FIRST REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED**]**

SENATE BILL NO. 514

100TH GENERAL ASSEMBLY

2019

2440S.01T

AN ACT

To repeal sections 191.603, 191.605, 191.607, 191.737, 192.067, 192.667, 193.015, 195.060, 195.080, 195.100, 196.100, 198.082, 208.146, 208.151, 208.225, 208.790, 208.930, 221.111, 332.361, 334.037, 334.104, 334.108, 334.735, 334.736, 334.747, 334.749, 335.175, 337.712, 338.010, 338.015, 338.055, 338.056, 338.140, 374.500, 376.690, 376.1040, 376.1042, 376.1224, 376.1350, 376.1356, 376.1363, 376.1372, 376.1385, 630.175, and 630.875, RSMo, and to enact in lieu thereof sixty-one new sections relating to health care with an emergency clause for a certain section.

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

Section A. Sections 191.603, 191.605, 191.607, 191.737, 192.067, 192.667, 193.015, 195.060, 195.080, 195.100,196.100, 198.082, 208.146, 208.151, 208.225, 208.790, 208.930, 221.111, 332.361, 334.037, 334.104, 334.108, 334.735, 334.736, 334.747, 334.749, 335.175, 337.712, 338.010, 338.015, 338.055, 338.056, 338.140, 374.500, 376.690, 376.1040, 376.1042, 376.1224, 376.1350, 376.1356, 376.1363, 376.1372, 376.1385, 630.175, and 630.875, RSMo, are repealed and sixty-one new sections enacted in lieu thereof, to be known as sections 21.790, 191.603, 191.605, 191.607, 191.737, 191.1164, 191.1165, 191.1167, 191.1168, 192.067, 192.667, 192.990, 193.015, 195.060, 195.080, 195.100, 195.550, 195.820, 196.100, 197.108, 198.082, 208.146, 208.151, 208.225, 208.790, 208.896, 208.930, 217.930, 221.111, 221.125, 332.361, 334.037, 334.104, 334.108, 334.735, 334.736, 334.747, 334.749, 335.175, 337.712, 338.010, 338.015, 338.055, 338.056, 338.140, 338.143, 338.665, 374.500, 376.690, 376.1040, 376.1042, 376.1224, 376.1345, 376.1350, 376.1356, 376.1363, 376.1364, 376.1372, 376.1385, 630.175, and 630.875, to read as follows:

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

21.790. 1. There is hereby established the "Task Force on Substance Abuse Prevention and Treatment". The task force shall be composed of six members from the house of representatives, six members from the senate, and four members appointed by the governor. The senate members of the task force shall be appointed by the president pro tempore of the senate and the house members by the speaker of the house of representatives. There shall be at least two members from the minority party of the senate and at least two members from the minority party of the house of representatives. The members appointed by the governor shall include one member from the health care industry, one member who is a first responder or law enforcement officer, one member who is a member of the judiciary or a prosecuting attorney, and one member representing a substance abuse prevention advocacy group.

2. The task force shall select a chairperson and a vice-chairperson, one of whom shall be a member of the senate and one a member of the house of representatives. A majority of the members shall constitute a quorum. The task force shall meet at least once during each legislative session and at all other times as the chairperson may designate.

3. The task force shall:

(1) Conduct hearings on current and estimated future drug and substance use and abuse within the state;

(2) Explore solutions to substance abuse issues; and

(3) Draft or modify legislation as necessary to effectuate the goals of finding and funding education and treatment solutions to curb drug and substance use and abuse.

4. The task force may make reasonable requests for staff assistance from the research and appropriations staffs of the senate and house of representatives and the joint committee on legislative research. In the performance of its duties, the task force may request assistance or information from all branches of government and state departments, agencies, boards, commissions, and offices.

5. The task force shall report annually to the general assembly and the governor. The report shall include recommendations for legislation pertaining to substance abuse prevention and treatment.

191.603. As used in sections 191.600 to 191.615, the following terms shall

mean:

(1) "Areas of defined need", areas designated by the department pursuant to section 191.605, when services of a physician, **including a psychiatrist,** chiropractor**,** or dentist are needed to improve the patient-health professional ratio in the area, to contribute health care professional services to an area of economic impact, or to contribute health care professional services to an area suffering from the effects of a natural disaster;

(2) "Chiropractor", a person licensed and registered pursuant to chapter 331;

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

(4) "General dentist", dentists licensed and registered pursuant to chapter 332 engaged in general dentistry and who are providing such services to the general population;

(5) "Primary care physician", physicians licensed and registered pursuant to chapter 334 engaged in general or family practice, internal medicine, pediatrics or obstetrics and gynecology as their primary specialties, and who are providing such primary care services to the general population**;**

(6) "Psychiatrist", the same meaning as in section 632.005.

191.605. The department shall designate counties, communities, or sections of urban areas as areas of defined need for medical, **psychiatric,** chiropractic**,** or dental services when such county, community or section of an urban area has been designated as a primary care health professional shortage area**, a mental health care professional shortage area,** or a dental health care professional shortage area by the federal Department of Health and Human Services, or has been determined by the director of the department of health and senior services to have an extraordinary need for health care professional services, without a corresponding supply of such professionals.

191.607. The department shall adopt and promulgate regulations establishing standards for determining eligible persons for loan repayment pursuant to sections 191.600 to 191.615. These standards shall include, but are not limited to the following:

(1) Citizenship or permanent residency in the United States;

(2) Residence in the state of Missouri;

(3) Enrollment as a full-time medical student in the final year of a course of study offered by an approved educational institution or licensed to practice medicine or osteopathy pursuant to chapter 334**, including psychiatrists**;

(4) Enrollment as a full-time dental student in the final year of course

study offered by an approved educational institution or licensed to practice general dentistry pursuant to chapter 332;

(5) Enrollment as a full-time chiropractic student in the final year of course study offered by an approved educational institution or licensed to practice chiropractic medicine pursuant to chapter 331;

(6) Application for loan repayment.

191.737. 1. Notwithstanding the physician-patient privilege, any physician or health care provider may refer to the children's division families in which children may have been exposed to a controlled substance listed in section 195.017, schedules I, II and III, or alcohol as evidenced by **a written assessment, made or approved by a physician, health care provider, or by the children's division, that documents the child as being at risk of abuse or neglect and either**:

(1) Medical documentation of signs and symptoms consistent with controlled substances or alcohol exposure in the child at birth; or

(2) Results of a confirmed toxicology test for controlled substances performed at birth on the mother or the child**[**; and

(3) A written assessment made or approved by a physician, health care provider, or by the children's division which documents the child as being at risk of abuse or neglect**]**.

2. Notwithstanding the physician-patient privilege, any physician or health care provider shall refer to the children's division families in which infants are born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder as evidenced by:

(1) Medical documentation of signs and symptoms consistent with controlled substances or alcohol exposure in the child at birth; or

(2) Results of a confirmed toxicology test for controlled substances performed at birth on the mother or the child.

[2**]** **3**. Nothing in this section shall preclude a physician or other mandated reporter from reporting abuse or neglect of a child as required pursuant to the provisions of section 210.115.

[3**]** **4**. Any physician or health care provider complying with the provisions of this section, in good faith, shall have immunity from any civil liability that might otherwise result by reason of such actions.

[4**]** **5**. Referral and associated documentation provided for in this section shall be confidential and shall not be used in any criminal prosecution.

191.1164. 1. Sections 191.1164 to 191.1168 shall be known and may be cited as the "Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act".

2. As used in sections 191.1164 to 191.1168, the following terms shall mean:

(1) "Behavioral therapy", an individual, family, or group therapy designed to help patients engage in the treatment process, modify their attitudes and behaviors related to substance use, and increase healthy life skills;

(2) "Department of insurance", the department that has jurisdiction regulating health insurers;

(3) "Financial requirements", deductibles, co-payments, coinsurance, or out-of-pocket maximums;

(4) "Health care professional", a physician or other health care practitioner licensed, accredited, or certified by the state of Missouri to perform specified health services;

(5) "Health insurance plan", an individual or group plan that provides, or pays the cost of, health care items or services;

(6) "Health insurer", any person or entity that issues, offers, delivers, or administers a health insurance plan;

(7) "Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)", the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 found at 42 U.S.C. 300gg-26 and its implementing and related regulations found at 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115;

(8) "Nonquantitative treatment limitation" or "NQTL", any limitation on the scope or duration of treatment that is not expressed numerically;

(9) "Pharmacologic therapy", a prescribed course of treatment that may include methadone, buprenorphine, naltrexone, or other FDA-approved or evidence-based medications for the treatment of substance use disorder;

(10) "Pharmacy benefits manager", an entity that contracts with pharmacies on behalf of health carriers or any health plan sponsored by the state or a political subdivision of the state;

(11) "Prior authorization", the process by which the health insurer or the pharmacy benefits manager determines the medical

necessity of otherwise covered health care services prior to the rendering of such health care services. "Prior authorization" also includes any health insurer's or utilization review entity's requirement that a subscriber or health care provider notify the health insurer or utilization review entity prior to receiving or providing a health care service;

(12) "Quantitative treatment limitation" or "QTL", numerical limits on the scope or duration of treatment, which include annual, episode, and lifetime day and visit limits;

(13) "Step therapy", a protocol or program that establishes the specific sequence in which prescription drugs for a medical condition that are medically appropriate for a particular patient are authorized by a health insurer or prescription drug management company;

(14) "Urgent health care service", a health care service with respect to which the application of the time period for making a non-expedited prior authorization, in the opinion of a physician with knowledge of the enrollee's medical condition:

(a) Could seriously jeopardize the life or health of the subscriber or the ability of the enrollee to regain maximum function; or

(b) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

3. For the purpose of this section, "urgent health care service" shall include services provided for the treatment of substance use disorders.

191.1165. 1. Medication-assisted treatment (MAT) shall include pharmacologic therapies. A formulary used by a health insurer or managed by a pharmacy benefits manager, or medical benefit coverage in the case of medications dispensed through an opioid treatment program, shall include:

(1) Buprenorphine tablets;

(2) Methadone;

(3) Naloxone;

(4) Extended-release injectable naltrexone; and

(5) Buprenorphine/naloxone combination.

2. All MAT medications required for compliance in this section shall be placed on the lowest cost-sharing tier of the formulary

managed by the health insurer or the pharmacy benefits manager.

3. MAT medications provided for in this section shall not be subject to any of the following:

(1) Any annual or lifetime dollar limitations;

(2) Financial requirements and quantitative treatment limitations that do not comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), specifically 45 CFR 146.136(c)(3);

(3) Step therapy or other similar drug utilization strategy or policy when it conflicts or interferes with a prescribed or recommended course of treatment from a licensed health care professional; and

(4) Prior authorization for MAT medications as specified in this section.

4. MAT medications outlined in this section shall apply to all health insurance plans delivered in the state of Missouri.

5. Any entity that holds itself out as a treatment program or that applies for licensure by the state to provide clinical treatment services for substance use disorders shall be required to disclose the MAT services it provides, as well as which of its levels of care have been certified by an independent, national, or other organization that has competencies in the use of the applicable placement guidelines and level of care standards.

6. The MO HealthNet program shall cover the MAT medications and services provided for in this section and include those MAT medications in its preferred drug lists for the treatment of substance use disorders and prevention of overdose and death. The preferred drug list shall include all current and new formulations and medications that are approved by the U.S. Food and Drug Administration for the treatment of substance use disorders.

7. Drug courts or other diversion programs that provide for alternatives to jail or prison for persons with a substance use disorder shall be required to ensure all persons under their care are assessed for substance use disorders using standard diagnostic criteria by a licensed physician who actively treats patients with substance use disorders. The court or other diversion program shall make available the MAT services covered under this section, consistent with a treatment plan developed by the physician, and shall not impose any

limitations on the type of medication or other treatment prescribed or the dose or duration of MAT recommended by the physician.

8. Requirements under this section shall not be subject to a covered person's prior success or failure of the services provided.

191.1167. Any contract provision, written policy, or written procedure in violation of sections 191.1164 to 191.1168 shall be deemed to be unenforceable and shall be null and void.

191.1168. If any provision of sections 191.1164 to 191.1168 or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of sections 191.1164 to 191.1168 which may be given effect without the invalid provision or application, and to that end the provisions of sections 191.1164 to 191.1168 are severable.

192.067. 1. The department of health and senior services, for purposes of conducting epidemiological studies to be used in promoting and safeguarding the health of the citizens of Missouri under the authority of this chapter is authorized to receive information from patient medical records. The provisions of this section shall also apply to the collection, analysis, and disclosure of nosocomial infection data from patient records collected pursuant to section 192.667 **and to the collection of data under section 192.990**.

2. The department shall maintain the confidentiality of all medical record information abstracted by or reported to the department. Medical information secured pursuant to the provisions of subsection 1 of this section may be released by the department only in a statistical aggregate form that precludes and prevents the identification of patient, physician, or medical facility except that medical information may be shared with other public health authorities and coinvestigators of a health study if they abide by the same confidentiality restrictions required of the department of health and senior services and except as otherwise authorized by the provisions of sections 192.665 to 192.667**, or section 192.990**. The department of health and senior services, public health authorities and coinvestigators shall use the information collected only for the purposes provided for in this section **[**and**],** section 192.667**, or section 192.990**.

3. No individual or organization providing information to the department in accordance with this section shall be deemed to be or be held liable, either civilly or criminally, for divulging confidential information unless such individual organization acted in bad faith or with malicious purpose.

4. The department of health and senior services is authorized to

reimburse medical care facilities, within the limits of appropriations made for that purpose, for the costs associated with abstracting data for special studies.

5. Any department of health and senior services employee, public health authority or coinvestigator of a study who knowingly releases information which violates the provisions of this section shall be guilty of a class A misdemeanor and, upon conviction, shall be punished as provided by law.

192.667. 1. All health care providers shall at least annually provide to the department charge data as required by the department. All hospitals shall at least annually provide patient abstract data and financial data as required by the department. Hospitals as defined in section 197.020 shall report patient abstract data for outpatients and inpatients. Ambulatory surgical centers and abortion facilities as defined in section 197.200 shall provide patient abstract data to the department. The department shall specify by rule the types of information 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 infections and procedures;

(4) Whether the data is subject to the same or greater level of confidentiality of the identity of an individual patient;

(5) Whether the National Healthcare Safety Network, or its successor, has the capacity to receive, analyze, and report the required data for all facilities;

(6) Whether the cost to implement the National Healthcare Safety Network infection data collection and reporting system is the same or less.

5. After considering the recommendations of the infection control advisory panel, and provided that the requirements of subsection 13 of this section can be met, the department shall implement guidelines from the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor. It shall be a condition of licensure for hospitals that meet the minimum public reporting requirements of the National Healthcare Safety Network and the Centers for Medicare and Medicaid Services to participate in the National Healthcare Safety Network, or its successor. Such hospitals shall permit the National Healthcare Safety Network, or its successor, to disclose

facility-specific infection data to the department as required under this section, and as necessary to provide the public reports required by the department. It shall be a condition of licensure for any ambulatory surgical center or abortion facility which does not voluntarily participate in the National Healthcare Safety Network, or its successor, to submit 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 provisions of section 192.067. The department shall not use or release any information provided under section 192.665 and this section which would enable any person to determine any health care provider's negotiated discounts with specific preferred provider organizations or other managed care organizations. The department shall not release data in a form which could be used to identify a patient. Any violation of this subsection is a class A misdemeanor.

8. The department shall undertake a reasonable number of studies and publish information, including at least an annual consumer guide, in collaboration with health care providers, business coalitions and consumers based

upon the information obtained pursuant to the provisions of section 192.665 and this section. The department shall allow all health care providers and associations and related organizations who have submitted data which will be used in any publication to review and comment on the publication prior to its publication or release for general use. The publication shall be made available to the public for a reasonable charge.

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

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

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

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

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

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

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

(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 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, 2004, shall be invalid and void.

