JOURNAL OF THE HOUSE

First Regular Session, 100th GENERAL ASSEMBLY

SEVENTIETH DAY, WEDNESDAY, MAY 15, 2019

The House met pursuant to adjournment.

Speaker Haahr in the Chair.

Prayer by Reverend Monsignor Robert A. Kurwicki, Chaplain.

Let the words of my mouth, and the meditation of my heart, be acceptable in Your sight, O Lord, my strength and my Redeemer. (Psalm 19:14)

Our God, who is in heaven, we come to You conscious of our shortcomings and our sins yet confident that You are with us and that, with You, sins are forgiven, discouragement gives way to encouragement, fear changes to faith, and a new glory enters human life.

Give us the courage of our convictions – the confidence to say "yes" to what is right, the courage to say "no" to what is wrong, and the wisdom and the insight to know the difference. May this spirit enter the hearts of all our people, so shall we be children of Yours, serving You faithfully all our days. Let the words of our mouths and the meditations of our hearts be acceptable in Your sight, O Lord, our strength and our Redeemer, in the people's house.

And the House says, "Amen!"

The Pledge of Allegiance to the flag was recited.

The Journal of the sixty-ninth day was approved as printed by the following vote:

AYES: 129

Allred	Anderson	Andrews	Appelbaum	Bailey
Baker	Baringer	Barnes	Basye	Beck
Billington	Black 137	Black 7	Bondon	Bromley
Burnett	Burns	Busick	Butz	Carpenter
Chipman	Christofanelli	Clemens	Coleman 32	Coleman 97
Deaton	DeGroot	Dinkins	Dogan	Dohrman
Eggleston	Ellebracht	Evans	Falkner III	Fishel
Fitzwater	Francis	Gannon	Green	Grier
Griesheimer	Griffith	Haden	Haffner	Hannegan
Hansen	Helms	Henderson	Hicks	Houx
Hovis	Hudson	Hurst	Ingle	Justus
Kelley 127	Kelly 141	Kendrick	Kidd	Knight
Kolkmeyer	Lavender	Lovasco	Love	Lynch
Mackey	Mayhew	McCreery	McDaniel	McGirl
Miller	Mitten	Morris 140	Morse 151	Mosley
Murphy	Neely	O'Donnell	Patterson	Pfautsch
Pierson Jr.	Pike	Plocher	Pogue	Pollitt 52
Pollock 123	Porter	Proudie	Quade	Razer

Reedy	Rehder	Toalson Reisch	Remole	Richey
Riggs	Roberts 161	Roberts 77	Rogers	Rone
Ross	Runions	Ruth	Sain	Sauls
Schnelting	Schroer	Sharpe	Shawan	Shields
Simmons	Smith	Solon	Sommer	Spencer
Stacy	Stephens 128	Stevens 46	Swan	Taylor
Trent	Veit	Vescovo	Walsh	Wiemann
Wilson	Wood	Wright	Mr. Speaker	

NOES: 004

Gray	Merideth	Moon	Rowland

PRESENT: 002

Bland Manlove	Unsicker

ABSENT WITH LEAVE: 025

Bangert	Bosley	Brown 27	Brown 70	Carter
Chappelle-Nadal	Ellington	Eslinger	Franks Jr.	Gregory
Hill	McGaugh	Messenger	Morgan	Muntzel
Pietzman	Price	Roden	Roeber	Shaul 113
Shull 16	Tate	Walker	Washington	Windham

VACANCIES: 003

COMMITTEE REPORTS

Committee on Fiscal Review, Chairman Houx reporting:

Mr. Speaker: Your Committee on Fiscal Review, to which was referred **SS#2 SCR 14**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (9): Anderson, Baringer, Burnett, Deaton, Gregory, Houx, Morgan, Walsh and Wiemann

Noes (0)

Absent (1): Wood

Mr. Speaker: Your Committee on Fiscal Review, to which was referred **HCS SS SCS SB 9**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (5): Anderson, Deaton, Houx, Walsh and Wiemann

