

FIRST REGULAR SESSION
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 758
100TH GENERAL ASSEMBLY

Reported from the Committee on Health and Pensions, May 8, 2019, with recommendation that the Senate Committee Substitute do pass.

1724S.03C

ADRIANE D. CROUSE, Secretary.

AN ACT

To repeal sections 192.067, 192.667, 193.015, 195.080, 195.100, 197.305, 197.318, 198.082, 208.225, 334.037, 334.104, 334.108, 334.735, 334.736, 334.747, 334.749, 335.175, 338.010, 376.1578, 630.175, and 630.875, RSMo, and to enact in lieu thereof forty new sections relating to health care, with penalty provisions.

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

Section A. Sections 192.067, 192.667, 193.015, 195.080, 195.100, 197.305, 197.318, 198.082, 208.225, 334.037, 334.104, 334.108, 334.735, 334.736, 334.747, 334.749, 335.175, 338.010, 376.1578, 630.175, and 630.875, RSMo, are repealed and forty new sections enacted in lieu thereof, to be known as sections 191.250, 191.1164, 191.1165, 191.1167, 191.1168, 192.067, 192.667, 192.990, 193.015, 195.080, 195.100, 195.805, 197.108, 197.305, 197.318, 198.082, 198.610, 198.612, 198.614, 198.616, 198.618, 198.620, 198.622, 198.624, 198.626, 198.628, 198.630, 208.225, 334.037, 334.104, 334.108, 334.735, 334.736, 334.747, 334.749, 335.175, 338.010, 376.1578, 630.175, and 630.875, to read as follows:

191.250. 1. This section shall be known and may be cited as "Simon's Law".

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

(1) "End-of-life medical decision order", a decision issued by a juvenile or family court pertaining to life-sustaining treatment, including do-not-resuscitate orders, provided on behalf of and in the best interests of a child under juvenile or family court jurisdiction under section 211.031;

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

9 **(2) "Reasonable medical judgment", a medical judgment that**
10 **would be made by a reasonably prudent health care provider who is**
11 **knowledgeable about the case and the treatment possibilities with**
12 **respect to the medical conditions involved.**

13 **3. For a child who is not under juvenile or family court**
14 **jurisdiction under section 211.031, no health care facility, nursing**
15 **home, physician, nurse, or medical staff shall institute a do-not-**
16 **resuscitate order or similar physician's order, either orally or in**
17 **writing, without the written or oral consent of at least one parent or**
18 **legal guardian of the patient or resident under eighteen years of age**
19 **who is not emancipated. If consent to implement a do-not-resuscitate**
20 **order or similar physician's order is granted orally, two witnesses other**
21 **than the parent, legal guardian, or physician shall be present and**
22 **willing to attest to the consent given by the legal guardian of the**
23 **patient or at least one parent of the patient. The provision of such**
24 **consent shall be immediately recorded in the patient's medical record,**
25 **specifying who provided the information, to whom the information was**
26 **provided, which parent or legal guardian gave the consent, who the**
27 **witnesses were, and the date and time the consent was obtained.**

28 **4. The requirements of subsection 3 of this section shall not**
29 **apply if a reasonably diligent effort of at least forty-eight hours without**
30 **success has been made to contact and inform each known parent or**
31 **legal guardian of the intent to implement a do-not-resuscitate order or**
32 **similar physician's order.**

33 **5. Consent previously given under subsection 3 of this section**
34 **may be revoked orally or in writing by the parent or legal guardian of**
35 **the patient or resident who granted the original permission. Such**
36 **revocation of prior consent shall take precedence over any prior**
37 **consent to implement a do-not-resuscitate order or similar physician's**
38 **order and shall be immediately recorded in the patient's or resident's**
39 **medical record, specifying who provided the information, to whom the**
40 **information was provided, which parent or legal guardian revoked**
41 **consent, who the witnesses were, and the date and time the revocation**
42 **was obtained.**

43 **6. For a child under juvenile court jurisdiction under section**
44 **211.031, a juvenile or family court may issue an end-of-life medical**
45 **decision order, a physician's order, or any other medical decision**

46 order, or may appoint a guardian for the child for that purpose. The
47 children's division shall not be appointed as guardian for a child to
48 make end-of-life medical decisions, including do-not-resuscitate orders.
49 In the event a child under the jurisdiction of a juvenile or family court
50 under section 211.031 is returned to the custody of the legal guardian
51 or parent, the legal guardian or parent may revoke the consent for the
52 end-of-life medical decisions or similar physician's orders ordered by
53 the court, including do-not-resuscitate orders for the child. Revocation
54 may be orally or in writing and shall be immediately recorded in the
55 patient's medical records, specifying who provided the information, to
56 whom the information was provided, which parent or legal guardian
57 revoked consent, who the witnesses were, and the date and time the
58 revocation was obtained.

59 7. For the purposes of this section, a relative caregiver under the
60 provisions of section 431.058 shall have the same authority given to a
61 parent or legal guardian of a nonemancipated patient or resident under
62 eighteen years of age, provided that such a patient or resident is not
63 under juvenile or family court jurisdiction under section 211.031.

64 8. Nothing in this section shall be construed to require any
65 health care facility, nursing home, physician, nurse, or medical staff to
66 provide or continue any treatment, including resuscitative efforts, food,
67 medication, oxygen, intravenous fluids, or nutrition, that would be:

68 (1) Medically inappropriate because, in their reasonable medical
69 judgment, providing such treatment would create a greater risk of
70 causing or hastening the death of the patient; or

71 (2) Medically inappropriate because, in their reasonable medical
72 judgment, providing such treatment would be potentially harmful or
73 cause unnecessary pain, suffering, or injury to the patient.

74 9. Nothing in this section shall require health care providers to
75 continue cardiopulmonary resuscitation or manual ventilation beyond
76 a time in which, in their reasonable medical judgment, there is no
77 further benefit to the patient or likely recovery of the patient.

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

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

- 6 (1) "Behavioral therapy", an individual, family, or group therapy
7 designed to help patients engage in the treatment process, modify their
8 attitudes and behaviors related to substance use, and increase healthy
9 life skills;
- 10 (2) "Department of insurance", the department that has
11 jurisdiction regulating health insurers;
- 12 (3) "Financial requirements", deductibles, co-payments,
13 coinsurance, or out-of-pocket maximums;
- 14 (4) "Health care professional", a physician or other health care
15 practitioner licensed, accredited, or certified by the state of Missouri
16 to perform specified health services;
- 17 (5) "Health insurance plan", an individual or group plan that
18 provides, or pays the cost of, health care items or services;
- 19 (6) "Health insurer", any person or entity that issues, offers,
20 delivers, or administers a health insurance plan;
- 21 (7) "Mental Health Parity and Addiction Equity Act of 2008
22 (MHPAEA)", the Paul Wellstone and Pete Domenici Mental Health
23 Parity and Addiction Equity Act of 2008 found at 42 U.S.C. 300gg-26 and
24 its implementing and related regulations found at 45 CFR 146.136, 45
25 CFR 147.160, and 45 CFR 156.115;
- 26 (8) "Nonquantitative treatment limitation" or "NQTL", any
27 limitation on the scope or duration of treatment that is not expressed
28 numerically;
- 29 (9) "Pharmacologic therapy", a prescribed course of treatment
30 that may include methadone, buprenorphine, naltrexone, or other FDA-
31 approved or evidence-based medications for the treatment of substance
32 use disorder;
- 33 (10) "Pharmacy benefits manager", an entity that contracts with
34 pharmacies on behalf of health carriers or any health plan sponsored
35 by the state or a political subdivision of the state;
- 36 (11) "Prior authorization", the process by which the health
37 insurer or the pharmacy benefits manager determines the medical
38 necessity of otherwise covered health care services prior to the
39 rendering of such health care services. "Prior authorization" also
40 includes any health insurer's or utilization review entity's requirement
41 that a subscriber or health care provider notify the health insurer or
42 utilization review entity prior to receiving or providing a health care

43 service;

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

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

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

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

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

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

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

6 (1) Buprenorphine tablets;

7 (2) Methadone;

8 (3) Naloxone;

9 (4) Extended-release injectable naltrexone; and

10 (5) Buprenorphine/naloxone combination.

11 2. All MAT medications required for compliance in this section
12 shall be placed on the lowest cost-sharing tier of the formulary
13 managed by the health insurer or the pharmacy benefits manager.

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

16 (1) Any annual or lifetime dollar limitations;

17 (2) Financial requirements and quantitative treatment

18 limitations that do not comply with the Mental Health Parity and
19 Addiction Equity Act of 2008 (MHPAEA), specifically 45 CFR
20 146.136(c)(3);

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

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

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

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

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

42 7. Drug courts or other diversion programs that provide for
43 alternatives to jail or prison for persons with a substance use disorder
44 shall be required to ensure all persons under their care are assessed
45 for substance use disorders using standard diagnostic criteria by a
46 licensed physician who actively treats patients with substance use
47 disorders. The court or other diversion program shall make available
48 the MAT services covered under this section, consistent with a
49 treatment plan developed by the physician, and shall not impose any
50 limitations on the type of medication or other treatment prescribed or
51 the dose or duration of MAT recommended by the physician.

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

191.1167. Any contract provision, written policy, or written

2 **procedure in violation of sections 191.1164 to 191.1168 shall be deemed**
3 **to be unenforceable and shall be null and void.**

191.1168. If any provision of sections 191.1164 to 191.1168 or the
2 **application thereof to any person or circumstance is held invalid, the**
3 **invalidity shall not affect other provisions or applications of sections**
4 **191.1164 to 191.1168 which may be given effect without the invalid**
5 **provision or application, and to that end the provisions of sections**
6 **191.1164 to 191.1168 are severable.**

192.067. 1. The department of health and senior services, for purposes
2 of conducting epidemiological studies to be used in promoting and safeguarding
3 the health of the citizens of Missouri under the authority of this chapter is
4 authorized to receive information from patient medical records. The provisions
5 of this section shall also apply to the collection, analysis, and disclosure of
6 nosocomial infection data from patient records collected pursuant to section
7 **192.667 and to the collection of data under section 192.990.**

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

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

24 4. The department of health and senior services is authorized to
25 reimburse medical care facilities, within the limits of appropriations made for
26 that purpose, for the costs associated with abstracting data for special studies.

27 5. Any department of health and senior services employee, public health
28 authority or coinvestigator of a study who knowingly releases information which

29 violates the provisions of this section shall be guilty of a class A misdemeanor
30 and, upon conviction, shall be punished as provided by law.

192.667. 1. All health care providers shall at least annually provide to
2 the department charge data as required by the department. All hospitals shall
3 at least annually provide patient abstract data and financial data as required by
4 the department. Hospitals as defined in section 197.020 shall report patient
5 abstract data for outpatients and inpatients. Ambulatory surgical centers and
6 abortion facilities as defined in section 197.200 shall provide patient abstract
7 data to the department. The department shall specify by rule the types of
8 information which shall be submitted and the method of submission.