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

20. Hospitals described in subsection 19 of this section shall meet the National Healthcare Safety Network requirements for reporting antimicrobial usage or resistance by using the Centers for Disease Control and Prevention's Antimicrobial Use and Resistance (AUR) Module when **[**regulations concerning Stage 3 of the Medicare and Medicaid Electronic Health Records Incentive Programs promulgated by the Centers for Medicare and Medicaid Services that enable the electronic interface for such reporting are effective**] conditions of participation promulgated by the Centers for Medicare and Medicaid Services requiring the electronic reporting of antibiotic use or antibiotic resistance by hospitals become effective**. When such antimicrobial usage or resistance reporting takes effect, hospitals shall authorize the National Healthcare Safety Network, or its successor, to disclose to the department facility-specific information reported to the AUR Module. Facility-

specific data on antibiotic usage and resistance collected under this subsection shall not be disclosed to the public, but the department may release case-specific information to other facilities, physicians, and the public if the department determines on a case-by-case basis that the release of such information is necessary to protect persons in a public health emergency. **Nothing in this section shall prohibit a hospital from voluntarily reporting antibiotic use or antibiotic resistance data 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.

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

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

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

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

3. The board shall be composed of no more than eighteen members, with a chair elected from among its membership. The board shall meet at least twice per year and shall approve the strategic priorities, funding allocations, work processes, and products of the board. Members of the board shall be appointed by the director of the department. Members shall serve four-year terms, except that the initial terms shall be staggered so that approximately one-third serve three, four, and five-year terms.

4. The board shall have a multidisciplinary and diverse membership that represents a variety of medical and nursing specialties, including, but not limited to, obstetrics and maternal-fetal care, as well as state or local public health officials, epidemiologists,

statisticians, community organizations, geographic regions, and other individuals or organizations that are most affected by maternal deaths and lack of access to maternal health care services.

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

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

(2) Identifying factors associated with maternal deaths;

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

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

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

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

(4) Consulting with relevant experts, as needed;

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

(6) Disseminating recommendations to policy makers, health care providers and facilities, and the general public;

(7) Recommending and promoting preventative strategies and making recommendations for systems changes;

(8) Protecting the confidentiality of the hospitals and individuals involved in any maternal deaths;

(9) Examining racial and social disparities in maternal deaths;

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

(11) Making publicly available the contact information of the board for use in such reporting;

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

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

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

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

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

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

9. Upon request by the department, health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, law enforcement agencies, driver's license bureaus, other state agencies, and facilities licensed by the department shall provide to the department data related to maternal deaths from sources such as medical records, autopsy reports, medical examiner's reports, coroner's reports, law enforcement reports, motor vehicle records, social services records, and other sources as appropriate. Such data requests shall be limited to maternal deaths which have occurred within the previous twenty-four months. No entity shall be held liable for civil damages or

be subject to any criminal or disciplinary action when complying in good faith with a request from the department for information under the provisions of this subsection.

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

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

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

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

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

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

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

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

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

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

193.015. As used in sections 193.005 to 193.325, unless the context clearly indicates otherwise, the following terms shall mean:

(1) "Advanced practice registered nurse", a person licensed to practice as an advanced practice registered nurse under chapter 335, and who has been delegated tasks outlined in section 193.145 by a physician with whom they have entered into a collaborative practice arrangement under chapter 334;

(2) "Assistant physician", as such term is defined in section 334.036, and who has been delegated tasks outlined in section 193.145 by a physician with whom they have entered into a collaborative practice arrangement under chapter 334;

(3) "Dead body", a human body or such parts of such human body from the condition of which it reasonably may be concluded that death recently occurred;

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

(5) "Final disposition", the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or fetus;

(6) "Institution", any establishment, public or private, which provides inpatient or outpatient medical, surgical, or diagnostic care or treatment or

nursing, custodian, or domiciliary care, or to which persons are committed by law;

(7) "Live birth", the complete expulsion or extraction from its mother of a child, irrespective of the duration of pregnancy, which after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached;

(8) "Physician", a person authorized or licensed to practice medicine or osteopathy pursuant to chapter 334;

(9) "Physician assistant", a person licensed to practice as a physician assistant pursuant to chapter 334, and who has been delegated tasks outlined in section 193.145 by a physician with whom they have entered into a **[**supervision agreement**] collaborative practice arrangement** under chapter 334;

(10) "Spontaneous fetal death", a noninduced death prior to the complete expulsion or extraction from its mother of a fetus, irrespective of the duration of pregnancy; the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles;

(11) "State registrar", state registrar of vital statistics of the state of Missouri;

(12) "System of vital statistics", the registration, collection, preservation, amendment and certification of vital records; the collection of other reports required by sections 193.005 to 193.325 and section 194.060; and activities related thereto including the tabulation, analysis and publication of vital statistics;

(13) "Vital records", certificates or reports of birth, death, marriage, dissolution of marriage and data related thereto;

(14) "Vital statistics", the data derived from certificates and reports of birth, death, spontaneous fetal death, marriage, dissolution of marriage and related reports.

195.060. 1. Except as provided in subsection 4 of this section, a pharmacist, in good faith, may sell and dispense controlled substances to any person only upon a prescription of a practitioner as authorized by statute, provided that the controlled substances listed in Schedule V may be sold without prescription in accordance with regulations of the department of health and senior services. All written prescriptions shall be signed by the person prescribing the same**, except for electronic prescriptions**. All prescriptions shall be dated on the day when issued and bearing the full name and address of

the patient for whom, or of the owner of the animal for which, the drug is prescribed, and the full name, address, and the registry number under the federal controlled substances laws of the person prescribing, if he or she is required by those laws to be so registered. If the prescription is for an animal, it shall state the species of the animal for which the drug is prescribed. The person filling the prescription shall either write the date of filling and his or her own signature on the prescription or retain the date of filling and the identity of the dispenser as electronic prescription information. The prescription or electronic prescription information shall be retained on file by the proprietor of the pharmacy in which it is filled for a period of two years, so as to be readily accessible for inspection by any public officer or employee engaged in the enforcement of this law. No prescription for a drug in Schedule I or II shall be filled more than six months after the date prescribed; no prescription for a drug in Schedule I or II shall be refilled; no prescription for a drug in Schedule III or IV shall be filled or refilled more than six months after the date of the original prescription or be refilled more than five times unless renewed by the practitioner.

2. A pharmacist, in good faith, may sell and dispense controlled substances to any person upon a prescription of a practitioner located in another state, provided that the:

(1) Prescription was issued according to and in compliance with the applicable laws of that state and the United States; and

(2) Quantity limitations in subsection 4 of section 195.080 apply to prescriptions dispensed to patients located in this state.

3. The legal owner of any stock of controlled substances in a pharmacy, upon discontinuance of dealing in such drugs, may sell the stock to a manufacturer, wholesaler, or pharmacist, but only on an official written order.

4. A pharmacist, in good faith, may sell and dispense any Schedule II drug or drugs to any person in emergency situations as defined by rule of the department of health and senior services upon an oral prescription by an authorized practitioner.

5. Except where a bona fide physician-patient-pharmacist relationship exists, prescriptions for narcotics or hallucinogenic drugs shall not be delivered to or for an ultimate user or agent by mail or other common carrier.

195.080. 1. Except as otherwise provided in this chapter and chapter 579, this chapter and chapter 579 shall not apply to the following cases: prescribing, administering, dispensing or selling at retail of liniments, ointments, and other preparations that are susceptible of external use only and that contain controlled

substances in such combinations of drugs as to prevent the drugs from being readily extracted from such liniments, ointments, or preparations, except that this chapter and chapter 579 shall apply to all liniments, ointments, and other preparations that contain coca leaves in any quantity or combination.

2. Unless otherwise provided in sections 334.037, 334.104, and 334.747, a practitioner, other than a veterinarian, shall not issue an initial prescription for more than a seven-day supply of any opioid controlled substance upon the initial consultation and treatment of a patient for acute pain. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription in compliance with the general provisions of this chapter and chapter 579. Prior to issuing an initial prescription for an opioid controlled substance, a practitioner shall consult with the patient regarding the quantity of the opioid and the patient's option to fill the prescription in a lesser quantity and shall inform the patient of the risks associated with the opioid prescribed. If, in the professional medical judgment of the practitioner, more than a seven-day supply is required to treat the patient's acute pain, the practitioner may issue a prescription for the quantity needed to treat the patient; provided, that the practitioner shall document in the patient's medical record the condition triggering the necessity for more than a seven-day supply and that a nonopioid alternative was not appropriate to address the patient's condition. The provisions of this subsection shall not apply to prescriptions for opioid controlled substances for a patient who is currently undergoing treatment for cancer **or sickle cell disease**, is receiving hospice care from a hospice certified under chapter 197 or palliative care, is a resident of a long-term care facility licensed under chapter 198, or is receiving treatment for substance abuse or opioid dependence.

3. A pharmacist or pharmacy shall not be subject to disciplinary action or other civil or criminal liability for dispensing or refusing to dispense medication in good faith pursuant to an otherwise valid prescription that exceeds the prescribing limits established by subsection 2 of this section.

4. Unless otherwise provided in this section, the quantity of Schedule II controlled substances prescribed or dispensed at any one time shall be limited to a thirty-day supply. The quantity of Schedule III, IV or V controlled substances prescribed or dispensed at any one time shall be limited to a ninety-day supply and shall be prescribed and dispensed in compliance with the general provisions of this chapter and chapter 579. The supply limitations provided in this subsection may be increased up to three months if the physician describes on the

prescription form or indicates via telephone, fax, or electronic communication to the pharmacy to be entered on or attached to the prescription form the medical reason for requiring the larger supply. The supply limitations provided in this subsection shall not apply if:

(1) The prescription is issued by a practitioner located in another state according to and in compliance with the applicable laws of that state and the United States and dispensed to a patient located in another state; or

(2) The prescription is dispensed directly to a member of the United States Armed Forces serving outside the United States.

5. The partial filling of a prescription for a Schedule II substance is permissible as defined by regulation by the department of health and senior services.

195.100. 1. It shall be unlawful to distribute any controlled substance in a commercial container unless such container bears a label containing an identifying symbol for such substance in accordance with federal laws.

2. It shall be unlawful for any manufacturer of any controlled substance to distribute such substance unless the labeling thereof conforms to the requirements of federal law and contains the identifying symbol required in subsection 1 of this section.

3. The label of a controlled substance in Schedule II, III or IV shall, when dispensed to or for a patient, contain a clear, concise warning that it is a criminal offense to transfer such narcotic or dangerous drug to any person other than the patient.

4. Whenever a manufacturer sells or dispenses a controlled substance and whenever a wholesaler sells or dispenses a controlled substance in a package prepared by him or her, the manufacturer or wholesaler shall securely affix to each package in which that drug is contained a label showing in legible English the name and address of the vendor and the quantity, kind, and form of controlled substance contained therein. No person except a pharmacist for the purpose of filling a prescription under this chapter, shall alter, deface, or remove any label so affixed.

5. Whenever a pharmacist or practitioner sells or dispenses any controlled substance on a prescription issued by a physician, physician assistant, dentist, podiatrist, veterinarian, or advanced practice registered nurse, the pharmacist or practitioner shall affix to the container in which such drug is sold or dispensed a label showing his or her own name and address of the pharmacy or practitioner for whom he or she is lawfully acting; the name of the patient or, if the patient

is an animal, the name of the owner of the animal and the species of the animal; the name of the physician, physician assistant, dentist, podiatrist, advanced practice registered nurse, or veterinarian by whom the prescription was written; the name of the collaborating physician if the prescription is written by an advanced practice registered nurse or **[**the supervising physician if the prescription is written by**]** a physician assistant, and such directions as may be stated on the prescription. No person shall alter, deface, or remove any label so affixed.

195.550. 1. Notwithstanding any other provision of this section or any other law to the contrary, beginning January 1, 2021, no person shall issue any prescription in this state for any Schedule II, III, or IV controlled substance unless the prescription is made by electronic prescription from the person issuing the prescription to a pharmacy, except for prescriptions:

(1) Issued by veterinarians;

(2) Issued in circumstances where electronic prescribing is not available due to temporary technological or electrical failure;

(3) Issued by a practitioner to be dispensed by a pharmacy located outside the state;

(4) Issued when the prescriber and dispenser are the same entity;

(5) Issued that include elements that are not supported by the most recently implemented version of the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard;

(6) Issued by a practitioner for a drug that the federal Food and Drug Administration requires the prescription to contain certain elements that are not able to be accomplished with electronic processing;

(7) Issued by a practitioner allowing for the dispensing of a nonpatient specific prescription pursuant to a standing order, approved protocol for drug therapy, collaborative drug management or comprehensive medication management, in response to a public health emergency, or other circumstances where the practitioner may issue a nonpatient specific prescription;

(8) Issued by a practitioner prescribing a drug under a research protocol;

(9) Issued by practitioners who have received an annual waiver, or a renewal thereof, from the requirement to use electronic prescribing, pursuant to a process established in regulation by the department of health and senior services, due to economic hardship, technological limitations, or other exceptional circumstances demonstrated by the practitioner;

(10) Issued by a practitioner under circumstances where, notwithstanding the practitioner's present ability to make an electronic prescription as required by this subsection, such practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition; or

(11) Issued where the patient specifically requests a written prescription.

2. A pharmacist who receives a written, oral, or faxed prescription is not required to verify that the prescription properly falls under one of the exceptions from the requirement to electronically prescribe. Pharmacists may continue to dispense medications from otherwise valid written, oral, or fax prescriptions that are consistent with state and federal laws and regulations.

3. An individual who violates the provisions of this section may be subject to discipline by his or her professional licensing board.

195.820. The department of health and senior services may establish through rule promulgation an administration and processing fee, exclusive of any application or license fee established under article XIV of the Missouri Constitution, if the funds in the Missouri veterans' health and care fund are insufficient to provide for the department's administration of the provisions of article XIV. Such fees shall be deposited in the Missouri veterans' health and care fund for use solely for the administration of the department's duties under article XIV. Such administration and processing fee shall not be increased more than once during a one-year period, but may be set to increase or decrease each year by the percentage of increase or decrease from the end of the previous calendar year of the Consumer Price Index, or successor index as published by the U.S. Department of Labor, or its successor agency.

196.100. 1. Any manufacturer, packer, distributor or seller of drugs or devices in this state shall comply with the current federal labeling requirements contained in the Federal Food, Drug and Cosmetic Act, as amended, and any federal regulations promulgated thereunder. Any drug or device which contains labeling that is not in compliance with the provisions of this section shall be deemed misbranded.

2. A drug dispensed on **an electronic prescription or** a written prescription signed by a licensed physician, dentist, or veterinarian, except a drug dispensed in the course of the conduct of a business of dispensing drugs pursuant to a diagnosis by mail, shall be exempt from the requirements of this section if such physician, dentist, or veterinarian is licensed by law to administer such drug, and such drug bears a label containing the name and place of business of the dispenser, the serial number and date of such prescription, and the name of such physician, dentist, or veterinarian.

3. The department is hereby directed to promulgate regulations exempting from any labeling or packaging requirement of sections 196.010 to 196.120, drugs and devices which are, in accordance with the practice of the trade, to be processed, labeled, or repacked in substantial quantities at establishments other than those where originally processed or packed, on condition that such drugs and devices are not adulterated or misbranded under the provisions of said sections upon removal from such processing, labeling, or repacking establishment.

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

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

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

(2) The name of any member of his or her immediate family who 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 result in a conflict of interest in conducting an inspection or survey for a hospital. Upon receiving such notice, the department, when assigning an inspector or surveyor to inspect or survey a hospital, for any purpose, shall take steps to verify the information and, if the department has reason to believe that such information is correct, the department shall not assign the inspector or surveyor to the hospital or any hospital within its organization so as to avoid an appearance of prejudice or favor to the hospital or bias on the part of the inspector or surveyor.

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

the department**[**,**];** by any community college**;** or by the vocational education department of any high school.

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

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

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

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

(2) Continuing in-service training to assure continuing competency in existing and new nursing skills. All nursing assistants trained prior to January 1, 1989, shall attend, by August 31, 1989, an entire special retraining program established by rule or regulation of the department which shall contain information on methods of handling mentally confused residents and which may be offered on premises by the employing facility**]**.

[4.**]** **5. Certified** nursing assistants who have not successfully completed

the nursing assistant training program prior to employment may begin duties as a **certified** nursing assistant **[**only after completing an initial twelve hours of basic orientation approved by the department**]** and may provide direct resident care only if under the **[**general**]** **direct** supervision of a licensed nurse prior to completion of the seventy-five classroom hours of the training program.