Noes (3): Baringer, Burnett and Morgan

Absent (2): Gregory and Wood

Mr. Speaker: Your Committee on Fiscal Review, to which was referred **HCS SB 164**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (9): Anderson, Baringer, Burnett, Deaton, Gregory, Houx, Morgan, Walsh and Wiemann

Noes (0)

Absent (1): Wood

MESSAGES FROM THE SENATE

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate has taken up and passed **SS#2 HB 219** entitled:

An act to repeal sections 191.603, 191.605, 191.607, 192.067, 192.667, 193.015, 195.060, 195.080, 195.100, 196.100, 198.082, 208.146, 208.151, 208.225, 208.790, 221.111, 332.361, 334.037, 334.104, 334.108, 334.735, 334.736, 334.747, 334.749, 335.175, 338.010, 338.015, 338.055, 338.056, 338.140, 374.500, 376.690, 376.1350, 376.1356, 376.1363, 376.1372, 376.1385, 630.175, and 630.875, RSMo, and to enact in lieu thereof fifty-two new sections relating to health care, with penalty provisions.

With Senate Amendment No. 1, Senate Amendment No. 2, Senate Amendment No. 3, Senate Amendment No. 4 and Senate Amendment No. 5.

Senate Amendment No. 1

AMEND Senate Substitute No. 2 for House Bill No. 219, Page 1, Section Title, Line 11, by inserting immediately after "provisions" the following:

", and with an emergency clause for a certain section"; and

Further amend said bill, Page 125, Section 376.690, Line 22, by inserting after all of said line the following:

"**376.1260. 1. (1) As used in this section, unless the context clearly requires otherwise, terms shall have the same meaning as ascribed to them in section 376.1350.**

(2) As used in this section, the term "off-label usage" shall mean when a Food and Drug Administration-approved drug is used for the practice of medicine in a manner that differs from the approved drug label, including but not limited to:

(a) Used for a different disease or medical condition;

(b) Administered in a different manner; or

(c) Administered in a different dose.

2. Each health benefit plan delivered, issued for delivery, continued, or renewed in the state shall provide coverage for an enrollee's off-label usage of drugs for purposes of cancer treatment when the drug has been prescribed or recommended to the enrollee by at least two licensed oncologists who attest the drug may extend the enrollee's life."; and

Further amend said bill, Page 148, Section 630.875, Line 9, by inserting after all of said line the following:

"Section B. Because of the need for timely and affordable access to medical treatments, the enactment of section 376.1260 of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the enactment of section 376.1260 of this act shall be in full force and effect upon its passage and approval."; and

Further amend the title and enacting clause accordingly.

Senate Amendment No. 2

AMEND Senate Substitute No. 2 for House Bill No. 219, Page 125, Section 376.690, Line 22 of said page, by inserting immediately after said line the following:

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

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

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

Further amend the title and enacting clause accordingly.

Senate Amendment No. 3

AMEND Senate Substitute No. 2 for House Bill No. 219, Page 36, Section 195.550, Line 1 of said page, by inserting after all of said line the following:

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

Further amend the title and enacting clause accordingly.

Senate Amendment No. 4

AMEND Senate Substitute No. 2 for House Bill No. 219, Page 102, Section 335.175, Line 28, by inserting after all of said line the following:

"337.712. 1. Applications for licensure as a marital and family therapist shall be in writing, submitted to the committee on forms prescribed by the committee and furnished to the applicant. **The form shall include a statement that the applicant has completed two hours of suicide assessment, referral, treatment, and management training.** The application shall contain the applicant's statements showing the applicant's education, experience and such other information as the committee may require. Each application shall contain a statement that it is made under oath or affirmation and that the information contained therein is true and correct to the best knowledge and belief of the applicant, subject to the penalties provided for the making of a false affidavit or declaration. Each application shall be accompanied by the fees required by the division.

