0572S.09F

SENATE SUBSTITUTE

FOR

SENATE COMMITTEE SUBSTITUTE

FOR

SENATE BILLS NOS. 70 & 128

AN ACT

To repeal sections 192.007, 192.667, 198.082, 208.909, 208.918, 208.924, 344.030, and 376.690, RSMo, and to enact in lieu thereof twelve new sections relating to the administration of health care services, with existing penalty provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

1 Section A. Sections 192.007, 192.667, 198.082, 208.909,
2 208.918, 208.924, 344.030, and 376.690, RSMo, are repealed and
3 twelve new sections enacted in lieu thereof, to be known as
4 sections 192.007, 192.667, 197.108, 198.082, 208.909, 208.918,
5 208.924, 208.935, 217.930, 221.125, 344.030, and 376.690, to read
6 as follows:
7 192.007. 1. The director of the department of health and
8 senior services shall be appointed by the governor by and with
9 the advice and consent of the senate. The director shall serve
10 at the pleasure of the governor and the director's salary shall
11 not exceed appropriations made for that purpose.
12 2. The director shall be a person of recognized character,
13 integrity and executive ability, **[**shall be a graduate of an
14 institution of higher education approved by recognized
15 accrediting agencies, and shall have had the administrative

1 experience necessary to enable him to successfully perform the
2 duties of his office. He shall have experience in public health
3 management and agency operation and management] and shall have,
4 at a minimum, the following qualifications:
5 (1) A medical doctor or a doctor of osteopathy degree with
6 a master's degree in public health and at least five years of
7 upper-level public health management or leadership experience;
8 (2) A doctorate or Ph.D. with a minimum of ten years of
9 public health experience; or
10 (3) A Ph.D. in a health-related field, which may include
11 nursing, public health, health policy, environmental health,
12 community health, or health education and a master's degree in
13 public health with a minimum of ten years of public health
14 management or leadership experience.
15
16 "Public health management or leadership experience" shall refer
17 to experience in a local, state, or federal public health agency
18 responsible for the entire population of a political subdivision.
19 192.667. 1. All health care providers shall at least
20 annually provide to the department charge data as required by the
21 department. All hospitals shall at least annually provide
22 patient abstract data and financial data as required by the
23 department. Hospitals as defined in section 197.020 shall report
24 patient abstract data for outpatients and inpatients. Ambulatory
25 surgical centers and abortion facilities as defined in section
26 197.200 shall provide patient abstract data to the department.
27 The department shall specify by rule the types of information
28 which shall be submitted and the method of submission.

2. The department shall collect data on the incidence of health care-associated infections from hospitals, ambulatory surgical centers, abortion facilities, and other facilities as necessary to generate the reports required by this section. Hospitals, ambulatory surgical centers, abortion facilities, and other facilities shall provide such data in compliance with this section. In order to streamline government and to eliminate duplicative reporting requirements, if the Centers for Medicare and Medicaid Services, or its successor entity, requires hospitals to submit health care-associated infection data, then hospitals and the department shall not be required to comply with the health care-associated infection data reporting requirements of subsections 2 to 17 of this section applicable to hospitals, except that the department shall post a link on its website to publicly reported data by hospitals on the Centers for Medicare and Medicaid Services' Hospital Compare website, or its successor.

3. The department shall promulgate rules specifying the standards and procedures for the collection, analysis, risk adjustment, and reporting of the incidence of health care-associated infections and the types of infections and procedures to be monitored pursuant to subsection 13 of this section. In promulgating such rules, the department shall:

(1) Use methodologies and systems for data collection established by the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor; and

(2) Consider the findings and recommendations of the

infection control advisory panel established pursuant to section 197.165.