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

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

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

31 (2) Consider the findings and recommendations of the infection control
32 advisory panel established pursuant to section 197.165.

33 4. By January 1, 2017, the infection control advisory panel created by
34 section 197.165 shall make recommendations to the department regarding the

35 Centers for Medicare and Medicaid Services' health care-associated infection data
36 collection, analysis, and public reporting requirements for hospitals, ambulatory
37 surgical centers, and other facilities in the federal Centers for Disease Control
38 and Prevention's National Healthcare Safety Network, or its successor, in lieu of
39 all or part of the data collection, analysis, and public reporting requirements of
40 this section. The advisory panel recommendations shall address which hospitals
41 shall be required as a condition of licensure to use the National Healthcare Safety
42 Network for data collection; the use of the National Healthcare Safety Network
43 for risk adjustment and analysis of hospital submitted data; and the use of the
44 Centers for Medicare and Medicaid Services' Hospital Compare website, or its
45 successor, for public reporting of the incidence of health care-associated infection
46 metrics. The advisory panel shall consider the following factors in developing its
47 recommendation:

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

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

52 (3) Whether the public is provided with the same or greater specificity of
53 reporting of infections by type of facility infections and procedures;

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

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

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

60 5. After considering the recommendations of the infection control advisory
61 panel, and provided that the requirements of subsection 13 of this section can be
62 met, the department shall implement guidelines from the federal Centers for
63 Disease Control and Prevention's National Healthcare Safety Network, or its
64 successor. It shall be a condition of licensure for hospitals that meet the
65 minimum public reporting requirements of the National Healthcare Safety
66 Network and the Centers for Medicare and Medicaid Services to participate in the
67 National Healthcare Safety Network, or its successor. Such hospitals shall
68 permit the National Healthcare Safety Network, or its successor, to disclose
69 facility-specific infection data to the department as required under this section,
70 and as necessary to provide the public reports required by the department. It

71 shall be a condition of licensure for any ambulatory surgical center or abortion
72 facility which does not voluntarily participate in the National Healthcare Safety
73 Network, or its successor, to submit facility-specific data to the department as
74 required under this section, and as necessary to provide the public reports
75 required by the department.

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

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

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

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

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

103 8. The department shall undertake a reasonable number of studies and
104 publish information, including at least an annual consumer guide, in
105 collaboration with health care providers, business coalitions and consumers based
106 upon the information obtained pursuant to the provisions of section 192.665 and

107 this section. The department shall allow all health care providers and
108 associations and related organizations who have submitted data which will be
109 used in any publication to review and comment on the publication prior to its
110 publication or release for general use. The publication shall be made available
111 to the public for a reasonable charge.

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

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

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

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

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

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

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

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

143 Healthcare Safety Network or its successor;

144 (2) Central line-related bloodstream infections;

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

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

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

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

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

165 15. Reports published pursuant to subsection 13 of this section shall be
166 published and readily accessible on the department's internet website. The
167 reports shall be distributed at least annually to the governor and members of the
168 general assembly. The department shall make such reports available to the
169 public for a period of at least two years.

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

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

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

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

204 20. Hospitals described in subsection 19 of this section shall meet the
205 National Healthcare Safety Network requirements for reporting antimicrobial
206 usage or resistance by using the Centers for Disease Control and Prevention's
207 Antimicrobial Use and Resistance (AUR) Module when [regulations concerning
208 Stage 3 of the Medicare and Medicaid Electronic Health Records Incentive
209 Programs promulgated by the Centers for Medicare and Medicaid Services that
210 enable the electronic interface for such reporting are effective] **conditions of**
211 **participation promulgated by the Centers for Medicare and Medicaid**
212 **Services requiring the electronic reporting of antibiotic use or**
213 **antibiotic resistance by hospitals become effective.** When such
214 antimicrobial usage or resistance reporting takes effect, hospitals shall authorize

215 the National Healthcare Safety Network, or its successor, to disclose to the
216 department facility-specific information reported to the AUR
217 Module. Facility-specific data on antibiotic usage and resistance collected under
218 this subsection shall not be disclosed to the public, but the department may
219 release case-specific information to other facilities, physicians, and the public if
220 the department determines on a case-by-case basis that the release of such
221 information is necessary to protect persons in a public health
222 emergency. **Nothing in this section shall prohibit a hospital from**
223 **voluntarily reporting antibiotic use or antibiotic resistance data**
224 **through the National Healthcare Safety Network, or its successor, prior**
225 **to the effective date of the conditions of participation requiring the**
226 **reporting.**

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

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

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

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

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

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

21 4. The board shall have a multidisciplinary and diverse

22 membership that represents a variety of medical and nursing
23 specialties, including, but not limited to, obstetrics and maternal-fetal
24 care, as well as state or local public health officials, epidemiologists,
25 statisticians, community organizations, geographic regions, and other
26 individuals or organizations that are most affected by maternal deaths
27 and lack of access to maternal health care services.

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

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

31 (2) Identifying factors associated with maternal deaths;

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

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

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

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

43 (4) Consulting with relevant experts, as needed;

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

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

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

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

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

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

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

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

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

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

69 7. (1) Before June 30, 2020, and annually thereafter, the board
70 shall submit to the Director of the Centers for Disease Control and
71 Prevention, the director of the department, the governor, and the
72 general assembly a report on maternal mortality in the state based on
73 data collected through ongoing comprehensive, multidisciplinary
74 reviews of all maternal deaths, and any other projects or efforts funded
75 by the board. The data shall be collected using best practices to
76 reliably determine and include all maternal deaths, regardless of the
77 outcome of the pregnancy and shall include data, findings, and
78 recommendations of the committee, and, as applicable, information on
79 the implementation during such year of any recommendations
80 submitted by the board in a previous year.

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

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

89 9. Upon request by the department, health care providers, health
90 care facilities, clinics, laboratories, medical examiners, coroners, law
91 enforcement agencies, driver's license bureaus, other state agencies,
92 and facilities licensed by the department shall provide to the
93 department data related to maternal deaths from sources such as
94 medical records, autopsy reports, medical examiner's reports, coroner's
95 reports, law enforcement reports, motor vehicle records, social services

96 records, and other sources as appropriate. Such data requests shall be
97 limited to maternal deaths which have occurred within the previous
98 twenty-four months. No entity shall be held liable for civil damages or
99 be subject to any criminal or disciplinary action when complying in
100 good faith with a request from the department for information under
101 the provisions of this subsection.

102 **10. (1) The board shall protect the privacy and confidentiality**
103 **of all patients, decedents, providers, hospitals, or any other**
104 **participants involved in any maternal deaths. In no case shall any**
105 **individually identifiable health information be provided to the public**
106 **or submitted to an information clearinghouse.**

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

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

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

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

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

132 **(5) All proceedings and activities of the board, opinions of**

133 members of such board formed as a result of such proceedings and
134 activities, and records obtained, created, or maintained under this
135 section, including records of interviews, written reports, statements,
136 notes, memoranda, or other data obtained by the department or any
137 other person, agency, or organization acting jointly or under contract
138 with the department in connection with the requirements of this
139 section, shall be confidential and shall not be subject to subpoena,
140 discovery, or introduction into evidence in any civil or criminal
141 proceeding; provided, however, that nothing in this section shall be
142 construed to limit or restrict the right to discover or use in any civil or
143 criminal proceeding anything that is available from another source and
144 entirely independent of the board's proceedings.

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

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

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

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

7 (2) "Assistant physician", as such term is defined in section 334.036, and
8 who has been delegated tasks outlined in section 193.145 by a physician with
9 whom they have entered into a collaborative practice arrangement under chapter
10 334;

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

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

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

16 (6) "Institution", any establishment, public or private, which provides
17 inpatient or outpatient medical, surgical, or diagnostic care or treatment or
18 nursing, custodian, or domiciliary care, or to which persons are committed by law;

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

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

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

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

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

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

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

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

195.080. 1. Except as otherwise provided in this chapter and chapter 579,
2 this chapter and chapter 579 shall not apply to the following cases: prescribing,
3 administering, dispensing or selling at retail of liniments, ointments, and other

4 preparations that are susceptible of external use only and that contain controlled
5 substances in such combinations of drugs as to prevent the drugs from being
6 readily extracted from such liniments, ointments, or preparations, except that
7 this chapter and chapter 579 shall apply to all liniments, ointments, and other
8 preparations that contain coca leaves in any quantity or combination.

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

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

35 4. Unless otherwise provided in this section, the quantity of Schedule II
36 controlled substances prescribed or dispensed at any one time shall be limited to
37 a thirty-day supply. The quantity of Schedule III, IV or V controlled substances
38 prescribed or dispensed at any one time shall be limited to a ninety-day supply
39 and shall be prescribed and dispensed in compliance with the general provisions

40 of this chapter and chapter 579. The supply limitations provided in this
41 subsection may be increased up to three months if the physician describes on the
42 prescription form or indicates via telephone, fax, or electronic communication to
43 the pharmacy to be entered on or attached to the prescription form the medical
44 reason for requiring the larger supply. The supply limitations provided in this
45 subsection shall not apply if:

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

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

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

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

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

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

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

20 5. Whenever a pharmacist or practitioner sells or dispenses any controlled
21 substance on a prescription issued by a physician, physician assistant, dentist,
22 podiatrist, veterinarian, or advanced practice registered nurse, the pharmacist or

23 practitioner shall affix to the container in which such drug is sold or dispensed
24 a label showing his or her own name and address of the pharmacy or practitioner
25 for whom he or she is lawfully acting; the name of the patient or, if the patient
26 is an animal, the name of the owner of the animal and the species of the animal;
27 the name of the physician, physician assistant, dentist, podiatrist, advanced
28 practice registered nurse, or veterinarian by whom the prescription was written;
29 the name of the collaborating physician if the prescription is written by an
30 advanced practice registered nurse or [the supervising physician if the
31 prescription is written by] a physician assistant, and such directions as may be
32 stated on the prescription. No person shall alter, deface, or remove any label so
33 affixed.

**195.805. 1. No edible marijuana-infused product sold in Missouri
2 pursuant to Article XIV of the Missouri Constitution shall be designed,
3 produced, or marketed in a manner that is designed to appeal to
4 persons under eighteen years of age, including, but not limited to, the
5 following:**

6 **(1) Candies, including lollipops, cotton candy, or any product
7 using the word "candy" or "candies" on the label; or**

8 **(2) Products in the shape of a human, animal, or fruit, including
9 realistic, artistic, caricature, or cartoon renderings.**

10 **2. Each increment of an edible marijuana-infused product
11 containing ten or more milligrams of tetrahydrocannabinols (THC)
12 shall be stamped with a diamond containing the letters "THC" and the
13 number of milligrams of THC in that increment.**

14 **3. Any licensed or certified entity regulated by the department
15 of health and senior services pursuant to Article XIV of the Missouri
16 Constitution found to have violated the provisions of this section shall
17 be subject to department sanctions, including an administrative
18 penalty, in accordance with the regulations promulgated by the
19 department pursuant to Article XIV of the Missouri Constitution.**

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

7 **2. For any inspection or survey of a hospital, regardless of the**

8 purpose, the department shall require every newly hired inspector or
9 surveyor at the time of hiring or any currently employed inspector or
10 surveyor as of August 28, 2019, to disclose:

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

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

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

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

25 4. The information provided under subsection 2 of this section
26 shall be considered a public record under the provisions of section
27 610.010.

