House _____ **Amendment NO.____**

Offered By

_____ _____

AMEND House Committee Substitute for Senate Bill No. 951, Page 3, Section 191.227, Line 72, by inserting after all of said section and line the following:

"191.1145. 1. As used in sections 191.1145 and 191.1146, the following terms shall mean:

(1) "Asynchronous store-and-forward transfer", the collection of a patient's relevant health information and the subsequent transmission of that information from an originating site to a health care provider at a distant site without the patient being present;

(2) "Clinical staff", any health care provider licensed in this state;

(3) "Distant site", a site at which a health care provider is located while providing health care services by means of telemedicine;

(4) "Health care provider", as that term is defined in section 376.1350;

(5) "Originating site", a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine. For the purposes of asynchronous store-and-forward transfer, originating site shall also mean the location at which the health care provider transfers information to the distant site;

(6) "Telehealth" or "telemedicine", the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology.

2. Any licensed health care provider shall be authorized to provide telehealth services if such services are within the scope of practice for which the health care provider is licensed and are provided with the same standard of care as services provided in person. <u>This section shall not be construed to prohibit a health carrier, as defined in section 376.1350, from reimbursing non-clinical staff for services otherwise allowed by law.</u>

3. In order to treat patients in this state through the use of telemedicine or telehealth, health care providers shall be fully licensed to practice in this state and shall be subject to regulation by their respective professional boards.

4. Nothing in subsection 3 of this section shall apply to:

(1) Informal consultation performed by a health care provider licensed in another state, outside of the context of a contractual relationship, and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation;

(2) Furnishing of health care services by a health care provider licensed and located in another state in case of an emergency or disaster; provided that, no charge is made for the medical assistance; or

(3) Episodic consultation by a health care provider licensed and located in another state who provides such consultation services on request to a physician in this state.

5. Nothing in this section shall be construed to alter the scope of practice of any health care provider or to authorize the delivery of health care services in a setting or in a manner not otherwise authorized by the laws of this state.

Action Taken_____ Date _____

6. No originating site for services or activities provided under this section shall be required to maintain immediate availability of on-site clinical staff during the telehealth services, except as necessary to meet the standard of care for the treatment of the patient's medical condition if such condition is being treated by an eligible health care provider who is not at the originating site, has not previously seen the patient in person in a clinical setting, and is not providing coverage for a health care provider who has an established relationship with the patient.

7. Nothing in this section shall be construed to alter any collaborative practice requirement as provided in chapters 334 and 335."; and

Further amend said bill, Page 5, Section 197.305, Line 68, by inserting after all of said section and line the following:

"208.670. 1. As used in this section, these terms shall have the following meaning:

(1) "Consultation", a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association;

(2) "Distant site", the same meaning as such term is defined in section 191.1145;

(3) "Originating site", the same meaning as such term is defined in section 191.1145;

(4) "Provider", **[**~~any provider of medical services and mental health services, including all other medical disciplines~~**]** the same meaning as the term "health care provider" is defined in section 191.1145, and such provider meets all other MO HealthNet eligibility requirements;

[~~(2)~~**]** (5) "Telehealth", the same meaning as such term is defined in section 191.1145.

2. **[**~~Reimbursement for the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program shall be allowed for orthopedics, dermatology, ophthalmology and optometry, in cases of diabetic retinopathy, burn and wound care, dental services which require a diagnosis, and maternal-fetal medicine ultrasounds.~~

~~3. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the practice of telehealth in the MO HealthNet program. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth, certification of agencies offering telehealth, and payment for services by providers. Telehealth providers shall be required to obtain participant consent before telehealth services are initiated and to ensure confidentiality of medical information.~~

~~4. Telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. Reimbursement for such services shall be made in the same way as reimbursement for in-person contacts.~~

~~5. The provisions of section 208.671 shall apply to the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program~~**]** The department of social services shall reimburse providers for services provided through telehealth if such providers can ensure services are rendered meeting the standard of care that would otherwise be expected should such services be provided in person. The department shall not restrict the originating site through rule or payment so long as the provider can ensure services are rendered meeting the standard of care that would otherwise be expected should such services be provided in person. Payment for services rendered via telehealth shall not depend on any minimum distance requirement between the originating and distant site. Reimbursement for telehealth services shall be made in the same way as reimbursement for in-person contact; however, consideration shall also be made for reimbursement to the originating site. Reimbursement for asynchronous store-and-forward may be capped at the reimbursement rate had the service been provided in person.