4. By January 1, 2017, the infection control advisory panel created by section 197.165 shall make recommendations to the department regarding the Centers for Medicare and Medicaid Services' health care-associated infection data collection, analysis, and public reporting requirements for hospitals, ambulatory surgical centers, and other facilities in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, in lieu of all or part of the data collection, analysis, and public reporting requirements of this section. The advisory panel recommendations shall address which hospitals shall be required as a condition of licensure to use the National Healthcare Safety Network for data collection; the use of the National Healthcare Safety Network for risk adjustment and analysis of hospital submitted data; and the use of the Centers for Medicare and Medicaid Services' Hospital Compare website, or its successor, for public reporting of the incidence of health care-associated infection metrics. The advisory panel shall consider the following factors in developing its recommendation:

(1) Whether the public is afforded the same or greater access to facility-specific infection control indicators and metrics;

(2) Whether the data provided to the public is subject to the same or greater accuracy of risk adjustment;

(3) Whether the public is provided with the same or greater specificity of reporting of infections by type of facility

1 infections and procedures;
2 (4) Whether the data is subject to the same or greater
3 level of confidentiality of the identity of an individual
4 patient;
5 (5) Whether the National Healthcare Safety Network, or its
6 successor, has the capacity to receive, analyze, and report the
7 required data for all facilities;
8 (6) Whether the cost to implement the National Healthcare
9 Safety Network infection data collection and reporting system is
10 the same or less.
11 5. After considering the recommendations of the infection
12 control advisory panel, and provided that the requirements of
13 subsection 13 of this section can be met, the department shall
14 implement guidelines from the federal Centers for Disease Control
15 and Prevention's National Healthcare Safety Network, or its
16 successor. It shall be a condition of licensure for hospitals
17 that meet the minimum public reporting requirements of the
18 National Healthcare Safety Network and the Centers for Medicare
19 and Medicaid Services to participate in the National Healthcare
20 Safety Network, or its successor. Such hospitals shall permit
21 the National Healthcare Safety Network, or its successor, to
22 disclose facility-specific infection data to the department as
23 required under this section, and as necessary to provide the
24 public reports required by the department. It shall be a
25 condition of licensure for any ambulatory surgical center or
26 abortion facility which does not voluntarily participate in the
27 National Healthcare Safety Network, or its successor, to submit
28 facility-specific data to the department as required under this

section, and as necessary to provide the public reports required by the department.

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

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

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

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

7. Information obtained by the department under the provisions of section 192.665 and this section shall not be public information. Reports and studies prepared by the department based upon such information shall be public information and may identify individual health care providers. The department of health and senior services may authorize the use of the data by other research organizations pursuant to the

1 provisions of section 192.067. The department shall not use or
2 release any information provided under section 192.665 and this
3 section which would enable any person to determine any health
4 care provider's negotiated discounts with specific preferred
5 provider organizations or other managed care organizations. The
6 department shall not release data in a form which could be used
7 to identify a patient. Any violation of this subsection is a
8 class A misdemeanor.
9 8. The department shall undertake a reasonable number of
10 studies and publish information, including at least an annual
11 consumer guide, in collaboration with health care providers,
12 business coalitions and consumers based upon the information
13 obtained pursuant to the provisions of section 192.665 and this
14 section. The department shall allow all health care providers
15 and associations and related organizations who have submitted
16 data which will be used in any publication to review and comment
17 on the publication prior to its publication or release for
18 general use. The publication shall be made available to the
19 public for a reasonable charge.
20 9. Any health care provider which continually and
21 substantially, as these terms are defined by rule, fails to
22 comply with the provisions of this section shall not be allowed
23 to participate in any program administered by the state or to
24 receive any moneys from the state.
25 10. A hospital, as defined in section 197.020, aggrieved by
26 the department's determination of ineligibility for state moneys
27 pursuant to subsection 9 of this section may appeal as provided
28 in section 197.071. An ambulatory surgical center or abortion

1 facility as defined in section 197.200 aggrieved by the
2 department's determination of ineligibility for state moneys
3 pursuant to subsection 9 of this section may appeal as provided
4 in section 197.221.

5 11. The department of health may promulgate rules providing
6 for collection of data and publication of the incidence of health
7 care-associated infections for other types of health facilities
8 determined to be sources of infections; except that, physicians'
9 offices shall be exempt from reporting and disclosure of such
10 infections.