28 5. Any person may notify the department if facts exist that would
29 lead a reasonable person to conclude that any inspector or surveyor
30 has any personal or business affiliation that would result in a conflict
31 of interest in conducting an inspection or survey for a hospital. Upon
32 receiving such notice, the department, when assigning an inspector or
33 surveyor to inspect or survey a hospital, for any purpose, shall take
34 steps to verify the information and, if the department has reason to
35 believe that such information is correct, the department shall not
36 assign the inspector or surveyor to the hospital or any hospital within
37 its organization so as to avoid an appearance of prejudice or favor to
38 the hospital or bias on the part of the inspector or surveyor.

197.305. As used in sections 197.300 to 197.366, the following terms
2 mean:

3 (1) "Affected persons", the person proposing the development of a new
4 institutional health service, the public to be served, and health care facilities
5 within the service area in which the proposed new health care service is to be
6 developed;

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

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

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

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

19 (6) "Expenditure minimum" shall mean:

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

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

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

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

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

41 (9) "New institutional health service":

42 (a) The development of a new health care facility costing in excess of the

43 applicable expenditure minimum;

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

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

49 (d) Predevelopment activities as defined in subdivision (12) hereof costing
50 in excess of one hundred fifty thousand dollars;

51 (e) Any change in licensed bed capacity of a health care facility licensed
52 under chapter 198 which increases the total number of beds by more than ten or
53 more than ten percent of total bed capacity, whichever is less, over a two-year
54 period, provided that any such health care facility seeking [a nonapplicability
55 review for] an increase in total beds or total bed capacity in an amount less than
56 described in this paragraph shall be eligible for such review only if the facility
57 has had no patient care class I deficiencies within the last eighteen months and
58 has maintained at least an eighty-five percent average occupancy rate for the
59 previous six quarters;

60 (f) Health services, excluding home health services, which are offered in
61 a health care facility and which were not offered on a regular basis in such health
62 care facility within the twelve-month period prior to the time such services would
63 be offered;

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

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

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

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

79 of need.

197.318. 1. As used in this section, the term "licensed and available"
2 means beds which are actually in place and for which a license has been issued.

3 2. The committee shall review all letters of intent and applications for
4 long-term care hospital beds meeting the requirements described in 42 CFR,
5 Section 412.23(e) under its criteria and standards for long-term care beds.

6 3. Sections 197.300 to 197.366 shall not be construed to apply to litigation
7 pending in state court on or before April 1, 1996, in which the Missouri health
8 facilities review committee is a defendant in an action concerning the application
9 of sections 197.300 to 197.366 to long-term care hospital beds meeting the
10 requirements described in 42 CFR, Section 412.23(e).

11 4. Notwithstanding any other provision of this chapter to the contrary:

12 (1) A facility licensed pursuant to chapter 198 may increase its licensed
13 bed capacity by:

14 (a) Submitting a letter of intent to expand to the department of health
15 and senior services and the health facilities review committee;

16 (b) Certification from the department of health and senior services that
17 the facility:

18 a. Has no patient care class I deficiencies within the last eighteen months;
19 and

20 b. Has maintained [a ninety-percent] **an eighty-five percent** average
21 occupancy rate for the previous six quarters;

22 (c) Has made an effort to purchase beds for eighteen months following the
23 date the letter of intent to expand is submitted pursuant to paragraph (a) of this
24 subdivision. For purposes of this paragraph, an "effort to purchase" means a copy
25 certified by the offeror as an offer to purchase beds from another licensed facility
26 in the same licensure category; and

27 (d) If an agreement is reached by the selling and purchasing entities, the
28 health facilities review committee shall issue a certificate of need for the
29 expansion of the purchaser facility upon surrender of the seller's license; or

30 (e) If no agreement is reached by the selling and purchasing entities, the
31 health facilities review committee shall permit an expansion for:

32 a. A facility with more than forty beds may expand its licensed bed
33 capacity within the same licensure category by twenty-five percent or thirty beds,
34 whichever is greater, if that same licensure category in such facility has
35 experienced an average occupancy of ninety-three percent or greater over the

36 previous six quarters;

37 b. A facility with fewer than forty beds may expand its licensed bed
38 capacity within the same licensure category by twenty-five percent or ten beds,
39 whichever is greater, if that same licensure category in such facility has
40 experienced an average occupancy of ninety-two percent or greater over the
41 previous six quarters;

42 c. A facility adding beds pursuant to subparagraphs a. or b. of this
43 paragraph shall not expand by more than fifty percent of its then licensed bed
44 capacity in the qualifying licensure category;

45 (2) Any beds sold shall, for five years from the date of relicensure by the
46 purchaser, remain unlicensed and unused for any long-term care service in the
47 selling facility, whether they do or do not require a license;

48 (3) The beds purchased shall, for two years from the date of purchase,
49 remain in the bed inventory attributed to the selling facility and be considered
50 by the department of social services as licensed and available for purposes of this
51 section;

52 (4) Any residential care facility licensed pursuant to chapter 198 may
53 relocate any portion of such facility's current licensed beds to any other facility
54 to be licensed within the same licensure category if both facilities are under the
55 same licensure ownership or control, and are located within six miles of each
56 other;

57 (5) A facility licensed pursuant to chapter 198 may transfer or sell
58 individual long-term care licensed **and available** beds to facilities qualifying
59 pursuant to paragraphs (a) and (b) of subdivision (1) of this subsection. Any
60 facility which transfers or sells licensed **and available** beds shall not expand its
61 licensed bed capacity in that licensure category for a period of five years from the
62 date the licensure is relinquished **and until the average occupancy of**
63 **licensed and available beds in that licensure category within a fifteen-**
64 **mile radius is eighty-five percent for the previous six quarters. Any**
65 **facility which transfers or sells licensed and available beds shall have**
66 **an average occupancy rate of less than seventy percent in the previous**
67 **six quarters.**

68 5. Any existing licensed and operating health care facility offering long-
69 term care services may replace one-half of its licensed beds at the same site or a
70 site not more than thirty miles from its current location if, for at least the most
71 recent four consecutive calendar quarters, the facility operates only fifty percent

72 of its then licensed capacity with every resident residing in a private room. In
73 such case:

74 (1) The facility shall report to the health and senior services vacant beds
75 as unavailable for occupancy for at least the most recent four consecutive
76 calendar quarters;

77 (2) The replacement beds shall be built to private room specifications and
78 only used for single occupancy; and

79 (3) The existing facility and proposed facility shall have the same owner
80 or owners, regardless of corporate or business structure, and such owner or
81 owners shall stipulate in writing that the existing facility beds to be replaced will
82 not later be used to provide long-term care services. If the facility is being
83 operated under a lease, both the lessee and the owner of the existing facility shall
84 stipulate the same in writing.

85 6. Nothing in this section shall prohibit a health care facility licensed
86 pursuant to chapter 198 from being replaced in its entirety within fifteen miles
87 of its existing site so long as the existing facility and proposed or replacement
88 facility have the same owner or owners regardless of corporate or business
89 structure and the health care facility being replaced remains unlicensed and
90 unused for any long-term care services whether they do or do not require a license
91 from the date of licensure of the replacement facility.

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

17 department of any high school.

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

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

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

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

46 (2) Continuing in-service training to assure continuing competency in
47 existing and new nursing skills. All nursing assistants trained prior to January
48 1, 1989, shall attend, by August 31, 1989, an entire special retraining program
49 established by rule or regulation of the department which shall contain
50 information on methods of handling mentally confused residents and which may
51 be offered on premises by the employing facility].

52 [4.] 5. **Certified nursing** [Nursing] assistants who have not

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

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

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

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

198.610. 1. The provisions of sections 198.610 to 198.630 shall be
2 **known and may be cited as the "Authorized Electronic Monitoring in**
3 **Long-Term Care Facilities Act".**

4 **2. For purposes of sections 198.610 to 198.630, the following terms**
5 **shall mean:**

6 **(1) "Authorized electronic monitoring", the placement and use of**
7 **an electronic monitoring device by a resident in his or her room in**
8 **accordance with the provisions of sections 198.610 to 198.630;**

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

10 **(3) "Electronic monitoring device", a surveillance instrument**
11 **with a fixed position video camera or an audio recording device, or a**
12 **combination thereof, that is installed in a resident's room under the**
13 **provisions of sections 198.610 to 198.630 and broadcasts or records**
14 **activity or sounds occurring in the room;**

15 **(4) "Facility", any residential care facility, assisted living facility,**
16 **intermediate care facility, or skilled nursing facility;**

17 **(5) "Resident", a person residing in a facility;**

18 **(6) "Resident's representative", a resident's legal representative.**

19 **198.612. 1. A resident may be permitted to conduct authorized**
20 **electronic monitoring of the resident's room through the use of**
21 **electronic monitoring devices placed in the room under the provisions**
22 **of sections 198.610 to 198.630 if the facility in which the resident**
23 **resides permits electronic monitoring devices in its policies and**
24 **procedures and if the electronic monitoring devices comply with the**
25 **facility's requirements therein.**

26 **2. Nothing in sections 198.610 to 198.630 shall be construed to**
27 **allow the use of an electronic monitoring device to take still**
28 **photographs or for the nonconsensual interception of private**
29 **communications.**

30 **3. Except as otherwise provided in this section, a resident, a**
31 **resident's representative, or the parent of a resident under eighteen**
32 **years of age and the facility shall consent in writing on a notification**
33 **and consent form prescribed by the department in order for authorized**
34 **electronic monitoring to be conducted in the resident's room. If the**
35 **resident has not affirmatively objected to the authorized electronic**
36 **monitoring and the resident's physician determines that the resident**
37 **lacks the ability to understand and appreciate the nature and**
38 **consequences of electronic monitoring, the following individuals may**
39 **consent on behalf of the resident in order of priority:**

40 **(1) An attorney-in-fact under a durable power of attorney for**
41 **health care;**

42 **(2) The resident's representative;**

43 **(3) The resident's spouse;**

44 **(4) The resident's parent;**

45 **(5) The resident's adult child who has the written consent of all**
46 **other adult children of the resident to act as the sole decision maker**
47 **regarding authorized electronic monitoring; or**

48 **(6) The resident's adult brother or sister who has the written**
49 **consent of all other adult siblings of the resident to act as the sole**
50 **decision maker regarding authorized electronic monitoring.**

51 **4. Prior to another person, other than a resident's**
52 **representative, consenting on behalf of a resident eighteen years of age**
53 **or older in accordance with the provisions of sections 198.610 to**
54 **198.630, the resident shall be asked by that person, in the presence of**

37 a facility employee, if he or she wants authorized electronic monitoring
38 to be conducted. The person shall explain to the resident:

39 (1) The type of electronic monitoring device to be used;

40 (2) The standard conditions that may be placed on the electronic
41 monitoring device's use including those listed in subdivision (7) of
42 subsection 2 of section 198.614;

43 (3) With whom the recording may be shared according to section
44 198.622; and

45 (4) The resident's ability to decline all recording.