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

7. Persons completing the training requirements of unlicensed assistive personnel under 19 CSR 30-20.125 or its successor regulation, and who have completed the competency 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.

208.146. 1. The program established under this section shall be known as the "Ticket to Work Health Assurance Program". Subject to appropriations and in accordance with the federal Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), Public Law 106-170, the medical assistance provided for in section 208.151 may be paid for a person who is employed and who:

(1) Except for earnings, meets the definition of disabled under the Supplemental Security Income Program or meets the definition of an employed individual with a medically improved disability under TWWIIA;

(2) Has earned income, as defined in subsection 2 of this section;

(3) Meets the asset limits in subsection 3 of this section;

(4) Has net income, as defined in subsection 3 of this section, that does not exceed the limit for permanent and totally disabled individuals to receive nonspenddown MO HealthNet under subdivision (24) of subsection 1 of section 208.151; and

(5) Has a gross income of two hundred fifty percent or less of the federal poverty level, excluding any earned income of the worker with a disability between two hundred fifty and three hundred percent of the federal poverty

level. For purposes of this subdivision, "gross income" includes all income of the person and the person's spouse that would be considered in determining MO HealthNet eligibility for permanent and totally disabled individuals under subdivision (24) of subsection 1 of section 208.151. Individuals with gross incomes in excess of one hundred percent of the federal poverty level shall pay a premium for participation in accordance with subsection 4 of this section.

2. For income to be considered earned income for purposes of this section, the department of social services shall document that Medicare and Social Security taxes are withheld from such income. Self-employed persons shall provide proof of payment of Medicare and Social Security taxes for income to be considered earned.

3. (1) For purposes of determining eligibility under this section, the available asset limit and the definition of available assets shall be the same as those used to determine MO HealthNet eligibility for permanent and totally disabled individuals under subdivision (24) of subsection 1 of section 208.151 except for:

(a) Medical savings accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed five thousand dollars per year; and

(b) Independent living accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed five thousand dollars per year. For purposes of this section, an "independent living account" means an account established and maintained to provide savings for transportation, housing, home modification, and personal care services and assistive devices associated with such person's disability.

(2) To determine net income, the following shall be disregarded:

(a) All earned income of the disabled worker;

(b) The first sixty-five dollars and one-half of the remaining earned income of a nondisabled spouse's earned income;

(c) A twenty dollar standard deduction;

(d) Health insurance premiums;

(e) A seventy-five dollar a month standard deduction for the disabled worker's dental and optical insurance when the total dental and optical insurance premiums are less than seventy-five dollars;

(f) All Supplemental Security Income payments, and the first fifty dollars of SSDI payments;

(g) A standard deduction for impairment-related employment expenses equal to one-half of the disabled worker's earned income.

4. Any person whose gross income exceeds one hundred percent of the federal poverty level shall pay a premium for participation in the medical assistance provided in this section. Such premium shall be:

(1) For a person whose gross income is more than one hundred percent but less than one hundred fifty percent of the federal poverty level, four percent of income at one hundred percent of the federal poverty level;

(2) For a person whose gross income equals or exceeds one hundred fifty percent but is less than two hundred percent of the federal poverty level, four percent of income at one hundred fifty percent of the federal poverty level;

(3) For a person whose gross income equals or exceeds two hundred percent but less than two hundred fifty percent of the federal poverty level, five percent of income at two hundred percent of the federal poverty level;

(4) For a person whose gross income equals or exceeds two hundred fifty percent up to and including three hundred percent of the federal poverty level, six percent of income at two hundred fifty percent of the federal poverty level.

5. Recipients of services through this program shall report any change in income or household size within ten days of the occurrence of such change. An increase in premiums resulting from a reported change in income or household size shall be effective with the next premium invoice that is mailed to a person after due process requirements have been met. A decrease in premiums shall be effective the first day of the month immediately following the month in which the change is reported.

6. If an eligible person's employer offers employer-sponsored health insurance and the department of social services determines that it is more cost effective, such person shall participate in the employer-sponsored insurance. The department shall pay such person's portion of the premiums, co-payments, and any other costs associated with participation in the employer-sponsored health insurance.

7. The provisions of this section shall expire August 28, **[**2019**]** **2025**.

208.151. 1. Medical assistance on behalf of needy persons shall be known as "MO HealthNet". For the purpose of paying MO HealthNet benefits and to comply with Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.) as amended, the following needy persons shall be eligible to receive MO HealthNet benefits to the extent and in the manner hereinafter provided:

(1) All participants receiving state supplemental payments for the aged, blind and disabled;

(2) All participants receiving aid to families with dependent children benefits, including all persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040. Participants eligible under this subdivision who are participating in treatment court, as defined in section 478.001, shall have their eligibility automatically extended sixty days from the time their dependent child is removed from the custody of the participant, subject to approval of the Centers for Medicare and Medicaid Services;

(3) All participants receiving blind pension benefits;

(4) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits under the eligibility standards in effect December 31, 1973, or less restrictive standards as established by rule of the family support division, who are sixty-five years of age or over and are patients in state institutions for mental diseases or tuberculosis;

(5) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children except for the requirements of subdivision (2) of subsection 1 of section 208.040, and who are residing in an intermediate care facility, or receiving active treatment as inpatients in psychiatric facilities or programs, as defined in 42 U.S.C. Section 1396d, as amended;

(6) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children benefits except for the requirement of deprivation of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(7) All persons eligible to receive nursing care benefits;

(8) All participants receiving family foster home or nonprofit private child-care institution care, subsidized adoption benefits and parental school care wherein state funds are used as partial or full payment for such care;

(9) All persons who were participants receiving old age assistance benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who continue to meet the eligibility requirements, except income, for these assistance categories, but who are no longer receiving such benefits because of the implementation of Title XVI of the federal Social Security Act, as amended;

(10) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child in the home;

(11) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child who is deprived of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(12) Pregnant women or infants under one year of age, or both, whose family income does not exceed an income eligibility standard equal to one hundred eighty-five percent of the federal poverty level as established and amended by the federal Department of Health and Human Services, or its successor agency;

(13) Children who have attained one year of age but have not attained six years of age who are eligible for medical assistance under 6401 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The family support division shall use an income eligibility standard equal to one hundred thirty-three percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency;

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the family support division shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide MO HealthNet coverage under this subdivision, the department of social services may revise the state MO HealthNet plan to extend coverage under 42 U.S.C. Section 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. Section 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. Section 1396a;

(15) The family support division shall not establish a resource eligibility standard in assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The MO HealthNet division shall define the amount and scope of benefits which are available to individuals eligible under each of the subdivisions (12), (13), and (14) of this subsection, in accordance with the requirements of federal law and regulations promulgated thereunder;

(16) Notwithstanding any other provisions of law to the contrary,

ambulatory prenatal care shall be made available to pregnant women during a period of presumptive eligibility pursuant to 42 U.S.C. Section 1396r-1, as amended;

(17) A child born to a woman eligible for and receiving MO HealthNet benefits under this section on the date of the child's birth shall be deemed to have applied for MO HealthNet benefits and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of time determined in accordance with applicable federal and state law and regulations so long as the child is a member of the woman's household and either the woman remains eligible for such assistance or for children born on or after January 1, 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon notification of such child's birth, the family support division shall assign a MO HealthNet eligibility identification number to the child so that claims may be submitted and paid under such child's identification number;

(18) Pregnant women and children eligible for MO HealthNet benefits pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for MO HealthNet benefits be required to apply for aid to families with dependent children. The family support division shall utilize an application for eligibility for such persons which eliminates information requirements other than those necessary to apply for MO HealthNet benefits. The division shall provide such application forms to applicants whose preliminary income information indicates that they are ineligible for aid to families with dependent children. Applicants for MO HealthNet benefits under subdivision (12), (13) or (14) of this subsection shall be informed of the aid to families with dependent children program and that they are entitled to apply for such benefits. Any forms utilized by the family support division for assessing eligibility under this chapter shall be as simple as practicable;

(19) Subject to appropriations necessary to recruit and train such staff, the family support division shall provide one or more full-time, permanent eligibility specialists to process applications for MO HealthNet benefits at the site of a health care provider, if the health care provider requests the placement of such eligibility specialists and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment of such eligibility specialists. The division may provide a health care provider with a part-time or temporary eligibility specialist at the site of a health care provider if the health care provider requests the placement of such an

eligibility specialist and reimburses the division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment, of such an eligibility specialist. The division may seek to employ such eligibility specialists who are otherwise qualified for such positions and who are current or former welfare participants. The division may consider training such current or former welfare participants as eligibility specialists for this program;

(20) Pregnant women who are eligible for, have applied for and have received MO HealthNet benefits under subdivision (2), (10), (11) or (12) of this subsection shall continue to be considered eligible for all pregnancy-related and postpartum MO HealthNet benefits provided under section 208.152 until the end of the sixty-day period beginning on the last day of their pregnancy. Pregnant women receiving substance abuse treatment within sixty days of giving birth shall, subject to appropriations and any necessary federal approval, be eligible for MO HealthNet benefits for substance abuse treatment and mental health services for the treatment of substance abuse for no more than twelve additional months, as long as the woman remains adherent with treatment. The department of mental health and the department of social services shall seek any necessary waivers or state plan amendments from the Centers for Medicare and Medicaid Services and shall develop rules relating to treatment plan adherence. No later than fifteen months after receiving any necessary waiver, the department of mental health and the department of social services shall report to the house of representatives budget committee and the senate appropriations committee on the compliance with federal cost neutrality requirements;

(21) Case management services for pregnant women and young children at risk shall be a covered service. To the greatest extent possible, and in compliance with federal law and regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192 or chapter 205 or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of intellectual disability and developmental disability program and the prenatal care program administered by the department of health and senior services. The department of social services shall by regulation establish the

methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective MO HealthNet-eligible high-risk mothers and enroll them in the state's MO HealthNet program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the MO HealthNet program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible and shall not include involvement in any MO HealthNet prepaid, case-managed programs;

(22) By January 1, 1988, the department of social services and the department of health and senior services shall study all significant aspects of presumptive eligibility for pregnant women and submit a joint report on the subject, including projected costs and the time needed for implementation, to the general assembly. The department of social services, at the direction of the general assembly, may implement presumptive eligibility by regulation promulgated pursuant to chapter 207;

(23) All participants who would be eligible for aid to families with dependent children benefits except for the requirements of paragraph (d) of subdivision (1) of section 208.150;

(24) (a) All persons who would be determined to be eligible for old age assistance benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriation;

(b) All persons who would be determined to be eligible for aid to the blind benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005, except that less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level;

(c) All persons who would be determined to be eligible for permanent and total disability benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f); or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1,

2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriations. Eligibility standards for permanent and total disability benefits shall not be limited by age;

(25) Persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage pursuant to 42 U.S.C. Section 1396a(a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. Section 1396r-1;

(26) **[**Effective August 28, 2013,**]** Persons who are in foster care under the responsibility of the state of Missouri on the date such persons attained the age of eighteen years, or at any time during the thirty-day period preceding their eighteenth birthday, **or persons who received foster care for at least six months in another state, are residing in Missouri, and are at least eighteen years of age,** without regard to income or assets, if such persons:

(a) Are under twenty-six years of age;

(b) Are not eligible for coverage under another mandatory coverage group; and

(c) Were covered by Medicaid while they were in foster care.

2. Rules and regulations to implement this section shall be promulgated in accordance with chapter 536. 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, 2002, shall be invalid and void.

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. Section 601, et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for MO HealthNet benefits for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. Section 601, et seq., as amended, in at least

three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for MO HealthNet benefits for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. Section 1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. Section 1396r-6 shall receive MO HealthNet benefits without fee for an additional six months. The MO HealthNet division may provide by rule and as authorized by annual appropriation the scope of MO HealthNet coverage to be granted to such families.

4. When any individual has been determined to be eligible for MO HealthNet benefits, such medical assistance will be made available to him or her for care and services furnished in or after the third month before the month in which he made application for such assistance if such individual was, or upon application would have been, eligible for such assistance at the time such care and services were furnished; provided, further, that such medical expenses remain unpaid.

5. The department of social services may apply to the federal Department of Health and Human Services for a MO HealthNet waiver amendment to the Section 1115 demonstration waiver or for any additional MO HealthNet waivers necessary not to exceed one million dollars in additional costs to the state, unless subject to appropriation or directed by statute, but in no event shall such waiver applications or amendments seek to waive the services of a rural health clinic or a federally qualified health center as defined in 42 U.S.C. Section 1396d(l)(1) and (2) or the payment requirements for such clinics and centers as provided in 42 U.S.C. Section 1396a(a)(15) and 1396a(bb) unless such waiver application is approved by the oversight committee created in section 208.955. A request for such a waiver so submitted shall only become effective by executive order not sooner than ninety days after the final adjournment of the session of the general assembly to which it is submitted, unless it is disapproved within sixty days of its submission to a regular session by a senate or house resolution adopted by a majority vote of the respective elected members thereof, unless the request for such a waiver is made subject to appropriation or directed by statute.

6. Notwithstanding any other provision of law to the contrary, in any given fiscal year, any persons made eligible for MO HealthNet benefits under

subdivisions (1) to (22) of subsection 1 of this section shall only be eligible if annual appropriations are made for such eligibility. This subsection shall not apply to classes of individuals listed in 42 U.S.C. Section 1396a(a)(10)(A)(I).

208.225. 1. To implement fully the provisions of section 208.152, the MO HealthNet division shall calculate the Medicaid per diem reimbursement rates of each nursing home participating in the Medicaid program as a provider of nursing home services based on its costs reported in the Title XIX cost report filed with the MO HealthNet division for its fiscal year as provided in subsection 2 of this section.

2. The recalculation of Medicaid rates to all Missouri facilities will be performed as follows: effective July 1, 2004, the department of social services shall use the Medicaid cost report containing adjusted costs for the facility fiscal year ending in 2001 and redetermine the allowable per-patient day costs for each facility. The department shall recalculate the class ceilings in the patient care, one hundred twenty percent of the median; ancillary, one hundred twenty percent of the median; and administration, one hundred ten percent of the median cost centers. Each facility shall receive as a rate increase one-third of the amount that is unpaid based on the recalculated cost determination.

3. Any intermediate care facility or skilled nursing facility, as such terms are defined in section 198.006, participating in MO HealthNet that incurs total capital expenditures, as such term is defined in section 197.305, in excess of two thousand dollars per bed shall be entitled to obtain from the MO HealthNet division a recalculation of its Medicaid per diem reimbursement rate based on its additional capital costs or all costs incurred during the facility fiscal year during which such capital expenditures were made. Such recalculated reimbursement rate shall become effective and payable when granted by the MO HealthNet division as of the date of application for a rate adjustment.

208.790. 1. The applicant shall have or intend to have a fixed place of residence in Missouri, with the present intent of maintaining a permanent home in Missouri for the indefinite future. The burden of establishing proof of residence within this state is on the applicant. The requirement also applies to persons residing in long-term care facilities located in the state of Missouri.

2. The department shall promulgate rules outlining standards for documenting proof of residence in Missouri. Documents used to show proof of residence shall include the applicant's name and address in the state of Missouri.

3. Applicant household income limits for eligibility shall be subject to appropriations, but in no event shall applicants have household income that is greater than one hundred eighty-five percent of the federal poverty level for the applicable family size for the applicable year as converted to the MAGI equivalent net income standard. **[**The provisions of this subsection shall only apply to Medicaid dual eligible individuals.**]**

4. The department shall promulgate rules outlining standards for documenting proof of household income.

208.896. 1. To ensure the availability of comprehensive and cost-effective choices for MO HealthNet participants who have been diagnosed with Alzheimer's or related disorders as defined in section 172.800, to live at home in the community of their choice and to receive support from the caregivers of their choice, the department of social services shall apply to the United States Secretary of Health and Human Services for a structured family caregiver waiver under Section 1915(c) of the federal Social Security Act. Federal approval of the waiver is necessary to implement the provisions of this section. Structured family caregiving shall be considered an agency-directed model, and no financial management services shall be required.