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

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

19 (a) Are usually associated with an elective surgical
20 procedure. An "elective surgical procedure" is a planned,
21 nonemergency surgical procedure that may be either medically
22 required such as a hip replacement or optional such as breast
23 augmentation;

24 (b) Demonstrate a high priority aspect such as affecting a
25 large number of patients, having a substantial impact for a
26 smaller population, or being associated with substantial cost,
27 morbidity, or mortality; or

28 (c) Are infections for which reports are collected by the

National Healthcare Safety Network or its successor;

(2) Central line-related bloodstream infections;

(3) Health care-associated infections specified for reporting by hospitals, ambulatory surgical centers, and other health care facilities by the rules of the Centers for Medicare and Medicaid Services to the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor; and

(4) Other categories of infections that may be established by rule by the department.

The department, in consultation with the advisory panel, shall be authorized to collect and report data on subsets of each type of infection described in this subsection.

13. In consultation with the infection control advisory panel established pursuant to section 197.165, the department shall develop and disseminate to the public reports based on data compiled for a period of twelve months. Such reports shall be updated quarterly and shall show for each hospital, ambulatory surgical center, abortion facility, and other facility metrics on risk-adjusted health care-associated infections under this section.

14. The types of infections under subsection 12 of this section to be publicly reported shall be determined by the department by rule and shall be consistent with the infections tracked by the National Healthcare Safety Network, or its successor.

15. Reports published pursuant to subsection 13 of this

section shall be published and readily accessible on the department's internet website. The reports shall be distributed at least annually to the governor and members of the general assembly. The department shall make such reports available to the public for a period of at least two years.

16. The Hospital Industry Data Institute shall publish a report of Missouri hospitals', ambulatory surgical centers', and abortion facilities' compliance with standardized quality of care measures established by the federal Centers for Medicare and Medicaid Services for prevention of infections related to surgical procedures. If the Hospital Industry Data Institute fails to do so by July 31, 2008, and annually thereafter, the department shall be authorized to collect information from the Centers for Medicare and Medicaid Services or from hospitals, ambulatory surgical centers, and abortion facilities and publish such information in accordance with this section.

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

18. The department shall promulgate rules to implement the provisions of section 192.131 and sections 197.150 to 197.160. 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

1 assembly pursuant to chapter 536 to review, to delay the
2 effective date, or to disapprove and annul a rule are
3 subsequently held unconstitutional, then the grant of rulemaking
4 authority and any rule proposed or adopted after August 28, 2004,
5 shall be invalid and void.
6 19. No later than August 28, 2017, each hospital, excluding
7 mental health facilities as defined in section 632.005, and each
8 ambulatory surgical center and abortion facility as defined in
9 section 197.200, shall in consultation with its medical staff
10 establish an antimicrobial stewardship program for evaluating the
11 judicious use of antimicrobials, especially antibiotics that are
12 the last line of defense against resistant infections. The
13 hospital's stewardship program and the results of the program
14 shall be monitored and evaluated by hospital quality improvement
15 departments and shall be available upon inspection to the
16 department. At a minimum, the antimicrobial stewardship program
17 shall be designed to evaluate that hospitalized patients receive,
18 in accordance with accepted medical standards of practice, the
19 appropriate antimicrobial, at the appropriate dose, at the
20 appropriate time, and for the appropriate duration.
21 20. Hospitals described in subsection 19 of this section
22 shall meet the National Healthcare Safety Network requirements
23 for reporting antimicrobial usage or resistance by using the
24 Centers for Disease Control and Prevention's Antimicrobial Use
25 and Resistance (AUR) Module when **[**regulations concerning Stage 3
26 of the Medicare and Medicaid Electronic Health Records Incentive
27 Programs promulgated by the Centers for Medicare and Medicaid
28 Services that enable the electronic interface for such reporting

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

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

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

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

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

(2) The name of any member of his or her immediate family who has been employed in the last ten years or is currently employed at a hospital and the approximate length of service and the job title at the hospital.

The disclosures under this subsection shall be made to the department whenever the event giving rise to disclosure first occurs.

3. For purposes of this section, the phrase "immediate family member" shall mean a husband, wife, natural or adoptive parent, child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, or grandchild.

4. The information provided under subsection 2 of this section shall be considered a public record under the provisions of section 610.010.