46 For the purposes of this subsection, a resident affirmatively objects if
47 he or she orally, visually, or through the use of auxiliary aids or
48 services declines authorized electronic monitoring. The resident's
49 response shall be documented on the notification and consent form.

50 5. A resident or roommate may consent to authorized electronic
51 monitoring with any conditions of the resident's choosing including,
52 but not limited to, the list of standard conditions provided in
53 subdivision (7) of subsection 2 of section 198.614. A resident or
54 roommate may request that the electronic monitoring device be turned
55 off or the visual recording component of the electronic monitoring
56 device be blocked at any time.

57 6. Prior to the authorized electronic monitoring, a resident shall
58 obtain the written consent of any other resident residing in the room
59 on the notification and consent form prescribed by the
60 department. Except as otherwise provided in this subsection, a
61 roommate, a roommate's legal representative, or the parent of a
62 roommate under eighteen years of age shall consent in writing to the
63 authorized electronic monitoring in the resident's room. If the
64 roommate has not affirmatively objected to the authorized electronic
65 monitoring in accordance with subsection 4 of this section and the
66 roommate's physician determines that the roommate lacks the ability
67 to understand and appreciate the nature and consequences of
68 electronic monitoring, the following individuals may consent on behalf
69 of the roommate, in order of priority:

70 (1) An attorney-in-fact under a durable power of attorney for
71 health care;

72 (2) The roommate's legal representative;

73 (3) The roommate's spouse;

74 (4) The roommate's parent;
75 (5) The roommate's adult child who has the written consent of all
76 other adult children of the roommate to act as the sole decision maker
77 regarding authorized electronic monitoring; or

78 (6) The roommate's adult brother or sister who has the written
79 consent of all other adult siblings of the roommate to act as the sole
80 decision maker regarding authorized electronic monitoring.

81 7. Consent by a roommate under subsection 6 of this section
82 authorizes the resident's use of any recording obtained under sections
83 198.610 to 198.630 as provided under section 198.622.

84 8. Any resident previously conducting authorized electronic
85 monitoring shall obtain consent from any new roommate before the
86 resident may resume authorized electronic monitoring. If a new
87 roommate does not consent to authorized electronic monitoring and the
88 resident conducting the authorized electronic monitoring does not
89 remove or disable the electronic monitoring device, the facility may
90 turn off the device.

91 9. Consent may be withdrawn by the resident or roommate at any
92 time, and the withdrawal of consent shall be documented in the
93 resident's clinical record. If a roommate withdraws consent and the
94 resident conducting the authorized electronic monitoring does not
95 remove or disable the electronic monitoring device, the facility may
96 turn off the electronic monitoring device.

198.614. 1. Authorized electronic monitoring may begin only
2 after a notification and consent form prescribed by the department has
3 been completed and submitted to the facility and the facility consents.

4 2. A resident shall notify the facility in writing of his or her
5 intent to install an electronic monitoring device by providing a
6 completed notification and consent form prescribed by the department
7 that shall include at minimum the following information:

8 (1) The resident's signed consent to electronic monitoring or the
9 signature of the person consenting on behalf of the resident in
10 accordance with section 198.612. If a person other than the resident
11 signs the consent form, the form shall document the following:

12 (a) The date the resident was asked if he or she wants authorized
13 electronic monitoring to be conducted in accordance with subsection
14 4 of section 198.612;

- 15 **(b) Who was present when the resident was asked; and**
16 **(c) An acknowledgment that the resident did not affirmatively**
17 **object;**
- 18 **(2) The resident's roommate's signed consent or the signature of**
19 **the person consenting on behalf of the roommate in accordance with**
20 **section 198.612, if applicable, and any conditions placed on the**
21 **roommate's consent. If a person other than the roommate signs the**
22 **consent form, the form shall document the following:**
- 23 **(a) The date the roommate was asked if he or she wants**
24 **authorized electronic monitoring to be conducted in accordance with**
25 **subsection 4 of section 198.612;**
- 26 **(b) Who was present when the roommate was asked; and**
27 **(c) An acknowledgment that the roommate did not affirmatively**
28 **object;**
- 29 **(3) The type of electronic monitoring device to be used;**
30 **(4) Any installation needs such as mounting of a device to a wall**
31 **or ceiling;**
- 32 **(5) The proposed date of installation for scheduling purposes;**
33 **(6) A copy of any contract for maintenance of the electronic**
34 **monitoring device by a commercial entity;**
- 35 **(7) A list of standard conditions or restrictions that the facility,**
36 **resident, or roommate may elect to place on the use of the electronic**
37 **monitoring device including, but not limited to:**
- 38 **(a) Prohibiting audio recording;**
39 **(b) Prohibiting broadcasting of audio or video; or**
40 **(c) Turning off the electronic monitoring device or blocking the**
41 **visual recording component of the electronic monitoring device for the**
42 **duration of an exam or procedure by a health care professional; while**
43 **dressing or bathing is performed; or for the duration of a visit with a**
44 **spiritual advisor, ombudsman, attorney, financial planner, intimate**
45 **partner, or other visitor; and**
- 46 **(8) Any other condition or restriction elected by the facility,**
47 **resident, or roommate on the use of an electronic monitoring device.**
- 48 **3. A copy of the completed notification and consent form shall be**
49 **placed in the resident's and any roommate's clinical record and a copy**
50 **shall be provided to the resident and his or her roommate, if**
51 **applicable.**

52 4. The department shall prescribe the notification and consent
53 form required in this section no later than sixty days after the effective
54 date of sections 198.610 to 198.630. If the department has not
55 prescribed such a form by that date, the attorney general shall post a
56 notification and consent form on its website for resident use until the
57 department has prescribed the form.

 198.616. 1. A resident authorized to conduct authorized
2 electronic monitoring shall do so at his or her own expense, including
3 paying purchase, installation, maintenance, and removal costs.

4 2. If a resident authorized to conduct authorized electronic
5 monitoring chooses to install an electronic monitoring device that uses
6 internet technology for visual or audio monitoring, such resident is
7 responsible for contracting with an internet service provider.

8 3. The electronic monitoring device shall be placed in a
9 conspicuously visible location in the room.

10 4. No facility shall charge the resident a fee for the cost of
11 electricity used by an electronic monitoring device.

12 5. All electronic monitoring device installations and supporting
13 services shall comply with the requirements of the National Fire
14 Protection Association (NFPA) 101 Life Safety Code (2015 edition).

 198.618. 1. If a resident of a facility conducts authorized
2 electronic monitoring, a sign shall be clearly and conspicuously posted
3 at all building entrances accessible to visitors. The notice shall be
4 entitled "Electronic Monitoring" and shall state in large, easy-to-read
5 type: "The rooms of some residents may be monitored electronically by
6 or on behalf of the residents."

7 2. A sign shall be clearly and conspicuously posted at the
8 entrance to a resident's room where authorized electronic monitoring
9 is being conducted. The notice shall state in large, easy-to-read type,
10 "This room is electronically monitored."

11 3. The facility is responsible for installing and maintaining the
12 signage required in this section.

 198.620. 1. No person or entity shall knowingly hamper, obstruct,
2 tamper with, or destroy an electronic monitoring device installed in a
3 resident's room without the permission of the resident or the individual
4 who consented on behalf of the resident and the facility, in accordance
5 with section 198.612.

6 2. No person or entity shall knowingly hamper, obstruct, tamper
7 with, or destroy a video or audio recording obtained in accordance
8 with sections 198.610 to 198.630 without the permission of the resident
9 or the individual who consented on behalf of the resident and the
10 facility, in accordance with section 198.612.

11 3. A person or entity that violates this section is guilty of a class
12 B misdemeanor. A person or entity that violates this section in the
13 commission of or to conceal a misdemeanor offense is guilty of a class
14 A misdemeanor. A person or entity that violates this section in the
15 commission of or to conceal a felony offense is guilty of a class D
16 felony.

17 4. It is not a violation of this section if a person or facility turns
18 off the electronic monitoring device or blocks the visual recording
19 component of the electronic monitoring device at the direction of the
20 resident or the person who consented on behalf of the resident in
21 accordance with section 198.612.

 198.622. 1. No facility shall access any video or audio recording
2 created through authorized electronic monitoring without the written
3 consent of the resident or the person who consented on behalf of the
4 resident and the facility, in accordance with section 198.612.

5 2. Except as required under the Freedom of Information Act, a
6 recording or copy of a recording made under sections 198.610 to 198.630
7 shall only be disseminated for the purpose of addressing concerns
8 relating to the health, safety, or welfare of a resident or residents.

9 3. The resident or person who consented on behalf of the
10 resident in accordance with section 198.612 shall provide a copy of any
11 video or audio recording to parties involved in a criminal or
12 administrative proceeding, upon a party's request, if the video or audio
13 recording was made during the time period that the conduct at issue
14 in the proceeding allegedly occurred.

 198.624. Any individual who has reasonable cause to believe, as
2 a result of any video or audio recording created through authorized
3 electronic monitoring in accordance with the provisions of sections
4 198.610 to 198.630, that a resident has been the victim of a sexual
5 assault shall report such suspected assault to a local law enforcement
6 entity and provide such entity with a copy of the video or audio
7 recording. Subject to applicable rules of evidence and procedure, any

8 video or audio recording created through authorized electronic
9 monitoring in accordance with the provisions of sections 198.610 to
10 198.630 may be admitted into evidence in a civil, criminal, or
11 administrative proceeding if the contents of the recording have not
12 been edited or artificially enhanced and the video recording includes
13 the date and time the events occurred.

198.626. Each facility shall report to the department, in a manner
2 prescribed by the department, the number of authorized electronic
3 monitoring notification and consent forms received annually. The
4 department shall report the total number of authorized electronic
5 monitoring notification and consent forms received from facilities to
6 the attorney general annually.

198.628. 1. No facility shall be civilly or criminally liable for the
2 inadvertent or intentional disclosure of a recording by a resident or a
3 person who consents on behalf of the resident for any purpose not
4 authorized by sections 198.610 to 198.630. Nothing in sections 198.610
5 to 198.630 shall permit or authorize a resident to use any device that in
6 any way violates any other state or federal law or regulation.

7 2. No facility shall be civilly or criminally liable for a violation
8 of a resident's right to privacy arising out of any electronic monitoring
9 conducted under sections 198.610 to 198.630.