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

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

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

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

Further amend the title and enacting clause accordingly.

Senate Amendment No. 5

AMEND Senate Substitute No. 2 for House Bill No. 219, Page 2, Section A, Line 2, by inserting after all of said line the following:

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

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

3. The task force shall:

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

(2) Explore solutions to substance abuse issues; and

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

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

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

Further amend the title and enacting clause accordingly.

Emergency clause adopted.

In which the concurrence of the House is respectfully requested.

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate has taken up and passed **SS SCS HCS HB 399** entitled:

An act to repeal sections 192.007, 208.909, 208.918, 208.924, 208.930, 376.427, 376.690, 376.1040, 376.1042, and 376.1224, RSMo, and to enact in lieu thereof eighteen new sections relating to healthcare, with an emergency clause for a certain section.

With Senate Amendment No. 1, Senate Amendment No. 2 and Senate Amendment No. 3.

Senate Amendment No. 1

AMEND Senate Committee Substitute for House Committee Substitute for House Bill No. 399, Page 3, Section 376.1224, Line 82, by striking “and” as it appears the third time on said line and inserting in lieu thereof the following:

"**or**".

Senate Amendment No. 2

AMEND Senate Committee Substitute for House Committee Substitute for House Bill No. 399, Page 1, Section Title, Line 3, by inserting after “disabilities”, “, with an emergency clause for a certain section”; and

Further amend said bill, Page 1, Section A, Line 2, by inserting after all of said line the following:

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

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

(1) Makes application to the department;

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) Bank statements; and

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

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

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

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

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

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

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

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

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

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

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

(2) A request for such hearing shall be made to the department of social services in writing in the form prescribed by the department of social services within ninety days after the mailing or delivery of the written decision of the department of health and senior services. The procedures for such requests and for the hearings shall be as set forth in section 208.080.

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

11. The department may promulgate rules and regulations, including emergency rules, to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. Any provisions of the existing rules regarding the personal care assistance program promulgated by the department of elementary and secondary education in title 5, code of state regulations, division 90, chapter 7, which are inconsistent with the provisions of this section are void and of no force and effect.

[~~12. The provisions of this section shall expire on June 30, 2019.~~**]**"; and

Further amend said bill, Page 8, Section 376.1224, Line 242, by inserting after all of said line the following:

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

Further amend the title and enacting clause accordingly.

Senate Amendment No. 3

AMEND Senate Committee Substitute for House Committee Substitute for House Bill No. 399, Page 1, Section Title, Line 3, of the title, by striking "health care for persons with disabilities" and inserting in lieu thereof the following:

"private health insurance"; and

Further amend said bill and page, Section A, Line 2, by inserting after all of said line the following:

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

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

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

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

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

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

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

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

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

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

(5) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within one hundred twenty days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the final offer by each party. A claim for unanticipated out-of-network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with subdivisions (3) to (5) of this subsection.

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

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

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

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

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

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

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall be binding on all parties. The arbitrator shall provide a copy of the final decision to the director. The initial request for arbitration, all correspondence and documents received by the department and the final arbitration decision shall be considered a closed record under section 374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of section 536.010.

6. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare-allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

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

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

(2) The nature of the service provided;

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

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

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

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

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

~~10.~~**]** The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to procedural requirements for arbitration. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void."; and

Further amend the title and enacting clause accordingly.

Emergency clause adopted.

In which the concurrence of the House is respectfully requested.

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate has taken up and passed **SCS HCS HB 447** entitled:

An act to repeal sections 58.095, 58.451, 58.720, 193.145, and 193.265, RSMo, and to enact in lieu thereof seven new sections relating to coroners.

With Senate Amendment No. 1, Senate Amendment No. 2, Senate Amendment No. 3 and Senate Amendment No. 4.