5. Any person may notify the department if facts exist that would lead a reasonable person to conclude that any inspector or surveyor has any personal or business affiliation that would

1 result in a conflict of interest in conducting an inspection or
2 survey for a hospital. Upon receiving such notice, the
3 department, when assigning an inspector or surveyor to inspect or
4 survey a hospital, for any purpose, shall take steps to verify
5 the information and, if the department has reason to believe that
6 such information is correct, the department shall not assign the
7 inspector or surveyor to the hospital or any hospital within its
8 organization so as to avoid an appearance of prejudice or favor
9 to the hospital or bias on the part of the inspector or surveyor.
10 198.082. 1. Each certified nursing assistant hired to work
11 in a skilled nursing or intermediate care facility after January
12 1, 1980, shall have successfully completed a nursing assistant
13 training program approved by the department or shall enroll in
14 and begin the first available approved training program which is
15 scheduled to commence within ninety days of the date of the
16 certified nursing assistant's employment and which shall be
17 completed within four months of employment. Training programs
18 shall be offered at any facility licensed **[**or approved**]** by the
19 department of health and senior services; any skilled nursing or
20 intermediate care unit in a Missouri veterans home, as defined in
21 section 42.002; or any hospital, as defined in section 197.020.
22 Training programs shall be **[**which is most**]** reasonably accessible
23 to the enrollees in each class. The program may be established
24 by **[**the**]** a skilled nursing or intermediate care facility, unit,
25 or hospital; by a professional organization**[**,**]**; or by the
26 department, and training shall be given by the personnel of the
27 facility, unit, or hospital; by a professional organization**[**,**]**;
28 by the department**[**,**]**; by any community college; or by the

1 vocational education department of any high school.

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

10 3. This section shall not apply to any person otherwise
11 regulated or licensed to perform health care services under the
12 laws of this state. It shall not apply to volunteers or to
13 members of religious or fraternal orders which operate and
14 administer the facility, if such volunteers or members work
15 without compensation.

16 [3.] 4. The training program [after January 1, 1989, shall
17 consist of at least the following:

18 (1) A training program consisting] requirements shall be
19 defined in regulation by the department and shall require [of] at
20 least seventy-five classroom hours of training [on basic nursing
21 skills, clinical practice, resident safety and rights, the social
22 and psychological problems of residents, and the methods of
23 handling and caring for mentally confused residents such as those
24 with Alzheimer's disease and related disorders,] and one hundred
25 hours supervised and on-the-job training. On-the-job training
26 sites shall include supervised practical training in a laboratory
27 or other setting in which the trainee demonstrates knowledge
28 while performing tasks on an individual under the direct

1 supervision of a registered nurse or a licensed practical nurse.
2 The **[**one hundred hours**]** training shall be completed within four
3 months of employment and may consist of normal employment as
4 nurse assistants or hospital nursing support staff under the
5 supervision of a licensed nurse**[**; and
6 (2) Continuing in-service training to assure continuing
7 competency in existing and new nursing skills. All nursing
8 assistants trained prior to January 1, 1989, shall attend, by
9 August 31, 1989, an entire special retraining program established
10 by rule or regulation of the department which shall contain
11 information on methods of handling mentally confused residents
12 and which may be offered on premises by the employing facility**]**.
13 **[**4.**]** 5. Certified nursing **[**Nursing**]** assistants who have not
14 successfully completed the nursing assistant training program
15 prior to employment may begin duties as a certified nursing
16 assistant **[**only after completing an initial twelve hours of basic
17 orientation approved by the department**]** and may provide direct
18 resident care only if under the **[**general**]** direct supervision of a
19 licensed nurse prior to completion of the seventy-five classroom
20 hours of the training program.
21 6. The competency evaluation shall be performed in a
22 facility, as defined in 42 CFR 483.5, or laboratory setting
23 comparable to the setting in which the individual shall function
24 as a certified nursing assistant.
25 7. Persons completing the training requirements of
26 unlicensed assistive personnel under 19 CSR 30-20.125 or its
27 successor regulation, and who have completed the competency
28 evaluation, shall be allowed to sit for the certified nursing

assistant examination and be deemed to have fulfilled the classroom and clinical standards for designation as a certified nursing assistant.

