution, either with or without a posttrial evidentiary hearing which may be called at the request of any party or the court. If a defendant makes the request for payment pursuant to this section, such request shall be binding only as to such defendant and shall not apply to or bind any other defendant.

3. As a condition to authorizing periodic payments of future damages, the court may require a judgment debtor who is not adequately insured to post security or purchase an annuity adequate to assure full payment of such damages

awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security or so much as remains to the judgment debtor.

4. **(1)** If a plaintiff and his **or her** attorney have agreed that attorney's fees shall be paid from the award, as part of a contingent fee arrangement, it shall be presumed that the fee will be paid at the time the judgment becomes final. If the attorney elects to receive part or all of such fees in periodic or installment payments from future damages, the method of payment and all incidents thereto shall be a matter between such attorney and the plaintiff and not subject to the terms of the payment of future damages, whether agreed to by the parties or determined by the court.

(2) In any action against a health care provider for damages for personal injury or death arising out of the rendering of or the failure to render health care services:

(a) If the case is settled prior to trial, attorney's fees shall be limited to the attorney's regular hourly rate of compensation; and

(b) If the case proceeds to trial, the prevailing party shall recover all expert witness fees and costs incurred by such prevailing party.

5. Upon the death of a judgment creditor, the right to receive payments of future damages, other than future medical damages, being paid by installments or periodic payments will pass in accordance with the Missouri probate code unless otherwise transferred or alienated prior to death. Payment of future medical damages will continue to the estate of the judgment creditor only for as long as necessary to enable the estate to satisfy medical expenses of the judgment creditor that were due and owing at the time of death, which resulted directly from the injury for which damages were awarded, and do not exceed the dollar amount of the total payments for such future medical damages outstanding at the time of death.

6. Nothing in this section shall prevent the parties from contracting and agreeing to settle and resolve the claim for future damages. If such an agreement is reached by the parties, the future periodic payment schedule shall not apply.

Section 1. To aid the discovery of how and if MO HealthNet recipients covered under managed care organization health plans are improving in health outcomes and to provide data to the state to target health disparities, the state of Missouri shall establish and maintain an

accountability system utilizing health information technology. Such system shall:

(1) Have the ability to interoperate to collect and aggregate data from disparate systems. Such disparate systems shall include, but not be limited to electronic medical records, claims and eligibility databases, state-managed registries such as public health and immunizations registries, and health information organizations;

(2) Provide a quarterly analysis of each of the state managed care organizations to ensure such organizations are meeting required metrics, goals, and quality measurements as defined in the managed care contract such as costs of managed care services as compared to fee-for-service providers, and to provide the state with needed data for future contract negotiations and incentive management;

(3) Meet all state health privacy laws and federal Health Insurance Portability and Accountability Act (HIPAA) requirements; and

(4) Meet federal data security requirements.

[208.955. 1. There is hereby established in the department of social services the "MO HealthNet Oversight Committee", which shall be appointed by January 1, 2008, and shall consist of nineteen members as follows:

(1) Two members of the house of representatives, one from each party, appointed by the speaker of the house of representatives and the minority floor leader of the house of representatives;

(2) Two members of the Senate, one from each party, appointed by the president pro tem of the senate and the minority floor leader of the senate;

(3) One consumer representative who has no financial interest in the health care industry and who has not been an employee of the state within the last five years;

(4) Two primary care physicians, licensed under chapter 334, who care for participants, not from the same geographic area, chosen in the same manner as described in section 334.120;

(5) Two physicians, licensed under chapter 334, who care for participants but who are not primary care physicians and are

not from the same geographic area, chosen in the same manner as described in section 334.120;

(6) One representative of the state hospital association;

(7) Two nonphysician health care professionals, the first nonphysician health care professional licensed under chapter 335 and the second nonphysician health care professional licensed under chapter 337, who care for participants;

(8) One dentist, who cares for participants, chosen in the same manner as described in section 332.021;

(9) Two patient advocates who have no financial interest in the health care industry and who have not been employees of the state within the last five years;

(10) One public member who has no financial interest in the health care industry and who has not been an employee of the state within the last five years; and

(11) The directors of the department of social services, the department of mental health, the department of health and senior services, or the respective directors' designees, who shall serve as ex officio members of the committee.

2. The members of the oversight committee, other than the members from the general assembly and ex officio members, shall be appointed by the governor with the advice and consent of the senate. A chair of the oversight committee shall be selected by the members of the oversight committee. Of the members first appointed to the oversight committee by the governor, eight members shall serve a term of two years, seven members shall serve a term of one year, and thereafter, members shall serve a term of two years. Members shall continue to serve until their successor is duly appointed and qualified. Any vacancy on the oversight committee shall be filled in the same manner as the original appointment. Members shall serve on the oversight committee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of social services for that purpose. The department of social services shall provide technical, actuarial, and administrative support services as required by the oversight

committee. The oversight committee shall:

(1) Meet on at least four occasions annually, including at least four before the end of December of the first year the committee is established. Meetings can be held by telephone or video conference at the discretion of the committee;

(2) Review the participant and provider satisfaction reports and the reports of health outcomes, social and behavioral outcomes, use of evidence-based medicine and best practices as required of the health improvement plans and the department of social services under section 208.950;

(3) Review the results from other states of the relative success or failure of various models of health delivery attempted;

(4) Review the results of studies comparing health plans conducted under section 208.950;

(5) Review the data from health risk assessments collected and reported under section 208.950;

(6) Review the results of the public process input collected under section 208.950;