Senate Amendment No. 1

AMEND Senate Committee Substitute for House Committee Substitute for House Bill No. 447, Page 1, Section Title, Line 3, by striking the word "coroners" and inserting in lieu thereof the following:

"the disposition of dead bodies"; and

Further amend said bill, Page 18, Section 193.265, Line 74, by inserting after all of said line the following:

"333.011. 1. As used in this chapter, unless the context requires otherwise, the following terms have the meanings indicated:

(1) "Board", the state board of embalmers and funeral directors created by this chapter;

(2) "Embalmer", any individual licensed to engage in the practice of embalming;

(3) "Funeral director", any individual licensed to engage in the practice of funeral directing;

(4) "Funeral establishment", a building, place, crematory, or premises devoted to or used in the care and preparation for burial or transportation of the human dead and includes every building, place or premises maintained for that purpose or held out to the public by advertising or otherwise to be used for that purpose;

(5) "Funeral merchandise", caskets, grave vaults, receptacles, and other personal property incidental to the final disposition of a dead human body, including grave markers, monuments, tombstones, and urns;

(6) **"Outdoor cremation", the cremation of a dead human body that occurs outdoors in a licensed or permitted outdoor human cremation facility;**

(7) "Outdoor human cremation facility", a licensed or permitted location that includes an outdoor funeral pyre with the ability to utilize a heating process to reduce a dead human body to bone fragments through heat and evaporation;

(8) "Person", any individual, partnership, corporation, cooperative, association, or other entity;

[~~(7)~~**] (9)** "Practice of embalming", the work of preserving, disinfecting and preparing by arterial embalming, including the chemical preparation of a dead human body for disposition. Practice of embalming includes all activities leading up to and including arterial and cavity embalming, including but not limited to raising of vessels and suturing of incisions of dead human bodies for funeral services, transportation, burial or cremation, or the holding of oneself out as being engaged in such work;

[~~(8)~~**] (10)** "Practice of funeral directing", engaging by an individual in the business of preparing, otherwise than by embalming, for the burial, disposal or transportation out of this state of, and the directing and supervising of the burial or disposal of, dead human bodies or engaging in the general control, supervision or management of the operations of a funeral establishment;

[~~(9)~~**] (11)** "Preneed agent", any person authorized to sell a preneed contract for or on behalf of a seller;

[~~(10)~~**] (12)** "Provider", the person designated or obligated to provide the final disposition, funeral, or burial services or facilities, or funeral merchandise described in a preneed contract;

[~~(11)~~**] (13)** "Seller", the person who executes a preneed contract with a purchaser and who is obligated under such preneed contract to remit payment to the provider.

2. All terms defined in sections 436.400 to 436.520 shall be deemed to have the same meaning when used in this chapter.

333.072. 1. An outdoor cremation facility shall comply with all local, state, and federal laws to ensure public health and safety.

2. Any licensed funeral establishment may include an outdoor cremation facility provided such facility complies with the provisions of this chapter and any regulations related to funeral establishments.

3. For each outdoor cremation, the funeral establishment shall apply to the board for a permit to perform an outdoor cremation at an outdoor human cremation facility. The board shall create an application form, which shall include:

(1) The name and address of the licensed funeral establishment;

(2) The name, license number, and signature of the funeral director that will be conducting the cremation;

(3) The name of the deceased;

(4) The date of death of the deceased;

(5) The name, address, and signature of the person exercising the right of sepulcher over the body of the deceased consenting to the outdoor cremation, or a written and signed authorization for outdoor cremation signed by the deceased prior to death;

(6) The address and written consent of the property owner or the person with the right of possession of the property where the outdoor cremation is to be performed;

(7) The date range, not to exceed one week, in which the outdoor cremation will take place;

(8) Evidence that the intended outdoor human cremation facility has the capacity to complete the cremation of a dead human body;

(9) A fee established by the board by rule; and

(10) Evidence of compliance with local, state, and federal laws related to public health and safety for the location of the facility.

4. The application for a permit shall be completed and filed at least three days prior to the date of the outdoor cremation.