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

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

(1) Supervising their personal care attendant;

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

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

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

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

(6) Providing the vendor with all necessary information to complete required paperwork for establishing the employer identification number; and

1 (7) Allowing the vendor to comply with its quality
2 assurance and supervision process, which shall include, but not
3 be limited to, bi-annual face-to-face home visits and monthly
4 case management activities.
5 2. Participating vendors shall be responsible for:
6 (1) Collecting time sheets or reviewing reports of
7 delivered services and certifying the accuracy thereof;
8 (2) The Medicaid reimbursement process, including the
9 filing of claims and reporting data to the department as required
10 by rule;
11 (3) Transmitting the individual payment directly to the
12 personal care attendant on behalf of the consumer;
13 (4) Monitoring the performance of the personal care
14 assistance services plan. Such monitoring shall occur during the
15 bi-annual face-to-face home visits under section 208.918. The
16 vendor shall document whether the attendant was present and if
17 services are being provided to the consumer as set forth in the
18 plan of care. If the attendant was not present or not providing
19 services, the vendor shall notify the department and the
20 department may suspend services to the consumer.
21 3. No state or federal financial assistance shall be
22 authorized or expended to pay for services provided to a consumer
23 under sections 208.900 to 208.927, if the primary benefit of the
24 services is to the household unit, or is a household task that
25 the members of the consumer's household may reasonably be
26 expected to share or do for one another when they live in the
27 same household, unless such service is above and beyond typical
28 activities household members may reasonably provide for another

1 household member without a disability.

2 4. No state or federal financial assistance shall be
3 authorized or expended to pay for personal care assistance
4 services provided by a personal care attendant who has not
5 undergone the background screening process under section
6 192.2495. If the personal care attendant has a disqualifying
7 finding under section 192.2495, no state or federal assistance
8 shall be made, unless a good cause waiver is first obtained from
9 the department in accordance with section 192.2495.

10 5. (1) All vendors shall, by July 1, 2015, have, maintain,
11 and use a telephone tracking system for the purpose of reporting
12 and verifying the delivery of consumer-directed services as
13 authorized by the department of health and senior services or its
14 designee. **[**Use of such a system prior to July 1, 2015, shall be
15 voluntary.**]** The telephone tracking system shall be used to
16 process payroll for employees and for submitting claims for
17 reimbursement to the MO HealthNet division. At a minimum, the
18 telephone tracking system shall:

19 (a) Record the exact date services are delivered;

20 (b) Record the exact time the services begin and exact time
21 the services end;

22 (c) Verify the telephone number from which the services are
23 registered;

24 (d) Verify that the number from which the call is placed is
25 a telephone number unique to the client;

26 (e) Require a personal identification number unique to each
27 personal care attendant;

28 (f) Be capable of producing reports of services delivered,

tasks performed, client identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service; and

(g) Be capable of producing reimbursement requests for consumer approval that assures accuracy and compliance with program expectations for both the consumer and vendor.

(2) **[**The department of health and senior services, in collaboration with other appropriate agencies, including centers for independent living, shall establish telephone tracking system pilot projects, implemented in two regions of the state, with one in an urban area and one in a rural area. Each pilot project shall meet the requirements of this section and section 208.918. The department of health and senior services shall, by December 31, 2013, submit a report to the governor and general assembly detailing the outcomes of these pilot projects. The report shall take into consideration the impact of a telephone tracking system on the quality of the services delivered to the consumer and the principles of self-directed care.

(3)**]** As new technology becomes available, the department may allow use of a more advanced tracking system, provided that such system is at least as capable of meeting the requirements of this subsection.

[(4)**]** (3) The department of health and senior services shall promulgate by rule the minimum necessary criteria of the telephone tracking system. 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

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

8 **[**6. In the event that a consensus between centers for
9 independent living and representatives from the executive branch
10 cannot be reached, the telephony report issued to the general
11 assembly and governor shall include a minority report which shall
12 detail those elements of substantial dissent from the main
13 report.