10 3. The department shall promulgate rules to adopt the form
11 described in subsection 2 of section 198.614. Any rule or portion of a
12 rule, as that term is defined in section 536.010, that is created under
13 the authority delegated in this section shall become effective only if it
14 complies with and is subject to all of the provisions of chapter 536 and,
15 if applicable, section 536.028. This section and chapter 536 are
16 nonseverable, and if any of the powers vested with the general
17 assembly pursuant to chapter 536 to review, to delay the effective date,
18 or to disapprove and annul a rule are subsequently held
19 unconstitutional, then the grant of rulemaking authority and any rule
20 proposed or adopted after August 28, 2019, shall be invalid and void.

198.630. 1. No person shall:

2 (1) Intentionally retaliate or discriminate against any resident
3 for consenting to authorized electronic monitoring under sections
4 198.610 to 198.630; or

5 (2) Prevent the installation or use of an electronic monitoring

6 **device by a resident who has received authorization from the facility**
7 **with notice and consent as required under section 198.614 that**
8 **otherwise meets the requirements of sections 198.610 to 198.630.**

9 **2. Sections 198.601 to 198.630 shall not be interpreted to allow**
10 **any facility to prohibit the use of recording devices in a manner**
11 **authorized under section 542.402.**

208.225. 1. To implement fully the provisions of section 208.152, the MO
2 HealthNet division shall calculate the Medicaid per diem reimbursement rates
3 of each nursing home participating in the Medicaid program as a provider of
4 nursing home services based on its costs reported in the Title XIX cost report
5 filed with the MO HealthNet division for its fiscal year as provided in subsection
6 2 of this section.

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

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

334.037. 1. A physician may enter into collaborative practice
2 arrangements with assistant physicians. Collaborative practice arrangements
3 shall be in the form of written agreements, jointly agreed-upon protocols, or
4 standing orders for the delivery of health care services. Collaborative practice

5 arrangements, which shall be in writing, may delegate to an assistant physician
6 the authority to administer or dispense drugs and provide treatment as long as
7 the delivery of such health care services is within the scope of practice of the
8 assistant physician and is consistent with that assistant physician's skill,
9 training, and competence and the skill and training of the collaborating
10 physician.

11 2. The written collaborative practice arrangement shall contain at least
12 the following provisions:

13 (1) Complete names, home and business addresses, zip codes, and
14 telephone numbers of the collaborating physician and the assistant physician;

15 (2) A list of all other offices or locations besides those listed in subdivision
16 (1) of this subsection where the collaborating physician authorized the assistant
17 physician to prescribe;

18 (3) A requirement that there shall be posted at every office where the
19 assistant physician is authorized to prescribe, in collaboration with a physician,
20 a prominently displayed disclosure statement informing patients that they may
21 be seen by an assistant physician and have the right to see the collaborating
22 physician;

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

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

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

30 (b) Maintain geographic proximity; except, the collaborative practice
31 arrangement may allow for geographic proximity to be waived for a maximum of
32 twenty-eight days per calendar year for rural health clinics as defined by Pub. L.
33 95-210 (42 U.S.C. Section 1395x), as amended, as long as the collaborative
34 practice arrangement includes alternative plans as required in paragraph (c) of
35 this subdivision. Such exception to geographic proximity shall apply only to
36 independent rural health clinics, provider-based rural health clinics if the
37 provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and
38 provider-based rural health clinics if the main location of the hospital sponsor is
39 greater than fifty miles from the clinic. The collaborating physician shall
40 maintain documentation related to such requirement and present it to the state

41 board of registration for the healing arts when requested; and

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

44 (6) A description of the assistant physician's controlled substance
45 prescriptive authority in collaboration with the physician, including a list of the
46 controlled substances the physician authorizes the assistant physician to
47 prescribe and documentation that it is consistent with each professional's
48 education, knowledge, skill, and competence;

49 (7) A list of all other written practice agreements of the collaborating
50 physician and the assistant physician;

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

53 (9) A description of the time and manner of the collaborating physician's
54 review of the assistant physician's delivery of health care services. The
55 description shall include provisions that the assistant physician shall submit a
56 minimum of ten percent of the charts documenting the assistant physician's
57 delivery of health care services to the collaborating physician for review by the
58 collaborating physician, or any other physician designated in the collaborative
59 practice arrangement, every fourteen days; and

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

66 3. The state board of registration for the healing arts under section
67 334.125 shall promulgate rules regulating the use of collaborative practice
68 arrangements for assistant physicians. Such rules shall specify:

69 (1) Geographic areas to be covered;

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

72 (3) In conjunction with deans of medical schools and primary care
73 residency program directors in the state, the development and implementation of
74 educational methods and programs undertaken during the collaborative practice
75 service which shall facilitate the advancement of the assistant physician's medical
76 knowledge and capabilities, and which may lead to credit toward a future

77 residency program for programs that deem such documented educational
78 achievements acceptable; and

79 (4) The requirements for review of services provided under collaborative
80 practice arrangements, including delegating authority to prescribe controlled
81 substances.

82 Any rules relating to dispensing or distribution of medications or devices by
83 prescription or prescription drug orders under this section shall be subject to the
84 approval of the state board of pharmacy. Any rules relating to dispensing or
85 distribution of controlled substances by prescription or prescription drug orders
86 under this section shall be subject to the approval of the department of health
87 and senior services and the state board of pharmacy. The state board of
88 registration for the healing arts shall promulgate rules applicable to assistant
89 physicians that shall be consistent with guidelines for federally funded
90 clinics. The rulemaking authority granted in this subsection shall not extend to
91 collaborative practice arrangements of hospital employees providing inpatient
92 care within hospitals as defined in chapter 197 or population-based public health
93 services as defined by 20 CSR 2150- 5.100 as of April 30, 2008.

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

98 5. Within thirty days of any change and on each renewal, the state board
99 of registration for the healing arts shall require every physician to identify
100 whether the physician is engaged in any collaborative practice arrangement,
101 including collaborative practice arrangements delegating the authority to
102 prescribe controlled substances, and also report to the board the name of each
103 assistant physician with whom the physician has entered into such
104 arrangement. The board may make such information available to the public. The
105 board shall track the reported information and may routinely conduct random
106 reviews of such arrangements to ensure that arrangements are carried out for
107 compliance under this chapter.

108 6. A collaborating physician [or supervising physician] shall not enter into
109 a collaborative practice arrangement [or supervision agreement] with more than
110 six full-time equivalent assistant physicians, full-time equivalent physician
111 assistants, or full-time equivalent advance practice registered nurses, or any
112 combination thereof. Such limitation shall not apply to collaborative

113 arrangements of hospital employees providing inpatient care service in hospitals
114 as defined in chapter 197 or population-based public health services as defined
115 by 20 CSR 2150-5.100 as of April 30, 2008, or to a certified registered nurse
116 anesthetist providing anesthesia services under the supervision of an
117 anesthesiologist or other physician, dentist, or podiatrist who is immediately
118 available if needed as set out in subsection 7 of section 334.104.

119 7. The collaborating physician shall determine and document the
120 completion of at least a one-month period of time during which the assistant
121 physician shall practice with the collaborating physician continuously present
122 before practicing in a setting where the collaborating physician is not
123 continuously present. No rule or regulation shall require the collaborating
124 physician to review more than ten percent of the assistant physician's patient
125 charts or records during such one-month period. Such limitation shall not apply
126 to collaborative arrangements of providers of population-based public health
127 services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

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

134 9. No contract or other agreement shall require a physician to act as a
135 collaborating physician for an assistant physician against the physician's will. A
136 physician shall have the right to refuse to act as a collaborating physician,
137 without penalty, for a particular assistant physician. No contract or other
138 agreement shall limit the collaborating physician's ultimate authority over any
139 protocols or standing orders or in the delegation of the physician's authority to
140 any assistant physician, but such requirement shall not authorize a physician in
141 implementing such protocols, standing orders, or delegation to violate applicable
142 standards for safe medical practice established by a hospital's medical staff.

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

147 11. All collaborating physicians and assistant physicians in collaborative
148 practice arrangements shall wear identification badges while acting within the

149 scope of their collaborative practice arrangement. The identification badges shall
150 prominently display the licensure status of such collaborating physicians and
151 assistant physicians.

152 12. (1) An assistant physician with a certificate of controlled substance
153 prescriptive authority as provided in this section may prescribe any controlled
154 substance listed in Schedule III, IV, or V of section 195.017, and may have
155 restricted authority in Schedule II, when delegated the authority to prescribe
156 controlled substances in a collaborative practice arrangement. Prescriptions for
157 Schedule II medications prescribed by an assistant physician who has a
158 certificate of controlled substance prescriptive authority are restricted to only
159 those medications containing hydrocodone. Such authority shall be filed with the
160 state board of registration for the healing arts. The collaborating physician shall
161 maintain the right to limit a specific scheduled drug or scheduled drug category
162 that the assistant physician is permitted to prescribe. Any limitations shall be
163 listed in the collaborative practice arrangement. Assistant physicians shall not
164 prescribe controlled substances for themselves or members of their
165 families. Schedule III controlled substances and Schedule II - hydrocodone
166 prescriptions shall be limited to a five-day supply without refill, except that
167 buprenorphine may be prescribed for up to a thirty-day supply without refill for
168 patients receiving medication-assisted treatment for substance use disorders
169 under the direction of the collaborating physician. Assistant physicians who are
170 authorized to prescribe controlled substances under this section shall register
171 with the federal Drug Enforcement Administration and the state bureau of
172 narcotics and dangerous drugs, and shall include the Drug Enforcement
173 Administration registration number on prescriptions for controlled substances.

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

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

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

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

10 2. Collaborative practice arrangements, which shall be in writing, may
11 delegate to a registered professional nurse the authority to administer, dispense
12 or prescribe drugs and provide treatment if the registered professional nurse is
13 an advanced practice registered nurse as defined in subdivision (2) of section
14 335.016. Collaborative practice arrangements may delegate to an advanced
15 practice registered nurse, as defined in section 335.016, the authority to
16 administer, dispense, or prescribe controlled substances listed in Schedules III,
17 IV, and V of section 195.017, and Schedule II - hydrocodone; except that, the
18 collaborative practice arrangement shall not delegate the authority to administer
19 any controlled substances listed in Schedules III, IV, and V of section 195.017, or
20 Schedule II - hydrocodone for the purpose of inducing sedation or general
21 anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III
22 narcotic controlled substance and Schedule II - hydrocodone prescriptions shall
23 be limited to a one hundred twenty-hour supply without refill. Such collaborative
24 practice arrangements shall be in the form of written agreements, jointly
25 agreed-upon protocols or standing orders for the delivery of health care services.
26 An advanced practice registered nurse may prescribe buprenorphine for up to a
27 thirty-day supply without refill for patients receiving medication-assisted
28 treatment for substance use disorders under the direction of the collaborating
29 physician.