2. The structured family caregiver waiver shall include:

(1) A choice for participants of qualified and credentialed caregivers, including family caregivers;

(2) A choice for participants of community settings in which they receive structured family caregiving. A caregiver may provide structured family caregiving services in the caregiver's home or the participant's home, but the caregiver shall reside full time in the same home as the participant;

(3) A requirement that caregivers under this section are added to the family care safety registry and comply with the provisions of sections 210.900 to 210.936;

(4) A requirement that all caregivers shall obtain liability insurance as required;

(5) A cap of three hundred participants to receive structured family caregiving;

(6) A requirement that all organizations serving as structured family caregiving agencies are considered in-home service provider

agencies and are accountable for documentation of services delivered, meeting the requirements set forth for these provider agencies, qualification and requalification of caregivers and homes, caregiver training, providing a case manager or registered nurse to create a service plan tailored to each participant's needs, professional staff support for eligible people, ongoing monitoring and support through monthly home visits, deployment of electronic daily notes, and remote consultation with families;

(7) Caregivers are accountable for providing for the participant's personal care needs. This includes, but is not limited to, laundry, housekeeping, shopping, transportation, and assistance with activities of daily living;

(8) A daily payment rate for services that is adequate to pay stipends to caregivers and pay provider agencies for the cost of providing professional staff support as required under this section and administrative functions required of in-home services provider agencies. The payment to the provider agency is not to exceed thirty-five percent of the daily reimbursement rate; and

(9) Daily payment rates for structured family caregiving services that do not exceed sixty percent of the daily nursing home cost cap established by the state each year.

3. (1) Within ninety days of the effective date of this section, the department of social services shall, if necessary to implement the provisions of this section, apply to the United States Secretary of Health and Human Services for a structured family caregiver waiver. The department of social services shall request an effective date before July 2, 2020, and shall, by such date, take all administrative actions necessary to ensure timely and equitable availability of structured family caregiving services for home- and community-based care participants.

(2) Upon receipt of an approved waiver under subdivision (1) of this subsection, the department of health and senior services shall 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, 2019, shall be invalid and void.

208.930. 1. As used in this section, the term "department" shall mean the department of health and senior services.

2. Subject to appropriations, the department may provide financial assistance for consumer-directed personal care assistance services through eligible vendors, as provided in sections 208.900 through 208.927, to each person who was participating as a non-MO HealthNet eligible client pursuant to sections 178.661 through 178.673 on June 30, 2005, and who:

(1) Makes application to the department;

(2) Demonstrates financial need and eligibility under subsection 3 of this section;

(3) Meets all the criteria set forth in sections 208.900 through 208.927, except for subdivision (5) of subsection 1 of section 208.903;

(4) Has been found by the department of social services not to be eligible to participate under guidelines established by the MO HealthNet plan; and

(5) Does not have access to affordable employer-sponsored health care insurance or other affordable health care coverage for personal care assistance services as defined in section 208.900. For purposes of this section, "access to affordable employer-sponsored health care insurance or other affordable health care coverage" refers to health insurance requiring a monthly premium less than or equal to one hundred thirty-three percent of the monthly average premium required in the state's current Missouri consolidated health care plan.

Payments made by the department under the provisions of this section shall be made only after all other available sources of payment have been exhausted.

3. (1) In order to be eligible for financial assistance for consumer-directed personal care assistance services under this section, a person shall demonstrate financial need, which shall be based on the adjusted gross income and the assets of the person seeking financial assistance and such person's spouse.

(2) In order to demonstrate financial need, a person seeking financial assistance under this section and such person's spouse must have an adjusted gross income, less disability-related medical expenses, as approved by the department, that is equal to or less than three hundred percent of the federal poverty level. The adjusted gross income shall be based on the most recent

income tax return.

(3) No person seeking financial assistance for personal care services under this section and such person's spouse shall have assets in excess of two hundred fifty thousand dollars.

4. The department shall require applicants and the applicant's spouse, and consumers and the consumer's spouse, to provide documentation for income, assets, and disability-related medical expenses for the purpose of determining financial need and eligibility for the program. In addition to the most recent income tax return, such documentation may include, but shall not be limited to:

(1) Current wage stubs for the applicant or consumer and the applicant's or consumer's spouse;

(2) A current W-2 form for the applicant or consumer and the applicant's or consumer's spouse;

(3) Statements from the applicant's or consumer's and the applicant's or consumer's spouse's employers;

(4) Wage matches with the division of employment security;

(5) Bank statements; and

(6) Evidence of disability-related medical expenses and proof of payment.

5. A personal care assistance services plan shall be developed by the department pursuant to section 208.906 for each person who is determined to be eligible and in financial need under the provisions of this section. The plan developed by the department shall include the maximum amount of financial assistance allowed by the department, subject to appropriation, for such services.

6. Each consumer who participates in the program is responsible for a monthly premium equal to the average premium required for the Missouri consolidated health care plan; provided that the total premium described in this section shall not exceed five percent of the consumer's and the consumer's spouse's adjusted gross income for the year involved.

7. (1) Nonpayment of the premium required in subsection 6 shall result in the denial or termination of assistance, unless the person demonstrates good cause for such nonpayment.

(2) No person denied services for nonpayment of a premium shall receive services unless such person shows good cause for nonpayment and makes payments for past-due premiums as well as current premiums.

(3) Any person who is denied services for nonpayment of a premium and who does not make any payments for past-due premiums for sixty consecutive days shall have their enrollment in the program terminated.

(4) No person whose enrollment in the program is terminated for nonpayment of a premium when such nonpayment exceeds sixty consecutive days shall be reenrolled unless such person pays any past-due premiums as well as current premiums prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument.

8. (1) Consumers determined eligible for personal care assistance services under the provisions of this section shall be reevaluated annually to verify their continued eligibility and financial need. The amount of financial assistance for consumer-directed personal care assistance services received by the consumer shall be adjusted or eliminated based on the outcome of the reevaluation. Any adjustments made shall be recorded in the consumer's personal care assistance services plan.

(2) In performing the annual reevaluation of financial need, the department shall annually send a reverification eligibility form letter to the consumer requiring the consumer to respond within ten days of receiving the letter and to provide income and disability-related medical expense verification documentation. If the department does not receive the consumer's response and documentation within the ten-day period, the department shall send a letter notifying the consumer that he or she has ten days to file an appeal or the case will be closed.

(3) The department shall require the consumer and the consumer's spouse to provide documentation for income and disability-related medical expense verification for purposes of the eligibility review. Such documentation may include but shall not be limited to the documentation listed in subsection 4 of this section.

9. (1) Applicants for personal care assistance services and consumers receiving such services pursuant to this section are entitled to a hearing with the department of social services if eligibility for personal care assistance services is denied, if the type or amount of services is set at a level less than the consumer believes is necessary, if disputes arise after preparation of the personal care assistance plan concerning the provision of such services, or if services are discontinued as provided in section 208.924. Services provided under the provisions of this section shall continue during the appeal process.

(2) A request for such hearing shall be made to the department of social services in writing in the form prescribed by the department of social services within ninety days after the mailing or delivery of the written decision of the department of health and senior services. The procedures for such requests and

for the hearings shall be as set forth in section 208.080.

10. Unless otherwise provided in this section, all other provisions of sections 208.900 through 208.927 shall apply to individuals who are eligible for financial assistance for personal care assistance services under this section.

11. The department may promulgate rules and regulations, including emergency 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. Any provisions of the existing rules regarding the personal care assistance program promulgated by the department of elementary and secondary education in title 5, code of state regulations, division 90, chapter 7, which are inconsistent with the provisions of this section are void and of no force and effect.

12. The provisions of this section shall expire on June 30, **[**2019**]** **2025**.

217.930. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than canceled or terminated, for a person who is an offender in a correctional center if:

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

(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 correctional center.

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

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

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

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

221.111. 1. A person commits the offense of possession of unlawful items

in a prison or jail if such person knowingly delivers, attempts to deliver, possesses, deposits, or conceals in or about the premises of any correctional center as the term "correctional center" is defined under section 217.010, or any city, county, or private jail:

(1) Any controlled substance as that term is defined by law, except upon the written **or electronic** prescription of a licensed physician, dentist, or veterinarian;

(2) Any other alkaloid of any kind or any intoxicating liquor as the term intoxicating liquor is defined in section 311.020;

(3) Any article or item of personal property which a prisoner is prohibited by law, by rule made pursuant to section 221.060, or by regulation of the department of corrections from receiving or possessing, except as herein provided;

(4) Any gun, knife, weapon, or other article or item of personal property that may be used in such manner as to endanger the safety or security of the institution or as to endanger the life or limb of any prisoner or employee thereof.

2. The violation of subdivision (1) of subsection 1 of this section shall be a class D felony; the violation of subdivision (2) of this section shall be a class E felony; the violation of subdivision (3) of this section shall be a class A misdemeanor; and the violation of subdivision (4) of this section shall be a class B felony.

3. The chief operating officer of a county or city jail or other correctional facility or the administrator of a private jail may deny visitation privileges to or refer to the county prosecuting attorney for prosecution any person who knowingly delivers, attempts to deliver, possesses, deposits, or conceals in or about the premises of such jail or facility any personal item which is prohibited by rule or regulation of such jail or facility. Such rules or regulations, including a list of personal items allowed in the jail or facility, shall be prominently posted for viewing both inside and outside such jail or facility in an area accessible to any visitor, and shall be made available to any person requesting such rule or regulation. Violation of this subsection shall be an infraction if not covered by other statutes.

4. Any person who has been found guilty of a violation of subdivision (2) of subsection 1 of this section involving any alkaloid shall be entitled to expungement of the record of the violation. The procedure to expunge the record shall be pursuant to section 610.123. The record of any person shall not be expunged if such person has been found guilty of knowingly delivering, attempting to deliver, possessing, depositing, or concealing any alkaloid of any

controlled substance in or about the premises of any correctional center, or city or county jail, or private prison or jail.

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.

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

(1) "Acute pain", shall have the same meaning as in section 195.010;

(2) "Long-acting or extended-release opioids", formulated in such a manner as to make the contained medicament available over an extended period of time following ingestion.

2. Any duly registered and currently licensed dentist in Missouri may write, and any pharmacist in Missouri who is currently licensed under the provisions of chapter 338 and any amendments thereto, may fill any prescription of a duly registered and currently licensed dentist in Missouri for any drug necessary or proper in the practice of dentistry, provided that no such prescription is in violation of either the Missouri or federal narcotic drug act.

[2.**]** **3.** Any duly registered and currently licensed dentist in Missouri may possess, have under his control, prescribe, administer, dispense, or distribute a "controlled substance" as that term is defined in section 195.010 only to the

extent that:

(1) The dentist possesses the requisite valid federal and state registration to distribute or dispense that class of controlled substance;

(2) The dentist prescribes, administers, dispenses, or distributes the controlled substance in the course of his professional practice of dentistry, and for no other reason;

(3) A bona fide dentist-patient relationship exists; and

(4) The dentist possesses, has under his control, prescribes, administers, dispenses, or distributes the controlled substance in accord with all pertinent requirements of the federal and Missouri narcotic drug and controlled substances acts, including the keeping of records and inventories when required therein.

4. Long-acting or extended-release opioids shall not be used for the treatment of acute pain. If in the professional judgement of the dentist, a long-acting or extended-release opioid is necessary to treat the patient, the dentist shall document and explain in the patient's dental record the reason for the necessity for the long-acting or extended-release opioid.

5. Dentists shall avoid prescribing doses greater than fifty morphine milligram equivalent (MME) per day for treatment of acute pain. If in the professional judgement of the dentist, doses greater than fifty MME are necessary to treat the patient, the dentist shall document and explain in the patient's dental record the reason for the necessity for the dose greater than fifty MME. The relative potency of opioids is represented by a value assigned to individual opioids known as a morphine milligram equivalent (MME). The MME value represents how many milligrams of a particular opioid is equivalent to one milligram of morphine. The Missouri dental board shall maintain a MME conversion chart and instructions for calculating MME on its website to assist licensees with calculating MME.

334.037. 1. A physician may enter into collaborative practice arrangements with assistant physicians. 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 an assistant physician 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 and is consistent with that assistant physician's skill,

training, and competence and the skill and training of the collaborating physician.

2. 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;

(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 to prescribe;

(3) A requirement that there shall be posted at every office where the assistant physician 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 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;

(5) The manner of collaboration between the collaborating physician and the assistant physician, including how the collaborating physician and the assistant physician shall:

(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 Pub. L. 95-210 (42 U.S.C. Section 1395x), as amended, as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. Such exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics if the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics if the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician shall maintain documentation related to such requirement and 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 controlled substance prescriptive authority in collaboration with the physician, including a list of the

controlled substances the physician authorizes the assistant physician 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;

(8) The duration of the written practice agreement between the collaborating physician and the assistant physician;

(9) A description of the time and manner of the collaborating physician's review of the assistant physician's delivery of health care services. The description shall include provisions that the assistant physician shall submit a minimum of ten percent of the charts documenting the assistant physician'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 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.

3. The state board of registration for the healing arts under section 334.125 shall promulgate rules regulating the use of collaborative practice arrangements for assistant physicians. Such rules shall specify:

(1) Geographic areas to be covered;

(2) The methods of treatment that may be covered by collaborative practice arrangements;

(3) In conjunction with deans of medical schools and primary care residency program directors in the state, the development and implementation of educational methods and programs undertaken during the collaborative practice service which shall facilitate the advancement of the assistant physician's medical knowledge and capabilities, and which may lead to credit toward a future residency program for programs that deem such documented educational achievements acceptable; and

(4) The requirements for review of services provided under 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. The state board of registration for the healing arts shall promulgate rules applicable to assistant physicians that 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 in chapter 197 or population-based public health services as defined by 20 CSR 2150- 5.100 as of April 30, 2008.

4. The state board of registration for the healing arts shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to an assistant physician provided the provisions of this section and the rules promulgated thereunder are satisfied.

5. 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 arrangement, including collaborative practice arrangements delegating the authority to prescribe controlled substances, and also report to the board the name of each assistant physician with whom the physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that arrangements are carried out for compliance under this chapter.

6. A collaborating physician **[**or supervising physician**]** shall not enter into a collaborative practice arrangement **[**or supervision agreement**]** with more than six full-time equivalent assistant physicians, full-time equivalent physician assistants, or full-time equivalent advance practice registered nurses, or any combination thereof. Such 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, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of section 334.104.

7. The collaborating physician shall determine and document the

completion of at least a one-month period of time during which the assistant physician shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. No rule or regulation shall require the collaborating physician to review more than ten percent of the assistant physician's patient charts or records during such one-month period. Such 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.

8. 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.

9. No contract or other agreement shall require a physician to act as a collaborating physician for an assistant physician 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. 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, but such requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff.

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

11. All collaborating physicians and assistant physicians in collaborative practice arrangements shall wear identification badges while acting within the scope of their collaborative practice arrangement. The identification badges shall prominently display the licensure status of such collaborating physicians and assistant physicians.

12. (1) An assistant physician with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to prescribe controlled substances in a collaborative practice arrangement. Prescriptions for

Schedule II medications prescribed by an assistant physician who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone. Such authority shall be filed with the state board of registration for the healing arts. The collaborating physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the assistant physician is permitted to prescribe. Any limitations shall be listed in the collaborative practice arrangement. Assistant physicians shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician. Assistant physicians who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

(2) The collaborating physician shall be responsible to determine and document the completion of at least one hundred twenty hours in a four-month period by the assistant physician during which the assistant physician shall practice with the collaborating physician on-site prior to prescribing controlled substances when the collaborating physician is not on-site. Such limitation shall not apply to assistant physicians of population-based public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009, or assistant physicians providing opioid addiction treatment.

(3) An assistant physician shall receive a certificate of controlled substance prescriptive authority from the state board of registration for the healing arts upon verification of licensure under section 334.036.

13. Nothing in this section or section 334.036 shall be construed to limit the authority of hospitals or hospital medical staff to make employment or medical staff credentialing or privileging decisions.

334.104. 1. A physician may enter into collaborative practice arrangements with 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 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 registered professional nurse and is consistent with that nurse's skill, training and competence.