208.677. **[**~~1. For purposes of the provision of telehealth services in the MO HealthNet program, the term "originating site" shall mean a telehealth site where the MO HealthNet participant receiving the telehealth service is located for the encounter. The standard of care in the practice of telehealth shall be the same as the standard of care for services provided in person. An originating site shall be one of the following locations:~~

~~(1) An office of a physician or health care provider;~~

~~(2) A hospital;~~

~~(3) A critical access hospital;~~

~~(4) A rural health clinic;~~
~~(5) A federally qualified health center;~~
~~(6) A long-term care facility licensed under chapter 198;~~
~~(7) A dialysis center;~~
~~(8) A Missouri state habilitation center or regional office;~~
~~(9) A community mental health center;~~
~~(10) A Missouri state mental health facility;~~
~~(11) A Missouri state facility;~~
~~(12) A Missouri residential treatment facility licensed by and under contract with the children's division. Facilities shall have multiple campuses and have the ability to adhere to technology requirements. Only Missouri licensed psychiatrists, licensed psychologists, or provisionally licensed psychologists, and advanced practice registered nurses who are MO HealthNet providers shall be consulting providers at these locations;~~
~~(13) A comprehensive substance treatment and rehabilitation (CSTAR) program;~~
~~(14) A school;~~
~~(15) The MO HealthNet recipient's home;~~
~~(16) A clinical designated area in a pharmacy; or~~
~~(17) A child assessment center as described in section 210.001.~~
~~2. If the originating site is a school, the school shall obtain permission from the parent or guardian of any student receiving telehealth services prior to each provision of service.~~**]** Prior to the provision of telehealth services in a school, the parent or guardian of the child shall provide authorization for the provision of such service. Such authorization shall include the ability for the parent or guardian to authorize services via telehealth in the school for the remainder of the school year."; and

Further amend said bill and page, Section 210.070, Line 8, by inserting after all of said section and line the following:

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

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

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

(b) Has successfully completed **[**~~Step 1 and~~**]** Step 2 of the United States Medical Licensing Examination or the equivalent of such **[**~~steps~~**]** step of any other board-approved medical licensing examination within the **[**~~two-year~~**]** three-year period immediately preceding application for licensure as an assistant physician, **[**~~but in no event more than~~**]** or within three years after graduation from a medical college or osteopathic medical college, whichever is later;

(c) Has not completed an approved postgraduate residency and has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such step of any other board-approved medical licensing examination within the immediately preceding **[**~~two-year~~**]** three-year period unless when such **[**~~two-year~~**]** three-year anniversary occurred he or she was serving as a resident physician in an accredited residency in the United States and continued to do so within thirty days prior to application for licensure as an assistant physician; and

(d) Has proficiency in the English language.

Any medical school graduate who could have applied for licensure and complied with the provisions of this subdivision at any time between August 28, 2014, and August 28, 2017, may apply for licensure and shall be deemed in compliance with the provisions of this subdivision;

(2) "Assistant physician collaborative practice arrangement", an agreement between a physician and an assistant physician that meets the requirements of this section and section 334.037;

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

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

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

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

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

3. (1) For purposes of this section, the licensure of assistant physicians shall take place within processes established by rules of the state board of registration for the healing arts. The board of healing arts is authorized to establish rules under chapter 536 establishing licensure and renewal procedures, supervision, collaborative practice arrangements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. No licensure fee for an assistant physician shall exceed the amount of any licensure fee for a physician assistant. An application for licensure may be denied or the licensure of an assistant physician may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule. No rule or regulation shall require an assistant physician to complete more hours of continuing medical education than that of a licensed physician.

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

(3) Any rules or regulations regarding assistant physicians in effect as of the effective date of this section that conflict with the provisions of this section and section 334.037 shall be null and void as of the effective date of this section.

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

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

6. The provisions of section 334.037 shall apply to all assistant physician collaborative practice arrangements. **[**~~To be eligible to practice as an assistant physician, a licensed assistant physician shall enter into an assistant physician collaborative practice arrangement within six months of his or her initial licensure and shall not have more than a six-month time period between collaborative practice arrangements during his or her licensure period.~~**]** Any renewal of licensure under this section shall include verification of actual practice under a collaborative practice arrangement in accordance with this subsection during the immediately preceding licensure period.