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

32 (1) Complete names, home and business addresses, zip codes, and
33 telephone numbers of the collaborating physician and the advanced practice

34 registered nurse;

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

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

43 (4) All specialty or board certifications of the collaborating physician and
44 all certifications of the advanced practice registered nurse;

45 (5) The manner of collaboration between the collaborating physician and
46 the advanced practice registered nurse, including how the collaborating physician
47 and the advanced practice registered nurse will:

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

50 (b) Maintain geographic proximity, except the collaborative practice
51 arrangement may allow for geographic proximity to be waived for a maximum of
52 twenty-eight days per calendar year for rural health clinics as defined by P.L.
53 95-210, as long as the collaborative practice arrangement includes alternative
54 plans as required in paragraph (c) of this subdivision. This exception to
55 geographic proximity shall apply only to independent rural health clinics,
56 provider-based rural health clinics where the provider is a critical access hospital
57 as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics
58 where the main location of the hospital sponsor is greater than fifty miles from
59 the clinic. The collaborating physician is required to maintain documentation
60 related to this requirement and to present it to the state board of registration for
61 the healing arts when requested; and

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

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

69 (7) A list of all other written practice agreements of the collaborating

70 physician and the advanced practice registered nurse;

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

73 (9) A description of the time and manner of the collaborating physician's
74 review of the advanced practice registered nurse's delivery of health care
75 services. The description shall include provisions that the advanced practice
76 registered nurse shall submit a minimum of ten percent of the charts
77 documenting the advanced practice registered nurse's delivery of health care
78 services to the collaborating physician for review by the collaborating physician,
79 or any other physician designated in the collaborative practice arrangement,
80 every fourteen days; and

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

87 4. The state board of registration for the healing arts pursuant to section
88 334.125 and the board of nursing pursuant to section 335.036 may jointly
89 promulgate rules regulating the use of collaborative practice arrangements. Such
90 rules shall be limited to specifying geographic areas to be covered, the methods
91 of treatment that may be covered by collaborative practice arrangements and the
92 requirements for review of services provided pursuant to collaborative practice
93 arrangements including delegating authority to prescribe controlled
94 substances. Any rules relating to dispensing or distribution of medications or
95 devices by prescription or prescription drug orders under this section shall be
96 subject to the approval of the state board of pharmacy. Any rules relating to
97 dispensing or distribution of controlled substances by prescription or prescription
98 drug orders under this section shall be subject to the approval of the department
99 of health and senior services and the state board of pharmacy. In order to take
100 effect, such rules shall be approved by a majority vote of a quorum of each
101 board. Neither the state board of registration for the healing arts nor the board
102 of nursing may separately promulgate rules relating to collaborative practice
103 arrangements. Such jointly promulgated rules shall be consistent with guidelines
104 for federally funded clinics. The rulemaking authority granted in this subsection
105 shall not extend to collaborative practice arrangements of hospital employees

106 providing inpatient care within hospitals as defined pursuant to chapter 197 or
107 population-based public health services as defined by 20 CSR 2150-5.100 as of
108 April 30, 2008.

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

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

139 7. Notwithstanding any law to the contrary, a certified registered nurse
140 anesthetist as defined in subdivision (8) of section 335.016 shall be permitted to
141 provide anesthesia services without a collaborative practice arrangement provided

142 that he or she is under the supervision of an anesthesiologist or other physician,
143 dentist, or podiatrist who is immediately available if needed. Nothing in this
144 subsection shall be construed to prohibit or prevent a certified registered nurse
145 anesthetist as defined in subdivision (8) of section 335.016 from entering into a
146 collaborative practice arrangement under this section, except that the
147 collaborative practice arrangement may not delegate the authority to prescribe
148 any controlled substances listed in Schedules III, IV, and V of section 195.017, or
149 Schedule II - hydrocodone.

150 8. A collaborating physician [or supervising physician] shall not enter into
151 a collaborative practice arrangement [or supervision agreement] with more than
152 six full-time equivalent advanced practice registered nurses, full-time equivalent
153 licensed physician assistants, or full-time equivalent assistant physicians, or any
154 combination thereof. This limitation shall not apply to collaborative
155 arrangements of hospital employees providing inpatient care service in hospitals
156 as defined in chapter 197 or population-based public health services as defined
157 by 20 CSR 2150- 5.100 as of April 30, 2008, or to a certified registered nurse
158 anesthetist providing anesthesia services under the supervision of an
159 anesthesiologist or other physician, dentist, or podiatrist who is immediately
160 available if needed as set out in subsection 7 of this section.

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

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

174 11. No contract or other agreement shall require a physician to act as a
175 collaborating physician for an advanced practice registered nurse against the
176 physician's will. A physician shall have the right to refuse to act as a
177 collaborating physician, without penalty, for a particular advanced practice

178 registered nurse. No contract or other agreement shall limit the collaborating
179 physician's ultimate authority over any protocols or standing orders or in the
180 delegation of the physician's authority to any advanced practice registered nurse,
181 but this requirement shall not authorize a physician in implementing such
182 protocols, standing orders, or delegation to violate applicable standards for safe
183 medical practice established by hospital's medical staff.

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

334.108. 1. Prior to prescribing any drug, controlled substance, or other
2 treatment through telemedicine, as defined in section 191.1145, or the internet,
3 a physician shall establish a valid physician-patient relationship as described in
4 section 191.1146. This relationship shall include:

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

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

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

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

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

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

20 (1) A hospital as defined in section 197.020;

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

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

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

26 (5) Conjunction with a physician assistant licensed pursuant to section
27 334.738;

28 (6) Conjunction with an assistant physician licensed under section
29 334.036;

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

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

34 3. No health care provider, as defined in section 376.1350, shall prescribe
35 any drug, controlled substance, or other treatment to a patient based solely on an
36 evaluation over the telephone; except that, a physician[,] **or** such physician's
37 on-call designee, **or** an advanced practice registered nurse, **a physician**
38 **assistant, or an assistant physician** in a collaborative practice arrangement
39 with such physician, [a physician assistant in a supervision agreement with such
40 physician, or an assistant physician in a supervision agreement with such
41 physician] may prescribe any drug, controlled substance, or other treatment that
42 is within his or her scope of practice to a patient based solely on a telephone
43 evaluation if a previously established and ongoing physician-patient relationship
44 exists between such physician and the patient being treated.

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

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

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

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

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

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

14 (5) "Department", the department of insurance, financial institutions and

15 professional registration or a designated agency thereof;

16 [(5)] (6) "License", a document issued to an applicant by the board
17 acknowledging that the applicant is entitled to practice as a physician assistant;

18 [(6)] (7) "Physician assistant", a person who has graduated from a
19 physician assistant program accredited by the [American Medical Association's
20 Committee on Allied Health Education and Accreditation or by its successor
21 agency] **Accreditation Review Commission on Education for the
22 Physician Assistant or its successor agency, prior to 2001, or the
23 Committee on Allied Health Education and Accreditation or the
24 Commission on Accreditation of Allied Health Education Programs**, who
25 has passed the certifying examination administered by the National Commission
26 on Certification of Physician Assistants and has active certification by the
27 National Commission on Certification of Physician Assistants who provides
28 health care services delegated by a licensed physician. A person who has been
29 employed as a physician assistant for three years prior to August 28, 1989, who
30 has passed the National Commission on Certification of Physician Assistants
31 examination, and has active certification of the National Commission on
32 Certification of Physician Assistants;

33 [(7)] (8) "Recognition", the formal process of becoming a certifying entity
34 as required by the provisions of sections 334.735 to 334.749;

35 [(8)] "Supervision", control exercised over a physician assistant working
36 with a supervising physician and oversight of the activities of and accepting
37 responsibility for the physician assistant's delivery of care. The physician
38 assistant shall only practice at a location where the physician routinely provides
39 patient care, except existing patients of the supervising physician in the patient's
40 home and correctional facilities. The supervising physician must be immediately
41 available in person or via telecommunication during the time the physician
42 assistant is providing patient care. Prior to commencing practice, the supervising
43 physician and physician assistant shall attest on a form provided by the board
44 that the physician shall provide supervision appropriate to the physician
45 assistant's training and that the physician assistant shall not practice beyond the
46 physician assistant's training and experience. Appropriate supervision shall
47 require the supervising physician to be working within the same facility as the
48 physician assistant for at least four hours within one calendar day for every
49 fourteen days on which the physician assistant provides patient care as described
50 in subsection 3 of this section. Only days in which the physician assistant

51 provides patient care as described in subsection 3 of this section shall be counted
52 toward the fourteen-day period. The requirement of appropriate supervision shall
53 be applied so that no more than thirteen calendar days in which a physician
54 assistant provides patient care shall pass between the physician's four hours
55 working within the same facility. The board shall promulgate rules pursuant to
56 chapter 536 for documentation of joint review of the physician assistant activity
57 by the supervising physician and the physician assistant.

58 2. (1) A supervision agreement shall limit the physician assistant to
59 practice only at locations described in subdivision (8) of subsection 1 of this
60 section, within a geographic proximity to be determined by the board of
61 registration for the healing arts.

62 (2) For a physician-physician assistant team working in a certified
63 community behavioral health clinic as defined by P.L. 113-93 and a rural health
64 clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as
65 amended, or a federally qualified health center as defined in 42 U.S.C. Section
66 1395 of the Public Health Service Act, as amended, no supervision requirements
67 in addition to the minimum federal law shall be required.

68 3.] 2. The scope of practice of a physician assistant shall consist only of
69 the following services and procedures:

70 (1) Taking patient histories;

71 (2) Performing physical examinations of a patient;

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

74 (4) Performing routine therapeutic procedures;

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

77 (6) Instructing and counseling patients regarding mental and physical
78 health using procedures reviewed and approved by a [licensed] **collaborating**
79 physician;

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

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

85 (9) Performing such other tasks not prohibited by law under the
86 [supervision of] **collaborative practice arrangement with** a licensed

87 physician as the physician['s] assistant has been trained and is proficient to
88 perform[; and
89 (10)].

90 3. Physician assistants shall not perform or prescribe abortions.

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

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

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

107 (3) All prescriptions shall conform with state and federal laws and
108 regulations and shall include the name, address and telephone number of the
109 physician assistant and the supervising physician;

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

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

116 5. A physician assistant shall clearly identify himself or herself as a
117 physician assistant and shall not use or permit to be used in the physician
118 assistant's behalf the terms "doctor", "Dr." or "doc" nor hold himself or herself out
119 in any way to be a physician or surgeon. No physician assistant shall practice or
120 attempt to practice without physician [supervision] **collaboration** or in any
121 location where the [supervising] **collaborating** physician is not immediately
122 available for consultation, assistance and intervention, except as otherwise

123 provided in this section, and in an emergency situation, nor shall any physician
124 assistant bill a patient independently or directly for any services or procedure by
125 the physician assistant; except that, nothing in this subsection shall be construed
126 to prohibit a physician assistant from enrolling with **a third party plan or** the
127 department of social services as a MO HealthNet or Medicaid provider while
128 acting under a [supervision agreement] **collaborative practice arrangement**
129 between the physician and physician assistant.

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

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

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

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

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

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

159 assistant shall:

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

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

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

169 (6) A description of the time and manner of the supervising physician's
170 review of the physician assistant's delivery of health care services. Such
171 description shall include provisions that the supervising physician, or a
172 designated supervising physician listed in the supervision agreement review a
173 minimum of ten percent of the charts of the physician assistant's delivery of
174 health care services every fourteen days.