2. Collaborative practice arrangements, which shall be in writing, may delegate to 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, and Schedule II - hydrocodone; 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, or Schedule II - hydrocodone for the purpose of inducing sedation or general anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic controlled substance and Schedule II - hydrocodone 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. An advanced practice registered nurse may prescribe buprenorphine for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician.

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 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 advanced practice registered nurse to prescribe;

(3) A requirement that there shall be posted at every office where the 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 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 advanced practice registered nurse;

(5) The manner of collaboration between the collaborating physician and the advanced practice registered nurse, including how the collaborating physician and the 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. Section 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 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 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 advanced practice registered nurse;

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

(9) A description of the time and manner of the collaborating physician's review of the advanced practice registered nurse's delivery of health care services. The description shall include provisions that the advanced practice registered nurse shall submit a minimum of ten percent of the charts documenting the 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 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 the board of nursing pursuant to section 335.036 may jointly promulgate rules regulating the use of collaborative practice arrangements. Such rules shall be limited to specifying geographic areas to be covered, the methods of treatment that may be covered by collaborative practice arrangements 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 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 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 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 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 not delegate the authority to prescribe any controlled substances listed in Schedules III, IV, and V of section 195.017, or Schedule II - hydrocodone.

8. A collaborating physician **[**or supervising physician**]** shall not enter into a collaborative practice arrangement **[**or supervision agreement**]** with more than six full-time equivalent advanced practice registered nurses, full-time equivalent licensed physician assistants, or full-time equivalent assistant physicians, or any combination thereof. 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, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of this section.

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 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 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 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 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 advanced practice registered nurse to serve as a collaborating advanced practice registered nurse for any collaborating physician against the advanced practice registered nurse's will. An advanced practice registered nurse shall have the right to refuse to collaborate, without penalty, with a particular physician.

334.108. 1. Prior to prescribing any drug, controlled substance, or other treatment through telemedicine, as defined in section 191.1145, or the internet, a physician shall establish a valid physician-patient relationship as described in

section 191.1146. This relationship shall include:

(1) Obtaining a reliable medical history and performing a physical examination of the patient, adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions or contraindications to the treatment recommended or provided;

(2) Having sufficient dialogue with the patient regarding treatment options and the risks and benefits of treatment or treatments;

(3) If appropriate, following up with the patient to assess the therapeutic outcome;

(4) Maintaining a contemporaneous medical record that is readily available to the patient and, subject to the patient's consent, to the patient's other health care professionals; and

(5) Maintaining the electronic prescription information as part of the patient's medical record.

2. The requirements of subsection 1 of this section may be satisfied by the prescribing physician's designee when treatment is provided in:

(1) A hospital as defined in section 197.020;

(2) A hospice program as defined in section 197.250;

(3) Home health services provided by a home health agency as defined in section 197.400;

(4) Accordance with a collaborative practice agreement as defined in section 334.104;

(5) Conjunction with a physician assistant licensed pursuant to section 334.738;

(6) Conjunction with an assistant physician licensed under section 334.036;

(7) Consultation with another physician who has an ongoing physician-patient relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications; or

(8) On-call or cross-coverage situations.

3. No health care provider, as defined in section 376.1350, shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an evaluation over the telephone; except that, a physician**[**,**]** **or** such physician's on-call designee, **or** an advanced practice registered nurse**, a physician assistant, or an assistant physician** in a collaborative practice arrangement with such physician, **[**a physician assistant in a supervision agreement with such physician, or an assistant physician in a supervision agreement with such physician**]** may

prescribe any drug, controlled substance, or other treatment that is within his or her scope of practice to a patient based solely on a telephone evaluation if a previously established and ongoing physician-patient relationship exists between such physician and the patient being treated.

4. No health care provider shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an internet request or an internet questionnaire.

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) **"Collaborative practice arrangement", written agreements, jointly agreed upon protocols, or standing orders, all of which shall be in writing, for the delivery of health care services;**

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

[(5)**]** **(6)** "License", a document issued to an applicant by the board acknowledging that the applicant is entitled to practice as a physician assistant;

[(6)**]** **(7)** "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**]** **Accreditation Review Commission on Education for the Physician Assistant or its successor agency, prior to 2001, or the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs**, 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)**]** **(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, within a geographic proximity to be determined by the board of registration for the healing arts.

(2) For a physician-physician assistant team working in a certified community behavioral health clinic as defined by P.L. 113-93 and a rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended, or a federally qualified health center as defined in 42 U.S.C. Section 1395 of the Public Health Service Act, as amended, no supervision requirements in addition to the minimum federal law shall be required.

3.**] 2.** 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**] collaborating** physician;

(7) Assisting the supervising 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**] collaborative practice arrangement with** a licensed physician as the physician**[**'s**]** assistant has been trained and is proficient to perform**[**; and

(10)**].**

3. Physician assistants shall not perform or prescribe abortions.

4. Physician assistants shall not prescribe 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 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 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 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 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; and

(5) A physician assistant shall not prescribe any drugs, medicines, devices or therapies the **[**supervising**]** **collaborating** physician is not qualified or authorized to prescribe.

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**]** **collaboration** 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; except that, nothing in this subsection shall be construed to prohibit a physician assistant from enrolling with **a third party plan or** the department of social services as a MO HealthNet or Medicaid provider while acting under a **[**supervision agreement**]** **collaborative practice arrangement** between the physician and physician assistant.

6. **[**For purposes of this section, the**]** **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**]** **collaboration, 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.

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 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 physician continuously present before practicing in a setting where a supervising physician is not continuously present.

11.**] 8. A physician may enter into collaborative practice arrangements with physician assistants. Collaborative practice arrangements, which shall be in writing, may delegate to a physician assistant the authority to prescribe, administer, or dispense drugs and provide treatment which is within the skill, training, and competence of the physician assistant. Collaborative practice arrangements may delegate to a physician assistant, as defined in section 334.735, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017, and Schedule II - hydrocodone. Schedule III narcotic controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill. Such collaborative practice arrangements shall be in the form of a written arrangement, jointly agreed-upon protocols, or standing orders for the delivery of health care services.**

9. 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 physician assistant;

(2) A list of all other offices or locations, other than those listed in subdivision (1) of this subsection, where the collaborating physician has authorized the physician assistant to prescribe;

(3) A requirement that there shall be posted at every office where the physician assistant is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure

statement informing patients that they may be seen by a physician assistant and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the physician assistant;

(5) The manner of collaboration between the collaborating physician and the physician assistant, including how the collaborating physician and the physician assistant will:

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

(b) Maintain geographic proximity, as determined by the board of registration for the healing arts; and

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

(6) A list of all other written collaborative practice arrangements of the collaborating physician and the physician assistant;

(7) The duration of the written practice arrangement between the collaborating physician and the physician assistant;

(8) A description of the time and manner of the collaborating physician's review of the physician assistant's delivery of health care services. The description shall include provisions that the physician assistant shall submit a minimum of ten percent of the charts documenting the physician assistant'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. Reviews may be conducted electronically;

(9) 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 physician assistant prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (8) of this subsection; and

(10) A statement that no collaboration requirements in addition to the federal law shall be required for a physician-physician assistant team working in a certified community behavioral health clinic as defined by Pub.L. 113-93, or a rural health clinic under the federal

Rural Health Services Act, Pub.L. 95-210, as amended, or a federally qualified health center as defined in 42 U.S.C. Section 1395 of the Public Health Service Act, as amended.

10. The state board of registration for the healing arts under section 334.125 may promulgate rules regulating the use of collaborative practice arrangements.

11. The state board of registration for the healing arts shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to a physician assistant, provided that the provisions of this section and the rules promulgated thereunder are satisfied.

12. 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 arrangement, including collaborative practice arrangements delegating the authority to prescribe controlled substances, and also report to the board the name of each physician assistant with whom the physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that the arrangements are carried out in compliance with this chapter.

13. The collaborating physician shall determine and document the completion of a period of time during which the physician assistant 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, 2009.

14. No contract or other **[**agreement**]** **arrangement** shall require a physician to act as a **[**supervising**]** **collaborating** 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**]** **collaborating** 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**]**. **No contract or other arrangement shall require any physician assistant to collaborate with any physician against the physician assistant's will. A physician assistant shall have the right to refuse to collaborate, without penalty, with a particular physician.**

[12.**]** **15.** Physician assistants shall file with the board a copy of their **[**supervising**]** **collaborating** physician form.

[13.**]** **16.** No physician shall be designated to serve as **[**supervising physician or**]** **a** collaborating physician for more than six full-time equivalent licensed physician assistants, full-time equivalent advanced practice registered nurses, or full-time equivalent assistant physicians, or any combination thereof. This limitation shall not apply to physician assistant **[**agreements**]** **collaborative practice arrangements** of hospital employees providing inpatient care service in hospitals as defined in chapter 197, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of section 334.104.

17. No arrangement made under this section shall supercede 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.

334.736. Notwithstanding any other provision of sections 334.735 to 334.749, the board may issue without examination a temporary license to practice as a physician assistant. Upon the applicant paying a temporary license fee and the submission of all necessary documents as determined by the board, the board may grant a temporary license to any person who meets the qualifications provided in **[**section**]** **sections** 334.735 **to 334.749** which shall be valid until the results of the next examination are announced. The temporary license may be renewed at the discretion of the board and upon payment of the temporary license fee.

334.747. 1. A physician assistant with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to

prescribe controlled substances in a **[**supervision agreement**]** **collaborative practice arrangement**. Such authority shall be listed on the **[**supervision verification**]** **collaborating physician** form on file with the state board of healing arts. The **[**supervising**]** **collaborating** physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the physician assistant is permitted to prescribe. Any limitations shall be listed on the **[**supervision**]** **collaborating physician** form. Prescriptions for Schedule II medications prescribed by a physician assistant with authority to prescribe delegated in a **[**supervision agreement**]** **collaborative practice arrangement** are restricted to only those medications containing hydrocodone. Physician assistants shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the **[**supervising**]** **collaborating** physician. Physician assistants who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

2. The **[**supervising**]** **collaborating** physician shall be responsible to determine and document the completion of at least one hundred twenty hours in a four-month period by the physician assistant during which the physician assistant shall practice with the **[**supervising**]** **collaborating** physician on-site prior to prescribing controlled substances when the **[**supervising**]** **collaborating** physician is not on-site. Such limitation shall not apply to physician assistants of population-based public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009.

3. A physician assistant shall receive a certificate of controlled substance prescriptive authority from the board of healing arts upon verification of the completion of the following educational requirements:

(1) Successful completion of an advanced pharmacology course that includes clinical training in the prescription of drugs, medicines, and therapeutic devices. A course or courses with advanced pharmacological content in a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency

shall satisfy such requirement;

(2) Completion of a minimum of three hundred clock hours of clinical training by the **[**supervising**]** **collaborating** physician in the prescription of drugs, medicines, and therapeutic devices;

(3) Completion of a minimum of one year of supervised clinical practice or supervised clinical rotations. One year of clinical rotations in a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency, which includes pharmacotherapeutics as a component of its clinical training, shall satisfy such requirement. Proof of such training shall serve to document experience in the prescribing of drugs, medicines, and therapeutic devices;

(4) A physician assistant previously licensed in a jurisdiction where physician assistants are authorized to prescribe controlled substances may obtain a state bureau of narcotics and dangerous drugs registration if a **[**supervising**]** **collaborating** physician can attest that the physician assistant has met the requirements of subdivisions (1) to (3) of this subsection and provides documentation of existing federal Drug Enforcement Agency registration.

334.749. 1. There is hereby established an "Advisory Commission for Physician Assistants" which shall guide, advise and make recommendations to the board. The commission shall also be responsible for the ongoing examination of the scope of practice and promoting the continuing role of physician assistants in the delivery of health care services. The commission shall assist the board in carrying out the provisions of sections 334.735 to 334.749.

2. The commission shall be appointed no later than October 1, 1996, and shall consist of five members, one member of the board, two licensed physician assistants, one physician and one lay member. The two licensed physician assistant members, the physician member and the lay member shall be appointed by the director of the division of professional registration. Each licensed physician assistant member shall be a citizen of the United States and a resident of this state, and shall be licensed as a physician assistant by this state. The physician member shall be a United States citizen, a resident of this state, have an active Missouri license to practice medicine in this state and shall be a **[**supervising**]** **collaborating** physician, at the time of appointment, to a licensed physician assistant. The lay member shall be a United States citizen and a resident of this state. The licensed physician assistant members shall be appointed to serve three-year terms, except that the first commission appointed shall consist of one member whose term shall be for one year and one member

whose term shall be for two years. The physician member and lay member shall each be appointed to serve a three-year term. No physician assistant member nor the physician member shall be appointed for more than two consecutive three-year terms. The president of the Missouri Academy of Physicians Assistants in office at the time shall, at least ninety days prior to the expiration of a term of a physician assistant member of a commission member or as soon as feasible after such a vacancy on the commission otherwise occurs, submit to the director of the division of professional registration a list of five physician assistants qualified and willing to fill the vacancy in question, with the request and recommendation that the director appoint one of the five persons so listed, and with the list so submitted, the president of the Missouri Academy of Physicians Assistants shall include in his or her letter of transmittal a description of the method by which the names were chosen by that association.

3. Notwithstanding any other provision of law to the contrary, any appointed member of the commission shall receive as compensation an amount established by the director of the division of professional registration not to exceed seventy dollars per day for commission business plus actual and necessary expenses. The director of the division of professional registration shall establish by rule guidelines for payment. All staff for the commission shall be provided by the state board of registration for the healing arts.

4. The commission shall hold an open annual meeting at which time it shall elect from its membership a chairman and secretary. The commission may hold such additional meetings as may be required in the performance of its duties, provided that notice of every meeting shall be given to each member at least ten days prior to the date of the meeting. A quorum of the commission shall consist of a majority of its members.

5. On August 28, 1998, all members of the advisory commission for registered physician assistants shall become members of the advisory commission for physician assistants and their successor shall be appointed in the same manner and at the time their terms would have expired as members of the advisory commission for registered physician assistants.

335.175. 1. No later than January 1, 2014, there is hereby established within the state board of registration for the healing arts and the state board of nursing the "Utilization of Telehealth by Nurses". An advanced practice registered nurse (APRN) providing nursing services under a collaborative practice arrangement under section 334.104 may provide such services outside the geographic proximity requirements of section 334.104 if the collaborating

physician and advanced practice registered nurse utilize telehealth in the care of the patient and if the services are provided in a rural area of need. Telehealth providers shall be required to obtain patient consent before telehealth services are initiated and ensure confidentiality of medical information.

2. As used in this section, "telehealth" shall have the same meaning as such term is defined in section 191.1145.

3. (1) The boards shall jointly promulgate rules governing the practice of telehealth under this section. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth.

(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, 2013, shall be invalid and void.

4. For purposes of this section, “rural area of need” means any rural area of this state which is located in a health professional shortage area as defined in section 354.650.

[5. Under section 23.253 of the Missouri sunset act:

(1) The provisions of the new program authorized under this section shall automatically sunset six years after August 28, 2013, unless reauthorized by an act of the general assembly; and

(2) If such program is reauthorized, the program authorized under this section shall automatically sunset twelve years after the effective date of the reauthorization of this section; and

(3) This section shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under this section is sunset.**]**

337.712. 1. Applications for licensure as a marital and family therapist shall be in writing, submitted to the committee on forms prescribed by the committee and furnished to the applicant. **The form shall include a statement that the applicant has completed two hours of suicide assessment, referral, treatment, and management training.** The application shall contain the applicant's statements showing the applicant's

education, experience and such other information as the committee may require. Each application shall contain a statement that it is made under oath or affirmation and that the information contained therein is true and correct to the best knowledge and belief of the applicant, subject to the penalties provided for the making of a false affidavit or declaration. Each application shall be accompanied by the fees required by the division.

2. The division shall mail a renewal notice to the last known address of each licensee prior to the licensure renewal date. Failure to provide the division with the information required for licensure, or to pay the licensure fee after such notice shall result in the expiration of the license. The license shall be restored if, within two years of the licensure date, the applicant provides written application and the payment of the licensure fee and a delinquency fee.