7. Each health carrier or health benefit plan that offers or issues health benefit plans that are delivered, issued for delivery, continued, or renewed in this state shall reimburse an assistant physician for the diagnosis, consultation, or treatment of an insured or enrollee on the same basis that the health carrier or health benefit plan covers the service when it is delivered by another comparable mid-level health care provider including, but not limited to, a physician assistant.

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

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

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

(2) A list of all other offices or locations besides those listed in subdivision (1) of this subsection

where the collaborating physician authorized the assistant physician to prescribe;

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

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

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

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

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

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

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

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

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

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

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

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

(1) Geographic areas to be covered;

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

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

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

Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. Any rules relating

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

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

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

6. A collaborating physician or supervising physician shall not enter into a collaborative practice arrangement or supervision agreement with more than [~~three~~] six full-time equivalent assistant physicians, full-time equivalent physician assistants, or full-time equivalent advance practice registered nurses, or any combination thereof. Such limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of section 334.104.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. The state board of registration for the healing arts pursuant to section 334.125 and the board of nursing pursuant to section 335.036 may jointly promulgate rules regulating the use of collaborative practice arrangements. Such rules shall be limited to specifying geographic areas to be covered, the methods of treatment that may be covered by collaborative practice arrangements and the requirements for review of services provided pursuant to collaborative practice arrangements including delegating authority to prescribe controlled substances. Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. Any rules relating to dispensing or distribution of controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the department of health and senior services and the state board of pharmacy. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither the state board of registration for the healing arts nor the board of nursing may separately promulgate rules relating to collaborative practice arrangements. Such jointly promulgated rules shall be consistent with guidelines for federally funded clinics. The rulemaking authority granted in this subsection shall not extend to collaborative practice arrangements of hospital employees providing inpatient care within hospitals as defined pursuant to chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

5. The state board of registration for the healing arts shall not deny, revoke, suspend or otherwise

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

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

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

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

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

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

11. No contract or other agreement shall require a physician to act as a collaborating physician for an advanced practice registered nurse against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular advanced practice registered nurse. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any advanced practice registered nurse, but this requirement shall not authorize a physician in implementing such protocols, standing orders, or

delegation to violate applicable standards for safe medical practice established by hospital's medical staff.

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

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

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

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

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

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

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

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

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

(8) "Supervision", control exercised over a physician assistant working with a supervising physician and oversight of the activities of and accepting responsibility for the physician assistant's delivery of care. The physician assistant shall only practice at a location where the physician routinely provides patient care, except existing patients of the supervising physician in the patient's home and correctional facilities. The supervising physician must be immediately available in person or via telecommunication during the time the physician assistant is providing patient care. Prior to commencing practice, the supervising physician and physician assistant shall attest on a form provided by the board that the physician shall provide supervision appropriate to the physician assistant's training and that the physician assistant shall not practice beyond the physician assistant's training and experience. Appropriate supervision shall require the supervising physician to be working within the same facility as the physician assistant for at least four hours within one calendar day for every fourteen days on which the physician assistant provides patient care as described in subsection 3 of this section. Only days in which the physician assistant provides patient care as described in subsection 3 of this section shall be counted toward the fourteen-day period. The requirement of appropriate supervision shall be applied so that no more than thirteen calendar days in which a physician assistant provides patient care shall pass between the physician's four hours working within the same facility. The board shall promulgate rules pursuant to chapter 536 for documentation of joint review of the physician assistant activity by the supervising physician and the physician assistant.

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

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

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

procedures:

(1) Taking patient histories;

(2) Performing physical examinations of a patient;

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

(4) Performing routine therapeutic procedures;

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

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

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

(8) Assisting in surgery;

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

(10) Physician assistants shall not perform or prescribe abortions.

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

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

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

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

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

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

5. A physician assistant shall clearly identify himself or herself as a physician assistant and shall not use or permit to be used in the physician assistant's behalf the terms "doctor", "Dr." or "doc" nor hold himself or herself out in any way to be a physician or surgeon. No physician assistant shall practice or attempt to practice without physician supervision or in any location where the supervising physician is not immediately available for consultation, assistance and intervention, except as otherwise provided in this section, and in an emergency situation, nor shall any physician assistant bill a patient independently or directly for any services or procedure by the physician assistant; except that, nothing in this subsection shall be construed to prohibit a physician assistant from enrolling with the department of social services as a MO HealthNet or Medicaid provider while acting under a supervision agreement between the physician and physician assistant.