(7) Advise and approve proposed design and implementation proposals for new health improvement plans submitted by the department, as well as make recommendations and suggest modifications when necessary;

(8) Determine how best to analyze and present the data reviewed under section 208.950 so that the health outcomes, participant and provider satisfaction, results from other states, health plan comparisons, financial impact of the various health improvement plans and models of care, study of provider access, and results of public input can be used by consumers, health care providers, and public officials;

(9) Present significant findings of the analysis required in subdivision (8) of this subsection in a report to the general assembly and governor, at least annually, beginning January 1, 2009;

(10) Review the budget forecast issued by the legislative budget office, and the report required under subsection (22) of subsection 1 of section 208.151, and after study:

(a) Consider ways to maximize the federal drawdown of funds;

(b) Study the demographics of the state and of the MO HealthNet population, and how those demographics are changing;

(c) Consider what steps are needed to prepare for the increasing numbers of participants as a result of the baby boom following World War II;

(11) Conduct a study to determine whether an office of inspector general shall be established. Such office would be responsible for oversight, auditing, investigation, and performance review to provide increased accountability, integrity, and oversight of state medical assistance programs, to assist in improving agency and program operations, and to deter and identify fraud, abuse, and illegal acts. The committee shall review the experience of all states that have created a similar office to determine the impact of creating a similar office in this state; and

(12) Perform other tasks as necessary, including but not limited to making recommendations to the division concerning the promulgation of rules and emergency rules so that quality of care, provider availability, and participant satisfaction can be assured.

3. By July 1, 2011, the oversight committee shall issue findings to the general assembly on the success and failure of health improvement plans and shall recommend whether or not any health improvement plans should be discontinued.

4. The oversight committee shall designate a subcommittee devoted to advising the department on the development of a comprehensive entry point system for long-term care that shall:

(1) Offer Missourians an array of choices including community-based, in-home, residential and institutional services;

(2) Provide information and assistance about the array of long-term care services to Missourians;

(3) Create a delivery system that is easy to understand and access through multiple points, which shall include but shall not be limited to providers of services;

(4) Create a delivery system that is efficient, reduces duplication, and streamlines access to multiple funding sources and

programs;

(5) Strengthen the long-term care quality assurance and quality improvement system;

(6) Establish a long-term care system that seeks to achieve timely access to and payment for care, foster quality and excellence in service delivery, and promote innovative and cost-effective strategies; and

(7) Study one-stop shopping for seniors as established in section 208.612.

5. The subcommittee shall include the following members:

(1) The lieutenant governor or his or her designee, who shall serve as the subcommittee chair;

(2) One member from a Missouri area agency on aging, designated by the governor;

(3) One member representing the in-home care profession, designated by the governor;

(4) One member representing residential care facilities, predominantly serving MO HealthNet participants, designated by the governor;

(5) One member representing assisted living facilities or continuing care retirement communities, predominantly serving MO HealthNet participants, designated by the governor;

(6) One member representing skilled nursing facilities, predominantly serving MO HealthNet participants, designated by the governor;

(7) One member from the office of the state ombudsman for long-term care facility residents, designated by the governor;

(8) One member representing Missouri centers for independent living, designated by the governor;

(9) One consumer representative with expertise in services for seniors or persons with a disability, designated by the governor;

(10) One member with expertise in Alzheimer's disease or related dementia;

(11) One member from a county developmental disability board, designated by the governor;

(12) One member representing the hospice care profession,

designated by the governor;

(13) One member representing the home health care profession, designated by the governor;

(14) One member representing the adult day care profession, designated by the governor;

(15) One member gerontologist, designated by the governor;

(16) Two members representing the aged, blind, and disabled population, not of the same geographic area or demographic group designated by the governor;

(17) The directors of the departments of social services, mental health, and health and senior services, or their designees; and

(18) One member of the house of representatives and one member of the senate serving on the oversight committee, designated by the oversight committee chair.

Members shall serve on the subcommittee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of health and senior services for that purpose. The department of health and senior services shall provide technical and administrative support services as required by the committee.

6. By October 1, 2008, the comprehensive entry point system subcommittee shall submit its report to the governor and general assembly containing recommendations for the implementation of the comprehensive entry point system, offering suggested legislative or administrative proposals deemed necessary by the subcommittee to minimize conflict of interests for successful implementation of the system. Such report shall contain, but not be limited to, recommendations for implementation of the following consistent with the provisions of section 208.950:

(1) A complete statewide universal information and assistance system that is integrated into the web-based electronic patient health record that can be accessible by phone, in-person, via MO HealthNet providers and via the internet that connects consumers to services or providers and is used to establish consumers' needs for services. Through the system, consumers

shall be able to independently choose from a full range of home, community-based, and facility-based health and social services as well as access appropriate services to meet individual needs and preferences from the provider of the consumer's choice;

(2) A mechanism for developing a plan of service or care via the web-based electronic patient health record to authorize appropriate services;

(3) A preadmission screening mechanism for MO HealthNet participants for nursing home care;

(4) A case management or care coordination system to be available as needed; and

(5) An electronic system or database to coordinate and monitor the services provided which are integrated into the web-based electronic patient health record.

7. Starting July 1, 2009, and for three years thereafter, the subcommittee shall provide to the governor, lieutenant governor and the general assembly a yearly report that provides an update on progress made by the subcommittee toward implementing the comprehensive entry point system.

8. The provisions of section 23.253 shall not apply to sections 208.950 to 208.955.**]**

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