3. A new certificate to replace any certificate lost, destroyed or mutilated may be issued subject to the rules of the division upon payment of a fee.

4. The committee shall set the amount of the fees authorized. The fees shall be set at a level to produce revenue which shall not substantially exceed the cost and expense of administering the provisions of sections 337.700 to 337.739. All fees provided for in sections 337.700 to 337.739 shall be collected by the director who shall deposit the same with the state treasurer to a fund to be known as the "Marital and Family Therapists' Fund".

5. The provisions of section 33.080 to the contrary notwithstanding, money in this fund shall not be transferred and placed to the credit of general revenue until the amount in the fund at the end of the biennium exceeds two times the amount of the appropriations from the marital and family therapists' fund for the preceding fiscal year or, if the division requires by rule renewal less frequently than yearly then three times the appropriation from the fund for the preceding fiscal year. The amount, if any, in the fund which shall lapse is that amount in the fund which exceeds the appropriate multiple of the appropriations from the marital and family therapists' fund for the preceding fiscal year.

338.010. 1. The "practice of pharmacy" means the interpretation, implementation, and evaluation of medical prescription orders, including any legend drugs under 21 U.S.C. Section 353; receipt, transmission, or handling of such orders or facilitating the dispensing of such orders; the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by the prescription order so long as the prescription order is specific to each patient for care by a pharmacist; the compounding, dispensing, labeling, and administration of drugs and devices pursuant to medical prescription orders and administration

of viral influenza, pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, and meningitis vaccines by written protocol authorized by a physician for persons at least seven years of age or the age recommended by the Centers for Disease Control and Prevention, whichever is higher, or the administration of pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, meningitis, and viral influenza vaccines by written protocol authorized by a physician for a specific patient as authorized by rule; the participation in drug selection according to state law and participation in drug utilization reviews; the proper and safe storage of drugs and devices and the maintenance of proper records thereof; consultation with patients and other health care practitioners, and veterinarians and their clients about legend drugs, about the safe and effective use of drugs and devices; **the prescribing and dispensing of any nicotine replacement therapy product under section 338.665;** and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management and control of a pharmacy. No person shall engage in the practice of pharmacy unless he **or she** is licensed under the provisions of this chapter. This chapter shall not be construed to prohibit the use of auxiliary personnel under the direct supervision of a pharmacist from assisting the pharmacist in any of his or her duties. This assistance in no way is intended to relieve the pharmacist from his or her responsibilities for compliance with this chapter and he or she will be responsible for the actions of the auxiliary personnel acting in his or her assistance. This chapter shall also not be construed to prohibit or interfere with any legally registered practitioner of medicine, dentistry, or podiatry, or veterinary medicine only for use in animals, or the practice of optometry in accordance with and as provided in sections 195.070 and 336.220 in the compounding, administering, prescribing, or dispensing of his or her own prescriptions.

2. Any pharmacist who accepts a prescription order for a medication therapeutic plan shall have a written protocol from the physician who refers the patient for medication therapy services. The written protocol and the prescription order for a medication therapeutic plan shall come from the physician only, and shall not come from a nurse engaged in a collaborative practice arrangement under section 334.104, or from a physician assistant engaged in a **[**supervision agreement**]** **collaborative practice arrangement** under section 334.735.

3. Nothing in this section shall be construed as to prevent any person, firm or corporation from owning a pharmacy regulated by sections 338.210 to 338.315, provided that a licensed pharmacist is in charge of such pharmacy.

4. Nothing in this section shall be construed to apply to or interfere with the sale of nonprescription drugs and the ordinary household remedies and such drugs or medicines as are normally sold by those engaged in the sale of general merchandise.

5. No health carrier as defined in chapter 376 shall require any physician with which they contract to enter into a written protocol with a pharmacist for medication therapeutic services.

6. This section shall not be construed to allow a pharmacist to diagnose or independently prescribe pharmaceuticals.

7. The state board of registration for the healing arts, under section 334.125, and the state board of pharmacy, under section 338.140, shall jointly promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Such rules shall require protocols to include provisions allowing for timely communication between the pharmacist and the referring physician, and any other patient protection provisions deemed appropriate by both boards. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither board shall separately promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. 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, 2007, shall be invalid and void.

8. The state board of pharmacy may grant a certificate of medication therapeutic plan authority to a licensed pharmacist who submits proof of successful completion of a board-approved course of academic clinical study beyond a bachelor of science in pharmacy, including but not limited to clinical assessment skills, from a nationally accredited college or university, or a certification of equivalence issued by a nationally recognized professional organization and approved by the board of pharmacy.

9. Any pharmacist who has received a certificate of medication therapeutic plan authority may engage in the designing, initiating, implementing, and

monitoring of a medication therapeutic plan as defined by a prescription order from a physician that is specific to each patient for care by a pharmacist.

10. Nothing in this section shall be construed to allow a pharmacist to make a therapeutic substitution of a pharmaceutical prescribed by a physician unless authorized by the written protocol or the physician's prescription order.

11. "Veterinarian", "doctor of veterinary medicine", "practitioner of veterinary medicine", "DVM", "VMD", "BVSe", "BVMS", "BSe (Vet Science)", "VMB", "MRCVS", or an equivalent title means a person who has received a doctor's degree in veterinary medicine from an accredited school of veterinary medicine or holds an Educational Commission for Foreign Veterinary Graduates (EDFVG) certificate issued by the American Veterinary Medical Association (AVMA).

12. In addition to other requirements established by the joint promulgation of rules by the board of pharmacy and the state board of registration for the healing arts:

(1) A pharmacist shall administer vaccines by protocol in accordance with treatment guidelines established by the Centers for Disease Control and Prevention (CDC);

(2) A pharmacist who is administering a vaccine shall request a patient to remain in the pharmacy a safe amount of time after administering the vaccine to observe any adverse reactions. Such pharmacist shall have adopted emergency treatment protocols;

(3) In addition to other requirements by the board, a pharmacist shall receive additional training as required by the board and evidenced by receiving a certificate from the board upon completion, and shall display the certification in his or her pharmacy where vaccines are delivered.

13. A pharmacist shall inform the patient that the administration of the vaccine will be entered into the ShowMeVax system, as administered by the department of health and senior services. The patient shall attest to the inclusion of such information in the system by signing a form provided by the pharmacist. If the patient indicates that he or she does not want such information entered into the ShowMeVax system, the pharmacist shall provide a written report within fourteen days of administration of a vaccine to the patient's primary health care provider, if provided by the patient, containing:

(1) The identity of the patient;

(2) The identity of the vaccine or vaccines administered;

(3) The route of administration;

(4) The anatomic site of the administration;

(5) The dose administered; and

(6) The date of administration.

338.015. 1. The provisions of sections 338.010 to 338.015 shall not be construed to inhibit the patient's freedom of choice to obtain prescription services from any licensed pharmacist. However, nothing in sections 338.010 to 338.315 abrogates the patient's ability to waive freedom of choice under any contract with regard to payment or coverage of prescription expense.

2. All pharmacists may provide pharmaceutical consultation and advice to persons concerning the safe and therapeutic use of their prescription drugs.

3. All patients shall have the right to receive a written prescription from their prescriber to take to the facility of their choice **or to have an electronic prescription transmitted to the facility of their choice**.

338.055. 1. The board may refuse to issue any certificate of registration or authority, permit or license required pursuant to this chapter for one or any combination of causes stated in subsection 2 of this section or if the designated pharmacist-in-charge, manager-in-charge, or any officer, owner, manager, or controlling shareholder of the applicant has committed any act or practice in subsection 2 of this section. The board shall notify the applicant in writing of the reasons for the refusal and shall advise the applicant of his or her right to file a complaint with the administrative hearing commission as provided by chapter 621.

2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:

(1) Use of any controlled substance, as defined in chapter 195, or alcoholic beverage to an extent that such use impairs a person's ability to perform the work of any profession licensed or regulated by this chapter;

(2) The person has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of any profession licensed or regulated under this chapter, for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude, whether or not

sentence is imposed;

(3) Use of fraud, deception, misrepresentation or bribery in securing any certificate of registration or authority, permit or license issued pursuant to this chapter or in obtaining permission to take any examination given or required pursuant to this chapter;

(4) Obtaining or attempting to obtain any fee, charge, tuition or other compensation by fraud, deception or misrepresentation;

(5) Incompetence, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by this chapter;

(6) Violation of, or assisting or enabling any person to violate, any provision of this chapter, or of any lawful rule or regulation adopted pursuant to this chapter;

(7) Impersonation of any person holding a certificate of registration or authority, permit or license or allowing any person to use his or her certificate of registration or authority, permit, license, or diploma from any school;

(8) Denial of licensure to an applicant or disciplinary action against an applicant or the holder of a license or other right to practice any profession regulated by this chapter granted by another state, territory, federal agency, or country whether or not voluntarily agreed to by the licensee or applicant, including, but not limited to, surrender of the license upon grounds for which denial or discipline is authorized in this state;

(9) A person is finally adjudged incapacitated by a court of competent jurisdiction;

(10) Assisting or enabling any person to practice or offer to practice any profession licensed or regulated by this chapter who is not registered and currently eligible to practice under this chapter;

(11) Issuance of a certificate of registration or authority, permit or license based upon a material mistake of fact;

(12) Failure to display a valid certificate or license if so required by this chapter or any rule promulgated hereunder;

(13) Violation of any professional trust or confidence;

(14) Use of any advertisement or solicitation which is false, misleading or deceptive to the general public or persons to whom the advertisement or solicitation is primarily directed;

(15) Violation of the drug laws or rules and regulations of this state, any other state or the federal government;

(16) The intentional act of substituting or otherwise changing the content, formula or brand of any drug prescribed by written**, electronic,** or oral prescription without prior written or oral approval from the prescriber for the respective change in each prescription; provided, however, that nothing contained herein shall prohibit a pharmacist from substituting or changing the brand of any drug as provided under section 338.056, and any such substituting or changing of the brand of any drug as provided for in section 338.056 shall not be deemed unprofessional or dishonorable conduct unless a violation of section 338.056 occurs;

(17) Personal use or consumption of any controlled substance unless it is prescribed, dispensed, or administered by a health care provider who is authorized by law to do so.

3. After the filing of such complaint, the proceedings shall be conducted in accordance with the provisions of chapter 621. Upon a finding by the administrative hearing commission that the grounds, provided in subsection 2 of this section, for disciplinary action are met, the board may, singly or in combination, censure or place the person named in the complaint on probation on such terms and conditions as the board deems appropriate for a period not to exceed five years, or may suspend, for a period not to exceed three years, or revoke the license, certificate, or permit. The board may impose additional discipline on a licensee, registrant, or permittee found to have violated any disciplinary terms previously imposed under this section or by agreement. The additional discipline may include, singly or in combination, censure, placing the licensee, registrant, or permittee named in the complaint on additional probation on such terms and conditions as the board deems appropriate, which additional probation shall not exceed five years, or suspension for a period not to exceed three years, or revocation of the license, certificate, or permit.

4. If the board concludes that a licensee or registrant has committed an act or is engaging in a course of conduct which would be grounds for disciplinary action which constitutes a clear and present danger to the public health and safety, the board may file a complaint before the administrative hearing commission requesting an expedited hearing and specifying the activities which give rise to the danger and the nature of the proposed restriction or suspension of the licensee's or registrant's license. Within fifteen days after service of the complaint on the licensee or registrant, the administrative hearing commission shall conduct a preliminary hearing to determine whether the alleged activities of the licensee or registrant appear to constitute a clear and present danger to the

public health and safety which justify that the licensee's or registrant's license or registration be immediately restricted or suspended. The burden of proving that the actions of a licensee or registrant constitute a clear and present danger to the public health and safety shall be upon the state board of pharmacy. The administrative hearing commission shall issue its decision immediately after the hearing and shall either grant to the board the authority to suspend or restrict the license or dismiss the action.

5. If the administrative hearing commission grants temporary authority to the board to restrict or suspend the licensee's or registrant's license, such temporary authority of the board shall become final authority if there is no request by the licensee or registrant for a full hearing within thirty days of the preliminary hearing. The administrative hearing commission shall, if requested by the licensee or registrant named in the complaint, set a date to hold a full hearing under the provisions of chapter 621 regarding the activities alleged in the initial complaint filed by the board.

6. If the administrative hearing commission dismisses the action filed by the board pursuant to subsection 4 of this section, such dismissal shall not bar the board from initiating a subsequent action on the same grounds.

338.056. 1. Except as provided in subsection 2 of this section, the pharmacist filling prescription orders for drug products prescribed by trade or brand name may select another drug product with the same active chemical ingredients of the same strength, quantity and dosage form, and of the same generic drug or interchangeable biological product type, as determined by the United States Adopted Names and accepted by the Federal Food and Drug Administration. Selection pursuant to this section is within the discretion of the pharmacist, except as provided in subsection 2 of this section. The pharmacist who selects the drug or interchangeable biological product to be dispensed pursuant to this section shall assume the same responsibility for selecting the dispensed drug or biological product as would be incurred in filling a prescription for a drug or interchangeable biological product prescribed by generic or interchangeable biologic name. The pharmacist shall not select a drug or interchangeable biological product pursuant to this section unless the product selected costs the patient less than the prescribed product.

2. A pharmacist who receives a prescription for a brand name drug or biological product may select a less expensive generically equivalent or interchangeable biological product unless:

(1) The patient requests a brand name drug or biological product; or

(2) The prescribing practitioner indicates that substitution is prohibited or displays "brand medically necessary", "dispense as written", "do not substitute", "DAW", or words of similar import on the prescription.

3. No prescription shall be valid without the signature of the prescriber**, except an electronic prescription**.

4. If an oral prescription is involved, the practitioner or the practitioner's agent, communicating the instructions to the pharmacist, shall instruct the pharmacist as to whether or not a therapeutically equivalent generic drug or interchangeable biological product may be substituted. The pharmacist shall note the instructions on the file copy of the prescription.

5. Notwithstanding the provisions of subsection 2 of this section to the contrary, a pharmacist may fill a prescription for a brand name drug by substituting a generically equivalent drug or interchangeable biological product when substitution is allowed in accordance with the laws of the state where the prescribing practitioner is located.

6. Violations of this section are infractions.

338.140. 1. The board of pharmacy shall have a common seal, and shall have power to adopt such rules and bylaws not inconsistent with law as may be necessary for the regulation of its proceedings and for the discharge of the duties imposed pursuant to sections 338.010 to 338.198, and shall have power to employ an attorney to conduct prosecutions or to assist in the conduct of prosecutions pursuant to sections 338.010 to 338.198.

2. The board shall keep a record of its proceedings.

3. The board of pharmacy shall make annually to the governor and, upon written request, to persons licensed pursuant to the provisions of this chapter a written report of its proceedings.

4. The board of pharmacy shall appoint an advisory committee composed of six members, one of whom shall be a representative of pharmacy but who shall not be a member of the pharmacy board, three of whom shall be representatives of wholesale drug distributors as defined in section 338.330, one of whom shall be a representative of drug manufacturers, and one of whom shall be a licensed veterinarian recommended to the board of pharmacy by the board of veterinary medicine. The committee shall review and make recommendations to the board on the merit of all rules and regulations dealing with pharmacy distributors, wholesale drug distributors, drug manufacturers, and veterinary legend drugs which are proposed by the board.

5. A majority of the board shall constitute a quorum for the transaction

of business.

6. Notwithstanding any other provisions of law to the contrary, the board may issue letters of reprimand, censure or warning to any holder of a license or registration required pursuant to this chapter for any violations that could result in disciplinary action as defined in section 338.055. **Alternatively, at the discretion of the board, the board may enter into a voluntary compliance agreement with a licensee, permit holder, or registrant to ensure or promote compliance with this chapter and the rules of the board, in lieu of board discipline. The agreement shall be a public record. The time limitation identified in section 324.043 for commencing a disciplinary proceeding shall be tolled while an agreement authorized by this section is in effect.**

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

(1) "Remote medication dispensing", dispensing or assisting in the dispensing of medication outside of a licensed pharmacy;

(2) "Technology assisted verification", the verification of medication or prescription information using a combination of scanning technology and visual confirmation by a pharmacist.