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

training program after January 1, 2008, shall have a master's degree from a physician assistant program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

337.025. 1. The provisions of this section shall govern the education and experience requirements for initial licensure as a psychologist for the following persons:

(1) A person who has not matriculated in a graduate degree program which is primarily psychological in nature on or before August 28, 1990; and

(2) A person who is matriculated after August 28, 1990, in a graduate degree program designed to train professional psychologists.

2. Each applicant shall submit satisfactory evidence to the committee that the applicant has received a doctoral degree in psychology from a recognized educational institution, and has had at least one year of satisfactory supervised professional experience in the field of psychology.

3. A doctoral degree in psychology is defined as:

(1) A program accredited, or provisionally accredited, by the American Psychological Association **[**~~or~~**]** (APA), the Canadian Psychological Association, or the Psychological Clinical Science Accreditation System (PCSAS) provided that such program include a supervised practicum, internship, field, or laboratory training appropriate to the practice of psychology; or

(2) A program designated or approved, including provisional approval, by the Association of State and Provincial Psychology Boards or the Council for the National Register of Health Service Providers in

Psychology, or both; or

(3) A graduate program that meets all of the following criteria:

(a) The program, wherever it may be administratively housed, shall be clearly identified and labeled as a psychology program. Such a program shall specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

(b) The psychology program shall stand as a recognizable, coherent organizational entity within the institution of higher education;

(c) There shall be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

(d) The program shall be an integrated, organized, sequence of study;

(e) There shall be an identifiable psychology faculty and a psychologist responsible for the program;

(f) The program shall have an identifiable body of students who are matriculated in that program for a degree;

(g) The program shall include a supervised practicum, internship, field, or laboratory training appropriate to the practice of psychology;

(h) The curriculum shall encompass a minimum of three academic years of full-time graduate study, with a minimum of one year's residency at the educational institution granting the doctoral degree; and

(i) Require the completion by the applicant of a core program in psychology which shall be met by the completion and award of at least one three-semester-hour graduate credit course or a combination of graduate credit courses totaling three semester hours or five quarter hours in each of the following areas:

a. The biological bases of behavior such as courses in: physiological psychology, comparative psychology, neuropsychology, sensation and perception, psychopharmacology;

b. The cognitive-affective bases of behavior such as courses in: learning, thinking, motivation, emotion, and cognitive psychology;

c. The social bases of behavior such as courses in: social psychology, group processes/dynamics, interpersonal relationships, and organizational and systems theory;

d. Individual differences such as courses in: personality theory, human development, abnormal psychology, developmental psychology, child psychology, adolescent psychology, psychology of aging, and theories of personality;

e. The scientific methods and procedures of understanding, predicting and influencing human behavior such as courses in: statistics, experimental design, psychometrics, individual testing, group testing, and research design and methodology.

4. Acceptable supervised professional experience may be accrued through preinternship, internship, predoctoral postinternship, or postdoctoral experiences. The academic training director or the postdoctoral training supervisor shall attest to the hours accrued to meet the requirements of this section. Such hours shall consist of:

(1) A minimum of fifteen hundred hours of experience in a successfully completed internship to be completed in not less than twelve nor more than twenty-four months; and

(2) A minimum of two thousand hours of experience consisting of any combination of the following:

(a) Preinternship and predoctoral postinternship professional experience that occurs following the completion of the first year of the doctoral program or at any time while in a doctoral program after completion of a master's degree in psychology or equivalent as defined by rule by the committee;

(b) Up to seven hundred fifty hours obtained while on the internship under subdivision (1) of this subsection but beyond the fifteen hundred hours identified in subdivision (1) of this subsection; or

(c) Postdoctoral professional experience obtained in no more than twenty-four consecutive calendar months. In no case shall this experience be accumulated at a rate of more than fifty hours per week. Postdoctoral supervised professional experience for prospective health service providers and other applicants shall involve and relate to the delivery of psychological services in accordance with professional requirements and relevant to the applicant's intended area of practice.