5. The funeral establishment shall provide written notice to the applicable local law enforcement agency at least twenty-four hours in advance of any outdoor cremation. Such notice shall include the date, location, and approximate time of the outdoor cremation, the name and contact information of the funeral director performing the outdoor cremation, and a copy of the permit from the board to perform the outdoor cremation. The funeral establishment must maintain a copy of such written notice in its records.

6. The board may inspect any location proposed for an outdoor cremation facility to ensure compliance with the provisions of chapters 333 and 436 and their accompanying regulations.

7. A licensed funeral director, or his or her designee, shall be present to supervise any cremation conducted at an outdoor cremation facility.

8. The board is hereby authorized to promulgate rules and regulations for establishing and regulating outdoor human cremation facilities. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2019, shall be invalid and void."; and

Further amend the title and enacting clause accordingly.

Senate Amendment No. 2

AMEND Senate Committee Substitute for House Committee Substitute for House Bill No. 447, Page 1, Section title, Line 3 of the title, by striking "coroners" and inserting in lieu thereof the following:

"the deceased"; and

Further amend said bill, Page 12, Section 193.145, Line 22, by inserting immediately after "193.265." an opening bracket "**[**"; and

Further amend Line 28, by inserting at the end of said line a closing bracket "**]**"; and

Further amend said bill and section, Page 13, Line 48, by inserting immediately after "certification" the following:

"**and attestation**"; and

Further amend Line 49, by inserting immediately after "certification" the following:

"**and attestation**"; and

Further amend said bill and section, Page 14, Line 68, by inserting immediately after "information" the following:

"**and attestation**"; and

Further amend Line 71, by inserting immediately after "data" the following:

"**and attestation**"; and

Further amend Line 73, by inserting immediately after "certification" the following:

"**and attestation**"; and

Further amend said bill and section, Page 15, Line 111, by striking " (1)"; and

Further amend Lines 116-122, by striking all of said lines; and

Further amend said bill, Page 17, Section 193.265, Line 72, by inserting immediately after "records." the following:

"**In the event that it is determined by the state registrar that any required information from any data provider was missing or incomplete on records or documentation that were filed with or submitted to the local registrar and then sent to the state registrar, the state registrar shall return the records or documentation to the local registrar so that the data provider, funeral director, or person in charge of the final disposition, can provide the missing or incomplete information. Nothing in this subsection removes any requirement in any statute or regulation as to when an affidavit or court order is necessary to amend a death certificate that has been issued.**"; and

Further amend said bill, Page 18, Section 193.265, Line 74, by inserting after all of said line the following:

"194.119. 1. As used in this section, the term "right of sepulcher" means the right to choose and control the burial, cremation, or other final disposition of a dead human body.

2. For purposes of this chapter and chapters 193, 333, and 436, and in all cases relating to the custody, control, and disposition of deceased human remains, including the common law right of sepulcher, where not otherwise defined, the term "next-of-kin" means the following persons in the priority listed if such person is eighteen years of age or older, is mentally competent, and is willing to assume responsibility for the costs of disposition:

(1) An attorney in fact designated in a durable power of attorney wherein the deceased specifically granted the right of sepulcher over his or her body to such attorney in fact;

(2) For a decedent who was on active duty in the United States military at the time of death, the person designated by such decedent in the written instrument known as the United States Department of Defense Form 93, Record of Emergency Data, in accordance with **[**~~P.L. 109-163, Section 564,~~**]** 10 U.S.C. Section 1482;

(3) The surviving spouse**, unless an action for the dissolution of the marriage has been filed and is pending in a court of competent jurisdiction**;

(4) Any surviving child of the deceased. If a surviving child is less than eighteen years of age and has a legal or natural guardian, such child shall not be disqualified on the basis of the child's age and such child's legal or natural guardian, if any, shall be entitled to serve in the place of the child unless such child's legal or natural guardian was subject to an action in dissolution from the deceased. In such event the person or persons who may serve as next-of-kin shall serve in the order provided in subdivisions (5) to (9) of this subsection;