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

18 208.918. 1. In order to qualify for an agreement with the
19 department, the vendor shall have a philosophy that promotes the
20 consumer's ability to live independently in the most integrated
21 setting or the maximum community inclusion of persons with
22 physical disabilities, and shall demonstrate the ability to
23 provide, directly or through contract, the following services:

24 (1) Orientation of consumers concerning the
25 responsibilities of being an employer**[,]** <u>and</u> supervision of
26 personal care attendants including the preparation and
27 verification of time sheets<u>. Such orientation shall include</u>
28 <u>notifying customers that falsification of attendant visit</u>

verification records shall be considered fraud and shall be reported to the department. Such orientation shall take place in the presence of the personal care attendant, to the fullest extent possible;

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

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

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

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

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

2. In order to maintain its agreement with the department, a vendor shall comply with the provisions of subsection 1 of this section and shall:

(1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports and an annual financial statement audit **[**submitted to the department**]** performed by a certified public accountant if the vendor's annual gross revenue is one hundred thousand dollars or more or, if the vendor's annual gross revenue is less than one hundred thousand dollars, an annual financial statement audit or annual financial statement review performed by a certified public accountant. Such reports, audits, and reviews shall be completed and made available upon

request to the department; [and]

(2) Demonstrate a positive impact on consumer outcomes regarding the provision of personal care assistance services as evidenced on accurate quarterly and annual service reports submitted to the department;

(3) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records:

(a) The department of health and senior services shall promulgate by rule a consumer-directed services division provider certification manager course; and

(b) The vendor shall perform with the consumer at least bi-annual face-to-face home visits to provide ongoing monitoring of the provision of services in the plan of care and assess the quality of care being delivered. The bi-annual face-to-face home visits do not preclude the vendor's responsibility from its ongoing diligence of case management activity oversight;

(4) Comply with all provisions of sections 208.900 to 208.927, and the regulations promulgated thereunder; and

(5) Maintain a business location which shall comply with any and all applicable city, county, state, and federal requirements, verified by the Missouri Medicaid audit and compliance unit.

3. No state or federal funds shall be authorized or expended if the owner, primary operator, certified manager, or any direct employee of the consumer-directed services vendor is also the personal care attendant, unless such person provides services solely on a temporary basis for no more than three days in a thirty-day period.

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

(1) The department learns of circumstances that require closure of a consumer's case, including one or more of the following: death, admission into a long-term care facility, no longer needing service, or inability of the consumer to consumer-direct personal care assistance service;

(2) The consumer has falsified records; provided false information of his or her condition, functional capacity, or level of care needs; or committed fraud;

(3) The consumer is noncompliant with the plan of care. Noncompliance requires persistent actions by the consumer which negate the services provided in the plan of care;

(4) The consumer or member of the consumer's household threatens or abuses the personal care attendant or vendor to the point where their welfare is in jeopardy and corrective action has failed;

(5) The maintenance needs of a consumer are unable to continue to be met because the plan of care hours exceed availability; and

(6) The personal care attendant is not providing services as set forth in the personal care assistance services plan and attempts to remedy the situation have been unsuccessful.

208.935. Subject to appropriations, the department of health and senior services shall develop, or contract with a state agency or third party to develop, an interactive assessment tool, which may include mobile as well as centralized functionality, for utilization when implementing the assessment

1 and authorization process for MO HealthNet home and community-
2 based services authorized by the division of senior and
3 disability services.
4 217.930. 1. (1) Medical assistance under MO HealthNet
5 shall be suspended, rather than canceled or terminated, for a
6 person who is an offender in a correctional center if:
7 (a) The department of social services is notified of the
8 person's entry into the correctional center;
9 (b) On the date of entry, the person was enrolled in the MO
10 HealthNet program; and
11 (c) The person is eligible for MO HealthNet except for
12 institutional status.
13 (2) A suspension under this subsection shall end on the
14 date the person is no longer an offender in a correctional
15 center.
16 (3) Upon release from incarceration, such person shall
17 continue to be eligible for receipt of MO HealthNet benefits
18 until such time as the person is otherwise determined to no
19 longer be eligible for the program.
20 2. The department of corrections shall notify the
21 department of social services:
22 (1) Within twenty days after receiving information that a
23 person receiving benefits under MO HealthNet is or will be an
24 offender in a correctional center; and
25 (2) Within forty-five days prior to the release of a person
26 who is qualified for suspension under subsection 1 of this
27 section.
28 221.125. 1. (1) Medical assistance under MO HealthNet

shall be suspended, rather than canceled or terminated, for a person who is an offender in a county jail, a city jail, or a private jail if:

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

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

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

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

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

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

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

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

(1) The applicant provides the board satisfactory proof that the applicant is of good moral character and a high school graduate or equivalent; and

(2) The applicant provides the board satisfactory proof that the applicant has had a minimum of three years' experience in health care administration, or two years of postsecondary education in health care administration, or has an associate degree or higher from an accredited academic institution, or has satisfactorily completed a course of instruction and training prescribed by the board, which includes instruction in the needs properly to be served by nursing homes, the protection of the interests of residents therein, and the elements of good nursing home administration, or has presented evidence satisfactory to the board of sufficient education, training, or experience in the foregoing fields to administer, supervise and manage a nursing home; and

(3) The applicant passes the examinations administered by the board. If an applicant fails to make a passing grade on either of the examinations such applicant may make application for reexamination on a form furnished by the board and may be retested. If an applicant fails either of the examinations a third time, the applicant shall be required to complete a course of instruction prescribed and approved by the board. After completion of the board-prescribed course of instruction, the applicant may reapply for examination. With regard to the national examination required for licensure, no examination scores from other states shall be recognized by the board after the applicant has failed his or her third attempt at the national

1 examination. There shall be a separate, nonrefundable fee for
2 each examination. The board shall set the amount of the fee for
3 examination by rules and regulations promulgated pursuant to
4 section 536.021. The fee shall be set at a level to produce
5 revenue which shall not substantially exceed the cost and expense
6 of administering the examination.
7 3. Nothing in **[**sections 344.010 to 344.108**]** this chapter,
8 or the rules or regulations thereunder shall be construed to
9 require an applicant for a license as a nursing home
10 administrator, who is employed by an institution listed and
11 certified by the Commission for Accreditation of Christian
12 Science Nursing Organizations/Facilities, Inc., to administer
13 institutions certified by such commission for the care and
14 treatment of the sick in accordance with the creed or tenets of a
15 recognized church or religious denomination, to demonstrate
16 proficiency in any techniques or to meet any educational
17 qualifications or standards not in accord with the remedial care
18 and treatment provided in such institutions. The applicant's
19 license shall be endorsed to confine the applicant's practice to
20 such institutions.
21 4. The board may issue a temporary emergency license for a
22 period not to exceed **[**ninety**]** one hundred and twenty days to a
23 person **[**twenty-one**]** eighteen years of age or over, of good moral
24 character and a high school graduate or equivalent to serve as an
25 acting nursing home administrator, provided such person is
26 replacing a licensed nursing home administrator who has died, has
27 been removed or has vacated the nursing home administrator's
28 position. No temporary emergency license may be issued to a

1 person who has had a nursing home administrator's license denied,
2 suspended or revoked. [A temporary emergency license may be
3 renewed for one additional ninety-day period upon a showing that
4 the person seeking the renewal of a temporary emergency license
5 meets the qualifications for licensure and has filed an
6 application for a regular license, accompanied by the application
7 fee, and the applicant has taken the examination or examinations
8 but the results have not been received by the board. No
9 temporary emergency license may be renewed more than one time.]
10 376.690. 1. As used in this section, the following terms
11 shall mean:
12 (1) "Emergency medical condition", the same meaning given
13 to such term in section 376.1350;
14 (2) "Facility", the same meaning given to such term in
15 section 376.1350;
16 (3) "Health care professional", the same meaning given to
17 such term in section 376.1350;
18 (4) "Health carrier", the same meaning given to such term
19 in section 376.1350;
20 (5) "Unanticipated out-of-network care", health care
21 services received by a patient in an in-network facility from an
22 out-of-network health care professional from the time the patient
23 presents with an emergency medical condition until the time the
24 patient is discharged.
25 2. (1) Health care professionals [may] <u>shall</u> send any
26 claim for charges incurred for unanticipated out-of-network care
27 to the patient's health carrier within one hundred eighty days of
28 the delivery of the unanticipated out-of-network care on a U.S.