5. Experience for those applicants who intend to seek health service provider certification and who have completed a program in one or more of the American Psychological Association designated health service provider delivery areas shall be obtained under the primary supervision of a licensed psychologist

who is also a health service provider or who otherwise meets the requirements for health service provider certification. Experience for those applicants who do not intend to seek health service provider certification shall be obtained under the primary supervision of a licensed psychologist or such other qualified mental health professional approved by the committee.

6. For postinternship and postdoctoral hours, the psychological activities of the applicant shall be performed pursuant to the primary supervisor's order, control, and full professional responsibility. The primary supervisor shall maintain a continuing relationship with the applicant and shall meet with the applicant a minimum of one hour per month in face-to-face individual supervision. Clinical supervision may be delegated by the primary supervisor to one or more secondary supervisors who are qualified psychologists. The secondary supervisors shall retain order, control, and full professional responsibility for the applicant's clinical work under their supervision and shall meet with the applicant a minimum of one hour per week in face-to-face individual supervision. If the primary supervisor is also the clinical supervisor, meetings shall be a minimum of one hour per week. Group supervision shall not be acceptable for supervised professional experience. The primary supervisor shall certify to the committee that the applicant has complied with these requirements and that the applicant has demonstrated ethical and competent practice of psychology. The changing by an agency of the primary supervisor during the course of the supervised experience shall not invalidate the supervised experience.

7. The committee by rule shall provide procedures for exceptions and variances from the requirements for once a week face-to-face supervision due to vacations, illness, pregnancy, and other good causes.

337.029. 1. A psychologist licensed in another jurisdiction who has had no violations and no suspensions and no revocation of a license to practice psychology in any jurisdiction may receive a license in Missouri, provided the psychologist passes a written examination on Missouri laws and regulations governing the practice of psychology and meets one of the following criteria:

(1) Is a diplomate of the American Board of Professional Psychology;

(2) Is a member of the National Register of Health Service Providers in Psychology;

(3) Is currently licensed or certified as a psychologist in another jurisdiction who is then a signatory to the Association of State and Provincial Psychology Board's reciprocity agreement;

(4) Is currently licensed or certified as a psychologist in another state, territory of the United States, or the District of Columbia and:

(a) Has a doctoral degree in psychology from a program accredited, or provisionally accredited, by the American Psychological Association <u>or the Psychological Clinical Science Accreditation System,</u> or that meets the requirements as set forth in subdivision (3) of subsection 3 of section 337.025;

(b) Has been licensed for the preceding five years; and

(c) Has had no disciplinary action taken against the license for the preceding five years; or

(5) Holds a current certificate of professional qualification (CPQ) issued by the Association of State and Provincial Psychology Boards (ASPPB).

2. Notwithstanding the provisions of subsection 1 of this section, applicants may be required to pass an oral examination as adopted by the committee.

3. A psychologist who receives a license for the practice of psychology in the state of Missouri on the basis of reciprocity as listed in subsection 1 of this section or by endorsement of the score from the examination of professional practice in psychology score will also be eligible for and shall receive certification from the committee as a health service provider if the psychologist meets one or more of the following criteria:

(1) Is a diplomate of the American Board of Professional Psychology in one or more of the specialties recognized by the American Board of Professional Psychology as pertaining to health service delivery;

(2) Is a member of the National Register of Health Service Providers in Psychology; or

(3) Has completed or obtained through education, training, or experience the requisite knowledge comparable to that which is required pursuant to section 337.033.

337.033. 1. A licensed psychologist shall limit his or her practice to demonstrated areas of competence as documented by relevant professional education, training, and experience. A psychologist trained in one area shall not practice in another area without obtaining additional relevant professional

education, training, and experience through an acceptable program of respecialization.

2. A psychologist may not represent or hold himself or herself out as a state certified or registered psychological health service provider unless the psychologist has first received the psychologist health service provider certification from the committee; provided, however, nothing in this section shall be construed to limit or prevent a licensed, whether temporary, provisional or permanent, psychologist who does not hold a health service provider certificate from providing psychological services so long as such services are consistent with subsection 1 of this section.