(5) (a) Any surviving parent of the deceased; or

(b) If the deceased is a minor, a surviving parent who has custody of the minor; or

(c) If the deceased is a minor and the deceased's parents have joint custody, the parent whose residence is the minor child's residence for purposes of mailing and education;

(6) Any surviving sibling of the deceased;

(7) The next nearest surviving relative of the deceased by consanguinity or affinity;

(8) Any person or friend who assumes financial responsibility for the disposition of the deceased's remains if no next-of-kin assumes such responsibility;

(9) The county coroner or medical examiner; provided however that such assumption of responsibility shall not make the coroner, medical examiner, the county, or the state financially responsible for the cost of disposition.

3. The next-of-kin of the deceased shall be entitled to control the final disposition of the remains of any dead human being consistent with all applicable laws, including all applicable health codes. **The next-of-kin may delegate the control of the final disposition of the remains of any dead human being to an agent through either a specific or general grant of power in accordance with section 404.710 if, at the time of delegation, the next-of-kin was eighteen years of age or older and mentally competent and the principal or agent is taking financial responsibility for the disposition.**

4. A funeral director or establishment is entitled to rely on and act according to the lawful instructions of any person claiming to be the next-of-kin of the deceased; provided however, in any civil cause of action against a funeral director or establishment licensed pursuant to this chapter for actions taken regarding the funeral arrangements for a deceased person in the director's or establishment's care, the relative fault, if any, of such funeral director or establishment may be reduced if such actions are taken in reliance upon a person's claim to be the deceased person's next-of-kin.

5. Any person who desires to exercise the right of sepulcher and who has knowledge of an individual or individuals with a superior right to control disposition shall notify such individual or individuals prior to making final arrangements.

6. If an individual with a superior claim is **[**~~personally served with written notice from~~**]** **notified in person or by written notice with delivery confirmation to such person's last known address by** a person with an inferior claim that such person desires to exercise the right of sepulcher and the individual so served does not object within forty-eight hours of **[**~~receipt~~**]** **such notice**, such individual shall be deemed to have waived such right. An individual with a superior right may also waive such right at any time if such waiver is in writing and dated.

7. If there is more than one person in a class who are equal in priority and the funeral director has no knowledge of any objection by other members of such class, the funeral director or establishment shall be entitled to rely on and act according to the instructions of the first such person in the class to make arrangements; provided that such person assumes responsibility for the costs of disposition and no other person in such class provides written notice of his or her objection. If the funeral director has knowledge that there is more than one person in a class who are equal in priority and who do not agree on the disposition, the decision of the majority of the members of such class shall control the disposition.

8. For purposes of conducting a majority vote under subsection 7 of this section, the funeral director shall allow voting by proxy using a written authorization or instrument."; and

Further amend the title and enacting clause accordingly.

Senate Amendment No. 3

AMEND Senate Committee Substitute for House Committee Substitute for House Bill No. 447, Page 18, Section 193.265, Line 74, by inserting immediately after said line the following:

"210.192. 1. The prosecuting attorney or the circuit attorney shall impanel a child fatality review panel for the county or city not within a county in which he or she serves to investigate the deaths of children under the age of eighteen years, who are eligible to receive a certificate of live birth. The panel shall be formed and shall operate according to the rules, guidelines and protocols provided by the department of social services.

2. The panel shall include, but shall not be limited to, the following:

(1) The prosecuting or circuit attorney;

(2) The coroner or medical examiner for the county or city not within a county;

(3) Law enforcement personnel in the county or city not within a county;

(4) A representative from the children's division;

(5) A provider of public health care services;

(6) A representative of the juvenile court;

(7) A provider of emergency medical services.