2. The board of pharmacy may approve, modify, and establish requirements for pharmacy pilot or demonstration research projects related to technology assisted verification or remote medication dispensing that are designed to enhance patient care or safety, improve patient outcomes, or expand access to pharmacy services.

3. To be approved, pilot or research projects shall be within the scope of the practice of pharmacy as defined by chapter 338, be under the supervision of a Missouri licensed pharmacist, and comply with applicable compliance and reporting as established by the board by rule, including any staff training or education requirements. Board approval shall be limited to a period of up to eighteen months, provided the board grant an additional six month extension if deemed necessary or appropriate to gather or complete research data or if deemed in the best interests of the patient. The board may rescind approval of a pilot project at any time if deemed necessary or appropriate in the interest of patient safety.

4. The provisions of this subsection shall expire on August 28, 2023. The board shall provide a final report on approved projects and

related data or findings to the general assembly on or before December 31, 2022. The name, location, approval dates, general description of and responsible pharmacist for an approved pilot or research project shall be deemed an open record.

338.665. 1. For the purposes of this chapter, "nicotine replacement therapy product" means any drug or product, regardless of whether it is available over-the-counter, that delivers small doses of nicotine to a person and that is approved by the federal Food and Drug Administration for the sole purpose of aiding in tobacco cessation or smoking cessation.

2. The board of pharmacy and the board of healing arts shall jointly promulgate rules governing a pharmacist's authority to prescribe and dispense nicotine replacement therapy products. Neither board shall separately promulgate rules governing a pharmacist's authority to prescribe and dispense nicotine replacement therapy products under this subsection.

3. Nothing in this section shall be construed to require third party payment for services described in this section.

4. 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, 2019, shall be invalid and void.

374.500. As used in sections 374.500 to 374.515, the following terms mean:

(1) "Certificate", a certificate of registration granted by the department of insurance, financial institutions and professional registration to a utilization review agent;

(2) "Director", the director of the department of insurance, financial institutions and professional registration;

(3) "Enrollee", an individual who has contracted for or who participates in coverage under a health insurance policy, an employee welfare benefit plan, a

health services corporation plan or any other benefit program providing payment, reimbursement or indemnification for health care costs for himself or eligible dependents or both himself and eligible dependents. The term "enrollee" shall not include an individual who has health care coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(4) "Provider of record", the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment and services rendered to an enrollee;

(5) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, **[**prospective**] prior authorization** review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

(6) "Utilization review agent", any person or entity performing utilization review, except:

(a) An agency of the federal government;

(b) An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government; or

(c) Any individual person employed or used by a utilization review agent for the purpose of performing utilization review services, including, but not limited to, individual nurses and physicians, unless such individuals are providing utilization review services to the applicable benefit plan, pursuant to a direct contractual relationship with the benefit plan;

(d) An employee health benefit plan that is self-insured and qualified pursuant to the federal Employee Retirement Income Security Act of 1974, as amended;

(e) A property-casualty insurer or an employee or agent working on behalf of a property-casualty insurer;

(f) A health carrier, as defined in section 376.1350, that is performing a review of its own health plan;

(7) "Utilization review plan", a summary of the utilization review procedures of a utilization review agent.

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

(1) "Emergency medical condition", the same meaning given to such term

in section 376.1350;

(2) "Facility", the same meaning given to such term in section 376.1350;

(3) "Health care professional", the same meaning given to such term in section 376.1350;

(4) "Health carrier", the same meaning given to such term in section 376.1350;

(5) "Unanticipated out-of-network care", health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged.

2. (1) Health care professionals **[**may**]** **shall** send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier within one hundred eighty days of the delivery of the unanticipated out-of-network care on a U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, or electronically using the 837 HIPAA format, or its successor.

(2) Within forty-five processing days, as defined in section 376.383, of receiving the health care professional's claim, the health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated out-of-network care based on the health care professional's services. If the health care professional participates in one or more of the carrier's commercial networks, the offer of reimbursement for unanticipated out-of-network care shall be the amount from the network which has the highest reimbursement.

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

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

(5) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within one hundred twenty days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the 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.

4. The director shall ensure access to an external arbitration process when a health care professional and health carrier cannot agree to a reimbursement under subdivision (3) of subsection 2 of this section. In order to ensure access, when notified of a parties' intent to arbitrate, the director shall randomly select an arbitrator for each case from the department's approved list of arbitrators or entities that provide binding arbitration. The director shall specify the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared equally between and will be directly billed to the health care professional and health carrier. These costs will include, but are not limited to, reasonable time necessary for the arbitrator to review materials in preparation for the arbitration, travel expenses and reasonable time following the arbitration for drafting of the final decision.

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall be binding on all parties. The arbitrator shall provide a copy of the final decision to the director. The initial request for arbitration, all correspondence and documents received by the department and the final arbitration decision shall be considered a closed record under section

374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of section 536.010.

6. The arbitrator shall determine a dollar amount due under 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 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, 2018, shall be

invalid and void.

376.1040. **1.** No multiple employer self-insured health plan shall be offered or advertised to the public **[**generally**]**. No plan shall be sold, solicited, or marketed by persons or entities defined in section 375.012 or sections 376.1075 to 376.1095. **Multiple employer self-insured health plans with a certificate of authority approved by the director under section 376.1002 shall be exempt from the restrictions set forth in this section.**

2. A health carrier acting as an administrator for a multiple employer self insured health plan shall permit any willing licensed broker to quote, sell, solicit, or market such plan to the extent permitted by this section; provided that such broker is appointed and in good standing with the health carrier and completes all required training.

376.1042. The sale, solicitation or marketing of any plan **in violation of section 376.1040** by an agent, agency or broker shall constitute a violation of section 375.141.

376.1224. 1. For purposes of this section, the following terms shall mean:

(1) "Applied behavior analysis", the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior;

(2) "Autism service provider":

(a) Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or

(b) Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst;

(3) "Autism spectrum disorders", a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;

(4) **"Developmental or physical disability", a severe chronic disability that:**

(a) Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services;

(b) Manifests before the individual reaches age nineteen;

(c) Is likely to continue indefinitely; and

(d) Results in substantial functional limitations in three or more of the following areas of major life activities:

a. Self-care;

b. Understanding and use of language;

c. Learning;

d. Mobility;

e. Self-direction; or

f. Capacity for independent living;

(5) "Diagnosis **[**of autism spectrum disorders**]**", medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder **or a developmental or physical disability**;

[(5)**] (6)** "Habilitative or rehabilitative care", professional, counseling, and guidance services and treatment programs, including applied behavior analysis **for those diagnosed with autism spectrum disorder**, that are necessary to develop the functioning of an individual;

[(6)**] (7)** "Health benefit plan", shall have the same meaning ascribed to it as in section 376.1350;

[(7)**] (8)** "Health carrier", shall have the same meaning ascribed to it as in section 376.1350;

[(8)**] (9)** "Line therapist", an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst;

[(9)**] (10)** "Pharmacy care", medications used to address symptoms of an autism spectrum disorder **or a developmental or physical disability** prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan;

[(10)**] (11)** "Psychiatric care", direct or consultative services provided by

a psychiatrist licensed in the state in which the psychiatrist practices;

[(11)**]** **(12)** "Psychological care", direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

[(12)**]** **(13)** "Therapeutic care", services provided by licensed speech therapists, occupational therapists, or physical therapists;

[(13)**]** **(14)** "Treatment **[**for autism spectrum disorders**]**", care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist**, or for an individual diagnosed with a developmental or physical disability by a licensed physician or licensed psychologist**, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

(a) Psychiatric care;

(b) Psychological care;

(c) Habilitative or rehabilitative care, including applied behavior analysis therapy **for those diagnosed with autism spectrum disorder**;

(d) Therapeutic care;

(e) Pharmacy care.

2. **Except as otherwise provided in subsection 12 of this section,** all **[**group**]** health benefit plans that are delivered, issued for delivery, continued, or renewed on or after January 1, **[**2011**]** **2020**, if written inside the state of Missouri, or written outside the state of Missouri but insuring Missouri residents, shall provide coverage for the diagnosis and treatment of autism spectrum disorders **and for the diagnosis and treatment of developmental or physical disabilities** to the extent that such diagnosis and treatment is not already covered by the health benefit plan.

3. With regards to a health benefit plan, a health carrier shall not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual or their dependent because the individual is diagnosed with autism spectrum disorder **or developmental or physical disabilities**.

4. (1) Coverage provided under this section **for autism spectrum disorder or developmental or physical disabilities** is limited to medically necessary treatment that is ordered by the insured's treating licensed physician or licensed psychologist, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, in accordance with a treatment plan.

(2) The treatment plan, upon request by the health benefit plan or health

carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

(3) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder **or developmental or physical disability**, a health carrier shall have the right to review the treatment plan not more than once every six months unless the health carrier and the individual's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual **[**being treated for an autism spectrum disorder**] receiving applied behavior analysis** and shall not apply to all individuals **[**being treated for autism spectrum disorders by a**] receiving applied behavior analysis from that autism service provider,** physician**,** or psychologist. The cost of obtaining any review or treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

5. **(1)** Coverage provided under this section for applied behavior analysis shall be subject to a maximum benefit of forty thousand dollars per calendar year for individuals through eighteen years of age. Such maximum benefit limit may be exceeded, upon prior approval by the health benefit plan, if the provision of applied behavior analysis services beyond the maximum limit is medically necessary for such individual. Payments made by a health carrier on behalf of a covered individual for any care, treatment, intervention, service or item, the provision of which was for the treatment of a health condition unrelated to the covered individual's autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection. Any coverage required under this section, other than the coverage for applied behavior analysis, shall not be subject to the age and dollar limitations described in this subsection.

[6.**] (2)** The maximum benefit limitation for applied behavior analysis described in **[**subsection 5**] subdivision (1)** of this **[**section**] subsection** shall be adjusted by the health carrier at least triennially for inflation to reflect the aggregate increase in the general price level as measured by the Consumer Price Index for All Urban Consumers for the United States, or its successor index, as defined and officially published by the United States Department of Labor, or its successor agency. Beginning January 1, 2012, and annually thereafter, the current value of the maximum benefit limitation for applied behavior analysis coverage adjusted for inflation in accordance with this subsection shall be calculated by the director of the department of insurance, financial institutions

and professional registration. The director shall furnish the calculated 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.**]** **(3)** Subject to the provisions set forth in subdivision (3) of subsection 4 of this section, coverage provided **for autism spectrum disorders** under this section shall not be subject to any limits on the number of visits an individual may make to an autism service provider, except that the maximum total benefit for applied behavior analysis set forth in **subdivision (1) of this** subsection **[**5 of this section**]** shall apply to this **[**subsection**]** **subdivision**.

6. Coverage for therapeutic care provided under this section for developmental or physical disabilities may be limited to a number of visits per calendar year, provided that upon prior approval by the health benefit plan, coverage shall be provided beyond the maximum calendar limit if such therapeutic care is medically necessary as determined by the health care plan.

[8.**]** **7.** This section shall not be construed as limiting benefits which are otherwise available to an individual under a health benefit plan. The health care coverage required by this section shall not be subject to any greater deductible, coinsurance, or co-payment than other physical health care services provided by a health benefit plan. Coverage of services may be subject to other general exclusions and limitations of the contract or benefit plan, not in conflict with the provisions of this section, such as coordination of benefits, exclusions for services provided by family or household members, and utilization review of health care services, including review of medical necessity and care management; however, coverage for treatment under this section shall not be denied on the basis that it is educational or habilitative in nature.

[9.**]** **8.** To the extent any payments or reimbursements are being made for applied behavior analysis, such payments or reimbursements shall be made to either:

(1) The autism service provider, as defined in this section; or

(2) The entity or group for whom such supervising person, who is certified as a board-certified behavior analyst by the Behavior Analyst Certification Board, works or is associated.

Such payments or reimbursements under this subsection to an autism service provider or a board-certified behavior analyst shall include payments or reimbursements for services provided by a line therapist under the supervision

of such provider or behavior analyst if such services provided by the line therapist are included in the treatment plan and are deemed medically necessary.

[10.**]** **9.** Notwithstanding any other provision of law to the contrary, health carriers shall not be held liable for the actions of line therapists in the performance of their duties.

[11.**]** **10.** The provisions of this section shall apply to any health care plans issued to employees and their dependents under the Missouri consolidated health care plan established pursuant to chapter 103 that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, **[**2011**]** **2020**. The terms "employees" and "health care plans" shall have the same meaning ascribed to them in section 103.003.

[12.**]** **11.** The provisions of this section shall also apply to the following types of plans that are established, extended, modified, or renewed on or after January 1, **[**2011**]** **2020**:

(1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section 1002(32);

(2) All self-insured group arrangements, to the extent not preempted by federal law;

(3) All plans provided through a multiple employer welfare arrangement, or plans provided through another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, or any waiver or exception to that act provided under federal law or regulation; and

(4) All self-insured school district health plans.

[13. The provisions of this section shall not automatically apply to an individually underwritten health benefit plan, but shall be offered as an option to any such plan.

14.**]** **12.** The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months or less duration, or any other supplemental policy. **The provisions of this section requiring coverage for autism spectrum disorders shall not apply to an individually underwritten health benefit plan issued prior to January 1, 2011. The provisions of this section requiring coverage for a developmental or physical disability shall not apply to a health benefit plan issued prior to January 1, 2014.**

[15.**]** **13.** Any health carrier or other entity subject to the provisions of

this section shall not be required to provide reimbursement for the applied behavior analysis delivered to a person insured by such health carrier or other entity to the extent such health carrier or other entity is billed for such services by any Part C early intervention program or any school district for applied behavior analysis rendered to the person covered by such health carrier or other entity. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education plan, or an individualized service plan. This section shall not be construed as affecting any obligation to provide reimbursement pursuant to section 376.1218.

[16.**]** **14.** The provisions of sections 376.383, 376.384, and 376.1350 to 376.1399 shall apply to this section.

[17. The director of the department of insurance, financial institutions and professional registration shall grant a small employer with a group health plan, as that term is defined in section 379.930, a waiver from the provisions of this section if the small employer demonstrates to the director by actual claims experience over any consecutive twelve-month period that compliance with this section has increased the cost of the health insurance policy by an amount of two and a half percent or greater over the period of a calendar year in premium costs to the small employer.

18.**]** **15.** The provisions of this section shall not apply to the Mo HealthNet program as described in chapter 208.

[19. (1) By February 1, 2012, and every February first thereafter, the department of insurance, financial institutions and professional registration shall submit a report to the general assembly regarding the implementation of the coverage required under this section. The report shall include, but shall not be limited to, the following:

(a) The total number of insureds diagnosed with autism spectrum disorder;

(b) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this section;

(c) The cost of such coverage per insured per month; and

(d) The average cost per insured for coverage of applied behavior analysis;

(2) All health carriers and health benefit plans subject to the provisions of this section shall provide the department with the data requested by the department for inclusion in the annual report.**]**

376.1345. 1. As used in this section, unless the context clearly

indicates otherwise, terms shall have the same meaning as ascribed to them in section 376.1350.

2. No health carrier, nor any entity acting on behalf of a health carrier, shall restrict methods of reimbursement to health care providers for health care services to a reimbursement method requiring the provider to pay a fee, discount the amount of their claim for reimbursement, or remit any other form of remuneration in order to redeem the amount of their claim for reimbursement.

3. If a health carrier initiates or changes the method used to reimburse a health care provider to a method of reimbursement that will require the health care provider to pay a fee, discount the amount of its claim for reimbursement, or remit any other form of remuneration to the health carrier or any entity acting on behalf of the health carrier in order to redeem the amount of its claim for reimbursement, the health carrier or an entity acting on its behalf shall:

(1) Notify such health care provider of the fee, discount, or other remuneration required to receive reimbursement through the new or different reimbursement method; and

(2) In such notice, provide clear instructions to the health care provider as to how to select an alternative payment method, and upon request such alternative payment method shall be used to reimburse the provider until the provider requests otherwise.

4. A health carrier shall allow the provider to select to be reimbursed by an electronic funds transfer through the Automated Clearing House Network as required pursuant to 45 C.F.R. Sections 162.925, 162.1601, and 162.1602, and if the provider makes such selection, the health carrier shall use such reimbursement method to reimburse the provider until the provider requests otherwise.