1 Centers of Medicare and Medicaid Services Form 1500, or its
2 successor form, or electronically using the 837 HIPAA format, or
3 its successor.
4 (2) Within forty-five processing days, as defined in
5 section 376.383, of receiving the health care professional's
6 claim, the health carrier shall offer to pay the health care
7 professional a reasonable reimbursement for unanticipated
8 out-of-network care based on the health care professional's
9 services. If the health care professional participates in one or
10 more of the carrier's commercial networks, the offer of
11 reimbursement for unanticipated out-of-network care shall be the
12 amount from the network which has the highest reimbursement.
13 (3) If the health care professional declines the health
14 carrier's initial offer of reimbursement, the health carrier and
15 health care professional shall have sixty days from the date of
16 the initial offer of reimbursement to negotiate in good faith to
17 attempt to determine the reimbursement for the unanticipated
18 out-of-network care.
19 (4) If the health carrier and health care professional do
20 not agree to a reimbursement amount by the end of the sixty-day
21 negotiation period, the dispute shall be resolved through an
22 arbitration process as specified in subsection 4 of this section.
23 (5) To initiate arbitration proceedings, either the health
24 carrier or health care professional must provide written
25 notification to the director and the other party within one
26 hundred twenty days of the end of the negotiation period,
27 indicating their intent to arbitrate the matter and notifying the
28 director of the billed amount and the date and amount of the

final offer by each party. A claim for unanticipated out-of-network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with subdivisions (3) to (5) of this subsection.

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

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

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

(3) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within forty-five processing days of receiving a claim from the health care professional for services provided.

(4) The in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for the unanticipated out-of-network care.

1 4. The director shall ensure access to an external
2 arbitration process when a health care professional and health
3 carrier cannot agree to a reimbursement under subdivision (3) of
4 subsection 2 of this section. In order to ensure access, when
5 notified of a parties' intent to arbitrate, the director shall
6 randomly select an arbitrator for each case from the department's
7 approved list of arbitrators or entities that provide binding
8 arbitration. The director shall specify the criteria for an
9 approved arbitrator or entity by rule. The costs of arbitration
10 shall be shared equally between and will be directly billed to
11 the health care professional and health carrier. These costs
12 will include, but are not limited to, reasonable time necessary
13 for the arbitrator to review materials in preparation for the
14 arbitration, travel expenses and reasonable time following the
15 arbitration for drafting of the final decision.
16 5. At the conclusion of such arbitration process, the
17 arbitrator shall issue a final decision, which shall be binding
18 on all parties. The arbitrator shall provide a copy of the final
19 decision to the director. The initial request for arbitration,
20 all correspondence and documents received by the department and
21 the final arbitration decision shall be considered a closed
22 record under section 374.071. However, the director may release
23 aggregated summary data regarding the arbitration process. The
24 decision of the arbitrator shall not be considered an agency
25 decision nor shall it be considered a contested case within the
26 meaning of section 536.010.
27 6. The arbitrator shall determine a dollar amount due under
28 subsection 2 of this section between one hundred twenty percent

of the Medicare-allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

7. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, or experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

8. The enrollee shall not be required to participate in the arbitration process. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section.

9. **[**This section shall take effect on January 1, 2019.

10.**]** The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to procedural requirements for arbitration. Any

1 rule or portion of a rule, as that term is defined in section
2 536.010, that is created under the authority delegated in this
3 section shall become effective only if it complies with and is
4 subject to all of the provisions of chapter 536 and, if
5 applicable, section 536.028. This section and chapter 536 are
6 nonseverable and if any of the powers vested with the general
7 assembly pursuant to chapter 536 to review, to delay the
8 effective date, or to disapprove and annul a rule are
9 subsequently held unconstitutional, then the grant of rulemaking
10 authority and any rule proposed or adopted after August 28, 2018,
11 shall be invalid and void.