3. "Relevant professional education and training" for health service provider certification, except those entitled to certification pursuant to subsection 5 or 6 of this section, shall be defined as a licensed psychologist whose graduate psychology degree from a recognized educational institution is in an area designated by the American Psychological Association as pertaining to health service delivery or a psychologist who subsequent to receipt of his or her graduate degree in psychology has either completed a respecialization program from a recognized educational institution in one or more of the American Psychological Association recognized clinical health service provider areas and who in addition has completed at least one year of postdegree supervised experience in such clinical area or a psychologist who has obtained comparable education and training acceptable to the committee through completion of postdoctoral fellowships or otherwise.

4. The degree or respecialization program certificate shall be obtained from a recognized program of graduate study in one or more of the health service delivery areas designated by the American Psychological Association as pertaining to health service delivery, which shall meet one of the criteria established by subdivisions (1) to (3) of this subsection:

(1) A doctoral degree or completion of a recognized respecialization program in one or more of the American Psychological Association designated health service provider delivery areas which is accredited, or provisionally accredited, either by the American Psychological Association or the Psychological Clinical Science Accreditation System; or

(2) A clinical or counseling psychology doctoral degree program or respecialization program designated, or provisionally approved, by the Association of State and Provincial Psychology Boards or the Council for the National Register of Health Service Providers in Psychology, or both; or

(3) A doctoral degree or completion of a respecialization program in one or more of the American Psychological Association designated health service provider delivery areas that meets the following criteria:

(a) The program, wherever it may be administratively housed, shall be clearly identified and labeled as being in one or more of the American Psychological Association designated health service provider delivery areas;

(b) Such a program shall specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists in one or more of the American Psychological Association designated health service provider delivery areas.

5. A person who is lawfully licensed as a psychologist pursuant to the provisions of this chapter on August 28, 1989, or who has been approved to sit for examination prior to August 28, 1989, and who subsequently passes the examination shall be deemed to have met all requirements for health service provider certification; provided, however, that such person shall be governed by the provisions of subsection 1 of this section with respect to limitation of practice.

6. Any person who is lawfully licensed as a psychologist in this state and who meets one or more of the following criteria shall automatically, upon payment of the requisite fee, be entitled to receive a health service provider certification from the committee:

(1) Is a diplomate of the American Board of Professional Psychology in one or more of the specialties recognized by the American Board of Professional Psychology as pertaining to health service delivery; or

(2) Is a member of the National Register of Health Service Providers in Psychology."; and

Further amend said bill, Page 7, Section 577.029, Line 16, by inserting after all of said section and line the following:

"[~~208.671. 1. As used in this section and section 208.673, the following terms shall~~

~~mean:~~

~~(1) "Asynchronous store-and-forward", the transfer of a participant's clinically important digital samples, such as still images, videos, audio, text files, and relevant data from an originating site through the use of a camera or similar recording device that stores digital samples that are forwarded via telecommunication to a distant site for consultation by a consulting provider without requiring the simultaneous presence of the participant and the participant's treating provider;~~

~~(2) "Asynchronous store-and-forward technology", cameras or other recording devices that store images which may be forwarded via telecommunication devices at a later time;~~

~~(3) "Consultation", a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association;~~

~~(4) "Consulting provider", a provider who, upon referral by the treating provider, evaluates a participant and appropriate medical data or images delivered through asynchronous store-and-forward technology. If a consulting provider is unable to render an opinion due to insufficient information, the consulting provider may request additional information to facilitate the rendering of an opinion or decline to render an opinion;~~

~~(5) "Distant site", the site where a consulting provider is located at the time the consultation service is provided;~~

~~(6) "Originating site", the site where a MO HealthNet participant receiving services and such participant's treating provider are both physically located;~~

~~(7) "Provider", any provider of medical, mental health, optometric, or dental health services, including all other medical disciplines, licensed and providing MO HealthNet services who has the authority to refer participants for medical, mental health, optometric, dental, or other health care services within the scope of practice and licensure of the provider;~~

~~(8) "Telehealth", as that term is defined in section 191.1145;~~

~~(9) "Treating provider", a provider who:~~

~~(a) Evaluates a participant;~~

~~(b) Determines the need for a consultation;~~

~~(c) Arranges the services of a consulting provider for the purpose of diagnosis and treatment; and~~

~~(d) Provides or supplements the participant's history and provides pertinent physical examination findings and medical information to the consulting provider.~~

~~2. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program. Such rules shall include, but not be limited to:~~