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

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

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

190 11.] **8. A physician may enter into collaborative practice**
191 **arrangements with physician assistants. Collaborative practice**
192 **arrangements, which shall be in writing, may delegate to a physician**
193 **assistant the authority to prescribe, administer, or dispense drugs and**
194 **provide treatment which is within the skill, training, and competence**

195 of the physician assistant. Collaborative practice arrangements may
196 delegate to a physician assistant, as defined in section 334.735, the
197 authority to administer, dispense, or prescribe controlled substances
198 listed in Schedules III, IV, and V of section 195.017, and Schedule II -
199 hydrocodone. Schedule III narcotic controlled substances and Schedule
200 II - hydrocodone prescriptions shall be limited to a one hundred
201 twenty-hour supply without refill. Such collaborative practice
202 arrangements shall be in the form of a written arrangement, jointly
203 agreed-upon protocols, or standing orders for the delivery of health
204 care services.

205 **9. The written collaborative practice arrangement shall contain**
206 **at least the following provisions:**

207 **(1) Complete names, home and business addresses, zip codes, and**
208 **telephone numbers of the collaborating physician and the physician**
209 **assistant;**

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

213 **(3) A requirement that there shall be posted at every office**
214 **where the physician assistant is authorized to prescribe, in**
215 **collaboration with a physician, a prominently displayed disclosure**
216 **statement informing patients that they may be seen by a physician**
217 **assistant and have the right to see the collaborating physician;**

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

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

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

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

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

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

231 **(7) The duration of the written practice arrangement between**

232 the collaborating physician and the physician assistant;

233 (8) A description of the time and manner of the collaborating
234 physician's review of the physician assistant's delivery of health care
235 services. The description shall include provisions that the physician
236 assistant shall submit a minimum of ten percent of the charts
237 documenting the physician assistant's delivery of health care services
238 to the collaborating physician for review by the collaborating
239 physician, or any other physician designated in the collaborative
240 practice arrangement, every fourteen days. Reviews may be conducted
241 electronically;

242 (9) The collaborating physician, or any other physician
243 designated in the collaborative practice arrangement, shall review
244 every fourteen days a minimum of twenty percent of the charts in
245 which the physician assistant prescribes controlled substances. The
246 charts reviewed under this subdivision may be counted in the number
247 of charts required to be reviewed under subdivision (8) of this
248 subsection; and

249 (10) A statement that no collaboration requirements in addition
250 to the federal law shall be required for a physician-physician assistant
251 team working in a certified community behavioral health clinic as
252 defined by P.L. 113-93, or a rural health clinic under the federal Rural
253 Health Services Act, P.L. 95-210, as amended, or a federally qualified
254 health center as defined in 42 U.S.C. Section 1395 of the Public Health
255 Service Act, as amended.

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

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

264 12. Within thirty days of any change and on each renewal, the
265 state board of registration for the healing arts shall require every
266 physician to identify whether the physician is engaged in any
267 collaborative practice arrangement, including collaborative practice
268 arrangements delegating the authority to prescribe controlled

269 substances, and also report to the board the name of each physician
270 assistant with whom the physician has entered into such
271 arrangement. The board may make such information available to the
272 public. The board shall track the reported information and may
273 routinely conduct random reviews of such arrangements to ensure that
274 the arrangements are carried out in compliance with this chapter.

275 13. The collaborating physician shall determine and document
276 the completion of a period of time during which the physician assistant
277 shall practice with the collaborating physician continuously present
278 before practicing in a setting where the collaborating physician is not
279 continuously present. This limitation shall not apply to collaborative
280 arrangements of providers of population-based public health services
281 as defined by 20 CSR 2150-5.100 as of April 30, 2009.

282 14. No contract or other [agreement] arrangement shall require a
283 physician to act as a [supervising] collaborating physician for a physician
284 assistant against the physician's will. A physician shall have the right to refuse
285 to act as a supervising physician, without penalty, for a particular physician
286 assistant. No contract or other agreement shall limit the [supervising]
287 collaborating physician's ultimate authority over any protocols or standing
288 orders or in the delegation of the physician's authority to any physician
289 assistant[, but this requirement shall not authorize a physician in implementing
290 such protocols, standing orders, or delegation to violate applicable standards for
291 safe medical practice established by the hospital's medical staff]. **No contract
292 or other arrangement shall require any physician assistant to
293 collaborate with any physician against the physician assistant's will. A
294 physician assistant shall have the right to refuse to collaborate, without
295 penalty, with a particular physician.**

296 [12.] 15. Physician assistants shall file with the board a copy of their
297 [supervising] collaborating physician form.

298 [13.] 16. No physician shall be designated to serve as [supervising
299 physician or] a collaborating physician for more than six full-time equivalent
300 licensed physician assistants, full-time equivalent advanced practice registered
301 nurses, or full-time equivalent assistant physicians, or any combination
302 thereof. This limitation shall not apply to physician assistant [agreements]
303 collaborative practice arrangements of hospital employees providing
304 inpatient care service in hospitals as defined in chapter 197, or to a certified

305 registered nurse anesthetist providing anesthesia services under the supervision
306 of an anesthesiologist or other physician, dentist, or podiatrist who is
307 immediately available if needed as set out in subsection 7 of section 334.104.

308 **17. No arrangement made under this section shall supercede**
309 **current hospital licensing regulations governing hospital medication**
310 **orders under protocols or standing orders for the purpose of delivering**
311 **inpatient or emergency care within a hospital, as defined in section**
312 **197.020, if such protocols or standing orders have been approved by the**
313 **hospital's medical staff and pharmaceutical therapeutics committee.**

334.736. Notwithstanding any other provision of sections 334.735 to
2 334.749, the board may issue without examination a temporary license to practice
3 as a physician assistant. Upon the applicant paying a temporary license fee and
4 the submission of all necessary documents as determined by the board, the board
5 may grant a temporary license to any person who meets the qualifications
6 provided in [section] **sections 334.735 to 334.749** which shall be valid until the
7 results of the next examination are announced. The temporary license may be
8 renewed at the discretion of the board and upon payment of the temporary license
9 fee.

334.747. 1. A physician assistant with a certificate of controlled
2 substance prescriptive authority as provided in this section may prescribe any
3 controlled substance listed in Schedule III, IV, or V of section 195.017, and may
4 have restricted authority in Schedule II, when delegated the authority to
5 prescribe controlled substances in a [supervision agreement] **collaborative**
6 **practice arrangement**. Such authority shall be listed on the [supervision
7 verification] **collaborating physician** form on file with the state board of
8 healing arts. The [supervising] **collaborating** physician shall maintain the
9 right to limit a specific scheduled drug or scheduled drug category that the
10 physician assistant is permitted to prescribe. Any limitations shall be listed on
11 the [supervision] **collaborating physician** form. Prescriptions for Schedule II
12 medications prescribed by a physician assistant with authority to prescribe
13 delegated in a [supervision agreement] **collaborative practice arrangement**
14 are restricted to only those medications containing hydrocodone. Physician
15 assistants shall not prescribe controlled substances for themselves or members
16 of their families. Schedule III controlled substances and Schedule II -
17 hydrocodone prescriptions shall be limited to a five-day supply without refill,
18 except that buprenorphine may be prescribed for up to a thirty-day supply

19 without refill for patients receiving medication-assisted treatment for substance
20 use disorders under the direction of the [supervising] **collaborating**
21 physician. Physician assistants who are authorized to prescribe controlled
22 substances under this section shall register with the federal Drug Enforcement
23 Administration and the state bureau of narcotics and dangerous drugs, and shall
24 include the Drug Enforcement Administration registration number on
25 prescriptions for controlled substances.

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

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

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

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

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

53 (4) A physician assistant previously licensed in a jurisdiction where
54 physician assistants are authorized to prescribe controlled substances may obtain

55 a state bureau of narcotics and dangerous drugs registration if a [supervising]
56 **collaborating** physician can attest that the physician assistant has met the
57 requirements of subdivisions (1) to (3) of this subsection and provides
58 documentation of existing federal Drug Enforcement Agency registration.

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

7 2. The commission shall be appointed no later than October 1, 1996, and
8 shall consist of five members, one member of the board, two licensed physician
9 assistants, one physician and one lay member. The two licensed physician
10 assistant members, the physician member and the lay member shall be appointed
11 by the director of the division of professional registration. Each licensed
12 physician assistant member shall be a citizen of the United States and a resident
13 of this state, and shall be licensed as a physician assistant by this state. The
14 physician member shall be a United States citizen, a resident of this state, have
15 an active Missouri license to practice medicine in this state and shall be a
16 [supervising] **collaborating** physician, at the time of appointment, to a licensed
17 physician assistant. The lay member shall be a United States citizen and a
18 resident of this state. The licensed physician assistant members shall be
19 appointed to serve three-year terms, except that the first commission appointed
20 shall consist of one member whose term shall be for one year and one member
21 whose term shall be for two years. The physician member and lay member shall
22 each be appointed to serve a three-year term. No physician assistant member nor
23 the physician member shall be appointed for more than two consecutive
24 three-year terms. The president of the Missouri Academy of Physicians
25 Assistants in office at the time shall, at least ninety days prior to the expiration
26 of a term of a physician assistant member of a commission member or as soon as
27 feasible after such a vacancy on the commission otherwise occurs, submit to the
28 director of the division of professional registration a list of five physician
29 assistants qualified and willing to fill the vacancy in question, with the request
30 and recommendation that the director appoint one of the five persons so listed,
31 and with the list so submitted, the president of the Missouri Academy of
32 Physicians Assistants shall include in his or her letter of transmittal a

33 description of the method by which the names were chosen by that association.

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

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

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

335.175. 1. No later than January 1, 2014, there is hereby established
2 within the state board of registration for the healing arts and the state board of
3 nursing the "Utilization of Telehealth by Nurses". An advanced practice
4 registered nurse (APRN) providing nursing services under a collaborative practice
5 arrangement under section 334.104 may provide such services outside the
6 geographic proximity requirements of section 334.104 if the collaborating
7 physician and advanced practice registered nurse utilize telehealth in the care of
8 the patient and if the services are provided in a rural area of need. Telehealth
9 providers shall be required to obtain patient consent before telehealth services
10 are initiated and ensure confidentiality of medical information.

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

13 3. (1) The boards shall jointly promulgate rules governing the practice of
14 telehealth under this section. Such rules shall address, but not be limited to,
15 appropriate standards for the use of telehealth.

16 (2) Any rule or portion of a rule, as that term is defined in section
17 536.010, that is created under the authority delegated in this section shall

18 become effective only if it complies with and is subject to all of the provisions of
19 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
20 nonseverable and if any of the powers vested with the general assembly pursuant
21 to chapter 536 to review, to delay the effective date, or to disapprove and annul
22 a rule are subsequently held unconstitutional, then the grant of rulemaking
23 authority and any rule proposed or adopted after August 28, 2013, shall be
24 invalid and void.