5. Violation of this section shall be deemed an unfair trade practice under sections 375.930 to 375.948.

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or **[**its designee**]** **a** utilization review **[**organization**]** **entity** that an admission, availability of care, continued stay or other health care service **furnished or proposed to be furnished to an enrollee** has been reviewed and, based upon

the information provided, does not meet the **utilization review entity or** health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, **or are experimental or investigational,** and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

(4) "Certification", a determination by a health carrier or **[**its designee**]** **a** utilization review **[**organization**]** **entity** that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness**, and that payment will be made for that health care service provided the patient is an enrollee of the health benefit plan at the time the service is provided**;

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

(6) "Clinical review criteria", the **written policies,** written screening procedures, **drug formularies or lists of covered drugs, determination rules,** decision abstracts, clinical protocols **[**and**], medical protocols,** practice guidelines**, and any other criteria or rationale** used by the health carrier **or utilization review entity** to determine the necessity and appropriateness of health care services;

(7) "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

(9) "Director", the director of the department of insurance, financial institutions and professional registration;

(10) "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

(12) "Emergency medical condition", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(13) "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(14) "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(15) "FDA", the federal Food and Drug Administration;

(16) "Facility", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services;

or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

(18) "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services; except that, health benefit plan shall not include any coverage pursuant to liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(19) "Health care professional", a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law;

(20) "Health care provider" or "provider", a health care professional or a facility;

(21) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease**, including but not limited to the provision of drugs or durable medical equipment**;

(22) "Health carrier", an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services; except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

(24) "Managed care plan", a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

(25) "Participating provider", a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the

health carrier;

(26) "Peer-reviewed medical literature", a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the Social Security Act **(42 U.S.C. 1395x)**, as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier;

(27) "Person", an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing;

(28) **"Prior authorization", a certification made pursuant to a prior authorization review, or notice as required by a health carrier or utilization review entity prior to the provision of health care services;**

(29) "**[**Prospective review**]** **Prior authorization review**", utilization review conducted prior to an admission or a course of treatment**, including but not limited to pre-admission review, pre-treatment review, utilization review, and case management**;

[(29)**]** **(30)** "Retrospective review", utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

[(30)**]** **(31)** "Second opinion", an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

[(31)**]** **(32)** "Stabilize", with respect to an emergency medical condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred;

[(32)**]** **(33)** "Standard reference compendia":

(a) The American Hospital Formulary Service-Drug Information; or

(b) The United States Pharmacopoeia-Drug Information;

[(33)**]** **(34)** "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, **[**prospective**]** **prior authorization** review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

[(34)**]** **(35)** "Utilization review **[**organization**]** **entity**", a utilization review agent as defined in section 374.500**, or an individual or entity that performs prior authorization reviews for a health carrier or health care provider. A health carrier or health care provider is a utilization review entity if it performs prior authorization review**.

376.1356. Whenever a health carrier contracts to have a utilization review **[**organization or other**]** entity perform the utilization review functions required by sections 376.1350 to 376.1390 or applicable rules and regulations, the health carrier shall be responsible for monitoring the activities of the utilization review **[**organization or**]** entity with which the health carrier contracts and for ensuring that the requirements of sections 376.1350 to 376.1390 and applicable rules and regulations are met.

376.1363. 1. A health carrier shall maintain written procedures for making utilization review decisions and for notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

2. For **[**initial**]** determinations, a health carrier shall make the determination within thirty-six hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

(1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the **[**initial**]** certification, and provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within two working days of making the **[**initial**]** certification;

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four

hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within one working day of making the adverse determination.

3. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information:

(1) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the enrollee and the provider within one working day after telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

(2) In the case of an adverse determination, the carrier shall notify by telephone or electronically the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the enrollee and the provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the enrollee until the enrollee has been notified of the determination.

4. For retrospective review determinations, a health carrier shall make the determination within thirty working days of receiving all necessary information. A carrier shall provide notice in writing of the carrier's determination to an enrollee within ten working days of making the determination.

5. A written notification of an adverse determination shall include the principal reason or reasons for the determination, **including the clinical rationale, and** the instructions for initiating an appeal or reconsideration of the determination**[**, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination**]**. A health carrier shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to **the health care provider and to** any party who received notice of the adverse determination **[**and who requests such information**]**.

6. A health carrier shall have written procedures to address the failure or inability of a provider or an enrollee to provide all necessary information for review. **These procedures shall be made available to health care providers on the health carrier's website or provider portal.** In cases

where the provider or an enrollee will not release necessary information, the health carrier may deny certification of an admission, procedure or service.

7. Provided the patient is an enrollee of the health benefit plan, no utilization review entity shall revoke, limit, condition, or otherwise restrict a prior authorization within forty-five working days of the date the health care provider receives the prior authorization.

8. Provided the patient is an enrollee of the health benefit plan at the time the service is provided, no health carrier, utilization review entity, or health care provider shall bill an enrollee for any health care service for which a prior authorization was in effect at the time the health care service was provided, except as consistent with cost-sharing requirements applicable to a covered benefit under the enrollee's health benefit plan. Such cost-sharing shall be subject to and applied toward any in-network deductible or out-of-pocket maximum applicable to the enrollee's health benefit plan.

376.1364. 1. Any utilization review entity performing prior authorization review shall provide a unique confirmation number to a provider upon receipt from that provider of a request for prior authorization. Except as otherwise requested by the provider in writing, unique confirmation numbers shall be transmitted or otherwise communicated through the same medium through which the requests for prior authorization were made.

2. No later than January 1, 2021, utilization review entities shall accept and respond to requests for prior authorization of drug benefits through a secure electronic transmission using the National Council for Prescription Drugs SCRIPT Standard Version 2017071 or a backwards-compatible successor adopted by the United States Department of Health and Human Services. For purposes of this subsection, facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

3. No later than January 1, 2021, utilization review entities shall accept and respond to requests for prior authorization of health care services and mental health services electronically. For purposes of this subsection, facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

4. No later than January 1, 2021, each health carrier utilizing prior authorization review shall develop a single secure electronic

prior authorization cover page for all of its health benefit plans utilizing prior authorization review, which the carrier or its utilization review entity shall use to accept and respond to, and which providers shall use to submit, requests for prior authorization. Such cover page shall include, but not be limited to, fields for patient or enrollee information, referring or requesting provider information, rendering or attending provider information, and required clinical information, and shall be supplemented by additional clinical information as required by the health carrier or utilization review entity.

376.1372. 1. In the certificate of coverage and the member handbook provided to enrollees, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of enrollees with respect to those procedures.

2. A health carrier shall include a summary of its utilization review procedures in material intended for prospective enrollees.

3. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

4. (1) A health carrier or utilization review entity shall make any current prior authorization requirements or restrictions, including written clinical review criteria, readily accessible on its website or provider portal. Requirements and restrictions, including step therapy protocols as such term is defined in section 376.2030, shall be described in detail.

(2) No health carrier or utilization review entity shall amend or implement a new prior authorization requirement or restriction prior to the change being reflected on the carrier or utilization review entity's website or provider portal as specified in subdivision (1) of this subsection.

(3) Health carriers and utilization review entities shall provide participating providers with written or electronic notice of the new or amended requirement not less than sixty days prior to implementing the requirement or restriction.

376.1385. 1. Upon receipt of a request for second-level review, a health carrier shall submit the grievance to a grievance advisory panel consisting of:

(1) Other enrollees; **and**

(2) Representatives of the health carrier that were not involved in the

circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance**[**; and**].**

[(3)**]** **2.** Where the grievance involves an adverse determination, **[**a majority of persons that are appropriate**] and the grievance advisory panel makes a preliminary decision that the determination should be upheld, the heath carrier shall submit the grievance for review to two independent** clinical peers in the same or similar specialty as would typically manage the case being reviewed **[**that**]** **who** were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance. **In the event that both independent reviews concur with the grievance advisory panel's preliminary decision, the panel's decision shall stand. In the event that both independent reviewers disagree with the grievance advisory panel's preliminary decision, the intitial adverse determination shall be overturned. In the event that one of the two independent reviewers disagrees with the grievance advisory panel's preliminary decision, the panel shall reconvene and make a final decision in its discretion.**

[2.**]** **3.** Review by the grievance advisory panel shall follow the same time frames as a first level review, except as provided for in section 376.1389 if applicable. Any decision of the grievance advisory panel shall include notice of the enrollee's or the health carrier's or plan sponsor's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice shall contain the toll-free telephone number and address of the director's office.

630.175. 1. No person admitted on a voluntary or involuntary basis to any mental health facility or mental health program in which people are civilly detained pursuant to chapter 632 and no patient, resident or client of a residential facility or day program operated, funded or licensed by the department shall be subject to physical or chemical restraint, isolation or seclusion unless it is determined by the head of the facility, the attending licensed physician, or in the circumstances specifically set forth in this section, by an advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**supervision agreement**]** **collaborative practice arrangement**, with the attending licensed physician that the chosen intervention is imminently necessary to protect the health and safety of the patient, resident, client or others and that it provides the least restrictive environment. An advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a

[supervision agreement**]** **collaborative practice arrangement**, with the attending licensed physician may make a determination that the chosen intervention is necessary for patients, residents, or clients of facilities or programs operated by the department, in hospitals as defined in section 197.020 that only provide psychiatric care and in dedicated psychiatric units of general acute care hospitals as hospitals are defined in section 197.020. Any determination made by the advanced practice registered nurse, physician assistant, or assistant physician shall be documented as required in subsection 2 of this section and reviewed in person by the attending licensed physician if the episode of restraint is to extend beyond:

(1) Four hours duration in the case of a person under eighteen years of age;

(2) Eight hours duration in the case of a person eighteen years of age or older; or

(3) For any total length of restraint lasting more than four hours duration in a twenty-four-hour period in the case of a person under eighteen years of age or beyond eight hours duration in the case of a person eighteen years of age or older in a twenty-four-hour period.

The review shall occur prior to the time limit specified under subsection 6 of this section and shall be documented by the licensed physician under subsection 2 of this section.

2. Every use of physical or chemical restraint, isolation or seclusion and the reasons therefor shall be made a part of the clinical record of the patient, resident or client under the signature of the head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**supervision agreement**]** **collaborative practice arrangement**, with the attending licensed physician.

3. Physical or chemical restraint, isolation or seclusion shall not be considered standard treatment or habilitation and shall cease as soon as the circumstances causing the need for such action have ended.

4. The use of security escort devices, including devices designed to restrict physical movement, which are used to maintain safety and security and to prevent escape during transport outside of a facility shall not be considered physical restraint within the meaning of this section. Individuals who have been civilly detained under sections 632.300 to 632.475 may be placed in security escort devices when transported outside of the facility if it is determined by the

head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**supervision agreement**]** **collaborative practice arrangement**, with the attending licensed physician that the use of security escort devices is necessary to protect the health and safety of the patient, resident, client, or other persons or is necessary to prevent escape. Individuals who have been civilly detained under sections 632.480 to 632.513 or committed under chapter 552 shall be placed in security escort devices when transported outside of the facility unless it is determined by the head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**supervision agreement**]** **collaborative practice arrangement**, with the attending licensed physician that security escort devices are not necessary to protect the health and safety of the patient, resident, client, or other persons or is not necessary to prevent escape.

5. Extraordinary measures employed by the head of the facility to ensure the safety and security of patients, residents, clients, and other persons during times of natural or man-made disasters shall not be considered restraint, isolation, or seclusion within the meaning of this section.

6. Orders issued under this section by the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**supervision agreement**]** **collaborative practice arrangement**, with the attending licensed physician shall be reviewed in person by the attending licensed physician of the facility within twenty-four hours or the next regular working day of the order being issued, and such review shall be documented in the clinical record of the patient, resident, or client.

7. For purposes of this subsection, "division" shall mean the division of developmental disabilities. Restraint or seclusion shall not be used in habilitation centers or community programs that serve persons with developmental disabilities that are operated or funded by the division unless such procedure is part of an emergency intervention system approved by the division and is identified in such person's individual support plan. Direct-care staff that serve persons with developmental disabilities in habilitation centers or community programs operated or funded by the division shall be trained in an emergency intervention system approved by the division when such emergency intervention system is identified in a consumer's individual support plan.

630.875. 1. This section shall be known and may be cited as the

"Improved Access to Treatment for Opioid Addictions Act" or "IATOA Act".

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

(1) "Department", the department of mental health;

(2) "IATOA program", the improved access to treatment for opioid addictions program created under subsection 3 of this section.

3. Subject to appropriations, the department shall create and oversee an "Improved Access to Treatment for Opioid Addictions Program", which is hereby created and whose purpose is to disseminate information and best practices regarding opioid addiction and to facilitate collaborations to better treat and prevent opioid addiction in this state. The IATOA program shall facilitate partnerships between assistant physicians, physician assistants, and advanced practice registered nurses practicing in federally qualified health centers, rural health clinics, and other health care facilities and physicians practicing at remote facilities located in this state. The IATOA program shall provide resources that grant patients and their treating assistant physicians, physician assistants, advanced practice registered nurses, or physicians access to knowledge and expertise through means such as telemedicine and Extension for Community Healthcare Outcomes (ECHO) programs established under section 191.1140.

4. Assistant physicians, physician assistants, and advanced practice registered nurses who participate in the IATOA program shall complete the necessary requirements to prescribe buprenorphine within at least thirty days of joining the IATOA program.

5. For the purposes of the IATOA program, a remote collaborating **[**or supervising**]** physician working with an on-site assistant physician, physician assistant, or advanced practice registered nurse shall be considered to be on-site. An assistant physician, physician assistant, or advanced practice registered nurse collaborating with a remote physician shall comply with all laws and requirements applicable to assistant physicians, physician assistants, or advanced practice registered nurses with on-site supervision before providing treatment to a patient.

6. An assistant physician, physician assistant, or advanced practice registered nurse collaborating with a physician who is waiver-certified for the use of buprenorphine may participate in the IATOA program in any area of the state and provide all services and functions of an assistant physician, physician assistant, or advanced practice registered nurse.

7. The department may develop curriculum and benchmark examinations on the subject of opioid addiction and treatment. The department may

collaborate with specialists, institutions of higher education, and medical schools for such development. Completion of such a curriculum and passing of such an examination by an assistant physician, physician assistant, advanced practice registered nurse, or physician shall result in a certificate awarded by the department or sponsoring institution, if any.

8. An assistant physician, physician assistant, or advanced practice registered nurse participating in the IATOA program may also:

(1) Engage in community education;

(2) Engage in professional education outreach programs with local treatment providers;

(3) Serve as a liaison to courts;

(4) Serve as a liaison to addiction support organizations;

(5) Provide educational outreach to schools;

(6) Treat physical ailments of patients in an addiction treatment program or considering entering such a program;

(7) Refer patients to treatment centers;

(8) Assist patients with court and social service obligations;

(9) Perform other functions as authorized by the department; and

(10) Provide mental health services in collaboration with a qualified licensed physician.

The list of authorizations in this subsection is a nonexclusive list, and assistant physicians, physician assistants, or advanced practice registered nurses participating in the IATOA program may perform other actions.

9. When an overdose survivor arrives in the emergency department, the assistant physician, physician assistant, or advanced practice registered nurse serving as a recovery coach or, if the assistant physician, physician assistant, or advanced practice registered nurse is unavailable, another properly trained recovery coach shall, when reasonably practicable, meet with the overdose survivor and provide treatment options and support available to the overdose survivor. The department shall assist recovery coaches in providing treatment options and support to overdose survivors.

10. The provisions of this section shall supersede any contradictory statutes, rules, or regulations. The department shall implement the improved access to treatment for opioid addictions program as soon as reasonably possible using guidance within this section. Further refinement to the improved access to treatment for opioid addictions program may be done through the rules process.

11. The department shall promulgate rules to implement the provisions of the improved access to treatment for opioid addictions act as soon as reasonably possible. 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, 2018, shall be invalid and void.

Section B. Because immediate action is necessary to ensure vital health care services for Missouri citizens, the repeal and reenactment of section 208.930 of section A of this act is deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of section 208.930 of section A of this act shall be in full force and effect upon its passage and approval.

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