~~(1) Appropriate standards for the use of asynchronous store-and-forward technology in the practice of telehealth;~~

~~(2) Certification of agencies offering asynchronous store-and-forward technology in the practice of telehealth;~~

~~(3) Timelines for completion and communication of a consulting provider's consultation or opinion, or if the consulting provider is unable to render an opinion, timelines for communicating a request for additional information or that the consulting provider declines to render an opinion;~~

~~(4) Length of time digital files of such asynchronous store-and-forward services are to be maintained;~~

~~(5) Security and privacy of such digital files;~~
~~(6) Participant consent for asynchronous store-and-forward services; and~~
~~(7) Payment for services by providers; except that, consulting providers who decline to render an opinion shall not receive payment under this section unless and until an opinion is rendered.~~

~~Telehealth providers using asynchronous store-and-forward technology shall be required to obtain participant consent before asynchronous store-and-forward services are initiated and to ensure confidentiality of medical information.~~
~~3. Asynchronous store-and-forward technology in the practice of telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. The total payment for both the treating provider and the consulting provider shall not exceed the payment for a face-to-face consultation of the same level.~~
~~4. The standard of care for the use of asynchronous store-and-forward technology in the practice of telehealth shall be the same as the standard of care for services provided in person.~~**]**

[~~208.673. 1. There is hereby established the "Telehealth Services Advisory Committee" to advise the department of social services and propose rules regarding the coverage of telehealth services in the MO HealthNet program utilizing asynchronous store-and-forward technology.~~
~~2. The committee shall be comprised of the following members:~~
~~(1) The director of the MO HealthNet division, or the director's designee;~~
~~(2) The medical director of the MO HealthNet division;~~
~~(3) A representative from a Missouri institution of higher education with expertise in telehealth;~~
~~(4) A representative from the Missouri office of primary care and rural health;~~
~~(5) Two board-certified specialists licensed to practice medicine in this state;~~
~~(6) A representative from a hospital located in this state that utilizes telehealth;~~
~~(7) A primary care physician from a federally qualified health center (FQHC) or rural health clinic;~~
~~(8) A primary care physician from a rural setting other than from an FQHC or rural health clinic;~~
~~(9) A dentist licensed to practice in this state; and~~
~~(10) A psychologist, or a physician who specializes in psychiatry, licensed to practice in this state.~~
~~3. Members of the committee listed in subdivisions (3) to (10) of subsection 2 of this section shall be appointed by the governor with the advice and consent of the senate. The first appointments to the committee shall consist of three members to serve three-year terms, three members to serve two-year terms, and three members to serve a one-year term as designated by the governor. Each member of the committee shall serve for a term of three years thereafter.~~
~~4. Members of the committee shall not receive any compensation for their services but shall be reimbursed for any actual and necessary expenses incurred in the performance of their duties.~~
~~5. Any member appointed by the governor may be removed from office by the governor without cause. If there is a vacancy for any cause, the governor~~

~~shall make an appointment to become effective immediately for the unexpired term.~~

~~6. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2016, shall be invalid and void.~~**]**

[~~208.675. For purposes of the provision of telehealth services in the MO HealthNet program, the following individuals, licensed in Missouri, shall be considered eligible health care providers:~~

~~(1) Physicians, assistant physicians, and physician assistants;~~

~~(2) Advanced practice registered nurses;~~

~~(3) Dentists, oral surgeons, and dental hygienists under the supervision of a currently registered and licensed dentist;~~

~~(4) Psychologists and provisional licensees;~~

~~(5) Pharmacists;~~

~~(6) Speech, occupational, or physical therapists;~~

~~(7) Clinical social workers;~~

~~(8) Podiatrists;~~

~~(9) Optometrists;~~

~~(10) Licensed professional counselors; and~~

~~(11) Eligible health care providers under subdivisions (1) to (10) of this section practicing in a rural health clinic, federally qualified health center, or community mental health center.~~**]**

Section B. Because immediate action is necessary to save the lives of Missouri citizens who are suffering from the opioid crisis, the repeal and reenactment of sections 195.070, 217.364, 334.036, and 374.426 and the enactment of sections 195.265 and 630.875 of this act are deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and are hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of sections 195.070, 217.364, 334.036, and 374.426 and the enactment of sections 195.265 and 630.875 of this act shall be in full force and effect upon their passage and approval."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.