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

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

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

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

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

338.010. 1. The "practice of pharmacy" means the interpretation,
2 implementation, and evaluation of medical prescription orders, including any
3 legend drugs under 21 U.S.C. Section 353; receipt, transmission, or handling of
4 such orders or facilitating the dispensing of such orders; the designing, initiating,
5 implementing, and monitoring of a medication therapeutic plan as defined by the
6 prescription order so long as the prescription order is specific to each patient for
7 care by a pharmacist; the compounding, dispensing, labeling, and administration
8 of drugs and devices pursuant to medical prescription orders and administration
9 of viral influenza, pneumonia, shingles, hepatitis A, hepatitis B, diphtheria,
10 tetanus, pertussis, and meningitis vaccines by written protocol authorized by a
11 physician for persons at least seven years of age or the age recommended by the
12 Centers for Disease Control and Prevention, whichever is higher, or the
13 administration of pneumonia, shingles, hepatitis A, hepatitis B, diphtheria,
14 tetanus, pertussis, meningitis, and viral influenza vaccines by written protocol
15 authorized by a physician for a specific patient as authorized by rule; the
16 participation in drug selection according to state law and participation in drug

17 utilization reviews; the proper and safe storage of drugs and devices and the
18 maintenance of proper records thereof; consultation with patients and other
19 health care practitioners, and veterinarians and their clients about legend drugs,
20 about the safe and effective use of drugs and devices; and the offering or
21 performing of those acts, services, operations, or transactions necessary in the
22 conduct, operation, management and control of a pharmacy. No person shall
23 engage in the practice of pharmacy unless he is licensed under the provisions of
24 this chapter. This chapter shall not be construed to prohibit the use of auxiliary
25 personnel under the direct supervision of a pharmacist from assisting the
26 pharmacist in any of his or her duties. This assistance in no way is intended to
27 relieve the pharmacist from his or her responsibilities for compliance with this
28 chapter and he or she will be responsible for the actions of the auxiliary
29 personnel acting in his or her assistance. This chapter shall also not be
30 construed to prohibit or interfere with any legally registered practitioner of
31 medicine, dentistry, or podiatry, or veterinary medicine only for use in animals,
32 or the practice of optometry in accordance with and as provided in sections
33 195.070 and 336.220 in the compounding, administering, prescribing, or
34 dispensing of his or her own prescriptions.

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

42 3. Nothing in this section shall be construed as to prevent any person,
43 firm or corporation from owning a pharmacy regulated by sections 338.210 to
44 338.315, provided that a licensed pharmacist is in charge of such pharmacy.

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

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

52 6. This section shall not be construed to allow a pharmacist to diagnose

53 or independently prescribe pharmaceuticals.

54 7. The state board of registration for the healing arts, under section
55 334.125, and the state board of pharmacy, under section 338.140, shall jointly
56 promulgate rules regulating the use of protocols for prescription orders for
57 medication therapy services and administration of viral influenza vaccines. Such
58 rules shall require protocols to include provisions allowing for timely
59 communication between the pharmacist and the referring physician, and any
60 other patient protection provisions deemed appropriate by both boards. In order
61 to take effect, such rules shall be approved by a majority vote of a quorum of each
62 board. Neither board shall separately promulgate rules regulating the use of
63 protocols for prescription orders for medication therapy services and
64 administration of viral influenza vaccines. Any rule or portion of a rule, as that
65 term is defined in section 536.010, that is created under the authority delegated
66 in this section shall become effective only if it complies with and is subject to all
67 of the provisions of chapter 536 and, if applicable, section 536.028. This section
68 and chapter 536 are nonseverable and if any of the powers vested with the
69 general assembly pursuant to chapter 536 to review, to delay the effective date,
70 or to disapprove and annul a rule are subsequently held unconstitutional, then
71 the grant of rulemaking authority and any rule proposed or adopted after August
72 28, 2007, shall be invalid and void.

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

80 9. Any pharmacist who has received a certificate of medication therapeutic
81 plan authority may engage in the designing, initiating, implementing, and
82 monitoring of a medication therapeutic plan as defined by a prescription order
83 from a physician that is specific to each patient for care by a pharmacist.

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

87 11. "Veterinarian", "doctor of veterinary medicine", "practitioner of
88 veterinary medicine", "DVM", "VMD", "BVSe", "BVMS", "BSe (Vet Science)",

89 "VMB", "MRCVS", or an equivalent title means a person who has received a
90 doctor's degree in veterinary medicine from an accredited school of veterinary
91 medicine or holds an Educational Commission for Foreign Veterinary Graduates
92 (EDFVG) certificate issued by the American Veterinary Medical Association
93 (AVMA).

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

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

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

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

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

- 116 (1) The identity of the patient;
117 (2) The identity of the vaccine or vaccines administered;
118 (3) The route of administration;
119 (4) The anatomic site of the administration;
120 (5) The dose administered; and
121 (6) The date of administration.

376.1578. 1. Within two working days after receipt of a faxed or mailed
2 completed application, the health carrier
3 shall send a notice of receipt to the practitioner. A health carrier shall provide

4 access to a provider web portal that allows the practitioner to receive notice of the
5 status of an electronically submitted application.

6 2. A health carrier shall assess a health care practitioner's credentialing
7 information and make a decision as to whether to approve or deny the
8 practitioner's credentialing application within sixty [business] days of the date
9 of receipt of the completed application. The sixty-day deadline established in this
10 section shall not apply if the application or subsequent verification of information
11 indicates that the practitioner has:

12 (1) A history of behavioral disorders or other impairments affecting the
13 practitioner's ability to practice, including but not limited to substance abuse;

14 (2) Licensure disciplinary actions against the practitioner's license to
15 practice imposed by any state or territory or foreign jurisdiction;

16 (3) Had the practitioner's hospital admitting or surgical privileges or other
17 organizational credentials or authority to practice revoked, restricted, or
18 suspended based on the practitioner's clinical performance; or

19 (4) A judgment or judicial award against the practitioner arising from a
20 medical malpractice liability lawsuit.

21 3. **Once a practitioner has been credentialed or re-credentialed**
22 **with a health carrier, the health carrier shall provide retroactive**
23 **payments for any covered services performed by the practitioner**
24 **during the application period.**

25 4. The department of insurance, financial institutions and professional
26 registration shall establish a mechanism for reporting alleged violations of this
27 section to the department.

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

13 environment. An advanced practice registered nurse in a collaborative practice
14 arrangement, or a physician assistant or an assistant physician with a
15 [supervision agreement] **collaborative practice arrangement**, with the
16 attending licensed physician may make a determination that the chosen
17 intervention is necessary for patients, residents, or clients of facilities or
18 programs operated by the department, in hospitals as defined in section 197.020
19 that only provide psychiatric care and in dedicated psychiatric units of general
20 acute care hospitals as hospitals are defined in section 197.020. Any
21 determination made by the advanced practice registered nurse, physician
22 assistant, or assistant physician shall be documented as required in subsection
23 2 of this section and reviewed in person by the attending licensed physician if the
24 episode of restraint is to extend beyond:

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

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

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

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

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

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

46 4. The use of security escort devices, including devices designed to restrict
47 physical movement, which are used to maintain safety and security and to
48 prevent escape during transport outside of a facility shall not be considered

49 physical restraint within the meaning of this section. Individuals who have been
50 civilly detained under sections 632.300 to 632.475 may be placed in security
51 escort devices when transported outside of the facility if it is determined by the
52 head of the facility, or the attending licensed physician, or the advanced practice
53 registered nurse in a collaborative practice arrangement, or a physician assistant
54 or an assistant physician with a [supervision agreement] **collaborative**
55 **practice arrangement**, with the attending licensed physician that the use of
56 security escort devices is necessary to protect the health and safety of the patient,
57 resident, client, or other persons or is necessary to prevent escape. Individuals
58 who have been civilly detained under sections 632.480 to 632.513 or committed
59 under chapter 552 shall be placed in security escort devices when transported
60 outside of the facility unless it is determined by the head of the facility, or the
61 attending licensed physician, or the advanced practice registered nurse in a
62 collaborative practice arrangement, or a physician assistant or an assistant
63 physician with a [supervision agreement] **collaborative practice**
64 **arrangement**, with the attending licensed physician that security escort devices
65 are not necessary to protect the health and safety of the patient, resident, client,
66 or other persons or is not necessary to prevent escape.

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

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

78 7. For purposes of this subsection, “division” shall mean the division of
79 developmental disabilities. Restraint or seclusion shall not be used in
80 habilitation centers or community programs that serve persons with
81 developmental disabilities that are operated or funded by the division unless such
82 procedure is part of an emergency intervention system approved by the division
83 and is identified in such person’s individual support plan. Direct-care staff that
84 serve persons with developmental disabilities in habilitation centers or

85 community programs operated or funded by the division shall be trained in an
86 emergency intervention system approved by the division when such emergency
87 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
2 "Improved Access to Treatment for Opioid Addictions Act" or "IATOA Act".

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

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

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

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

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

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

32 6. An assistant physician, physician assistant, or advanced practice
33 registered nurse collaborating with a physician who is waiver-certified for the use

34 of buprenorphine may participate in the IATOA program in any area of the state
35 and provide all services and functions of an assistant physician, physician
36 assistant, or advanced practice registered nurse.

37 7. The department may develop curriculum and benchmark examinations
38 on the subject of opioid addiction and treatment. The department may
39 collaborate with specialists, institutions of higher education, and medical schools
40 for such development. Completion of such a curriculum and passing of such an
41 examination by an assistant physician, physician assistant, advanced practice
42 registered nurse, or physician shall result in a certificate awarded by the
43 department or sponsoring institution, if any.

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

- 46 (1) Engage in community education;
- 47 (2) Engage in professional education outreach programs with local
48 treatment providers;
- 49 (3) Serve as a liaison to courts;
- 50 (4) Serve as a liaison to addiction support organizations;
- 51 (5) Provide educational outreach to schools;
- 52 (6) Treat physical ailments of patients in an addiction treatment program
53 or considering entering such a program;
- 54 (7) Refer patients to treatment centers;
- 55 (8) Assist patients with court and social service obligations;
- 56 (9) Perform other functions as authorized by the department; and
- 57 (10) Provide mental health services in collaboration with a qualified
58 licensed physician.

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

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

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

76 11. The department shall promulgate rules to implement the provisions
77 of the improved access to treatment for opioid addictions act as soon as
78 reasonably possible. Any rule or portion of a rule, as that term is defined in
79 section 536.010, that is created under the authority delegated in this section shall
80 become effective only if it complies with and is subject to all of the provisions of
81 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
82 nonseverable, and if any of the powers vested with the general assembly pursuant
83 to chapter 536 to review, to delay the effective date, or to disapprove and annul
84 a rule are subsequently held unconstitutional, then the grant of rulemaking
85 authority and any rule proposed or adopted after August 28, 2018, shall be
86 invalid and void.

✓