3. The prosecuting or circuit attorney shall organize the panel and shall call the first organizational meeting of the panel. The panel shall elect a chairman who shall convene the panel to meet to review all deaths of children under the age of eighteen years, who are eligible to receive a certificate of live birth, which meet guidelines for review as set forth by the department of social services. In addition, the panel may review at its own discretion any child death reported to it by the medical examiner or coroner, even if it does not meet criteria for review as set forth by the department. The panel shall issue a final report, which shall be a public record, of each investigation to the department of social services, state technical assistance team and to the director of the department of health and senior services. The final report shall include a completed summary report form. The form shall be developed by the director of the department of social services in consultation with the director of the department of health and senior services. **[**~~The department of health and senior services shall analyze the child fatality review panel reports and periodically prepare epidemiological reports which describe the incidence, causes, location and other factors pertaining to childhood deaths.~~**]** The department of health and senior services and department of social services shall make recommendations and develop programs to prevent childhood injuries and deaths.

4. The child fatality review panel shall enjoy such official immunity as exists at common law.

210.194. 1. The director of the department of social services, in consultation with the director of the department of health and senior services, shall promulgate rules, guidelines and protocols for child fatality review panels established pursuant to section 210.192 and for state child fatality review panels.

2. The director shall promulgate guidelines and protocols for coroner and medical examiners to use to help them to identify suspicious deaths of children under the age of eighteen years, who are eligible to receive a certificate of live birth.

3. No rule or portion of a rule promulgated under the authority of sections 210.192 to 210.196 shall become effective unless it has been promulgated pursuant to the provisions of section 536.024.

4. All meetings conducted**[**~~, all reports and records~~**] and work product, including internal memoranda, summaries or minutes of meetings, and written, audio, or electronic records and communications,** made and maintained pursuant to sections 210.192 to 210.196 by the department of social services and department of health and senior services and its divisions, including the state technical assistance team, or other appropriate persons, officials, or state child fatality review panel and local child fatality review panel shall be confidential **[**~~and shall not be open to the general public except for the annual report pursuant to section 210.195~~**], unless otherwise provided in this subsection, section 210.150, section 210.195, or section 660.520. The state technical assistance team shall make nonidentifiable, aggregate data on child fatalities publicly available. Identifiable data shall be released at the discretion of the director of the department of social services, except for any data that was obtained only from birth or death certificate records provided by the department of health and senior services. In those cases, the release of identifiable data shall be at the discretion of the state registrar**.

210.195. 1. The director of the department of social services shall establish a special team which shall:

(1) Develop and implement protocols for the evaluation and review of child fatalities;

(2) Provide training, expertise and assistance to county child fatality review panels for the review of child fatalities;

(3) When required and unanimously requested by the county fatality review panel, assist in the review and prosecution of specific child fatalities; and

(4) The special team may be known as the department of social services, state technical assistance team.

2. The director of the department of social services shall appoint regional coordinators to serve as resources to child fatality review panels established pursuant to section 210.192.

3. The director of the department of social services shall appoint a state child fatality review panel which shall meet at least biannually to provide oversight and make recommendations to the department of social services, state technical assistance team. The department of social services, state technical assistance team shall gather data from local child fatality review panels to identify systemic problems and shall submit findings and recommendations to the director of the department of social services, the governor, the speaker of the house of representatives, the president pro tempore of the senate, the children's services commission, juvenile officers, and the chairman of the local child fatality review panel, at least once a year, on ways to prevent further child abuse and injury deaths. **The report shall include a summary of compliance with the provisions of sections 210.192 to 210.196 for each county or city not within a county.**"; and

Further amend the title and enacting clause accordingly.

Senate Amendment No. 4

AMEND Senate Committee Substitute for House Committee Substitute for House Bill No. 447, Page 12, Section 58.720, Line 102, by inserting after all of said line the following:

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

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

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

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

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

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

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

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

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

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

4. The board shall have a multidisciplinary and diverse membership that represents a variety of medical and nursing specialties, including, but not limited to, obstetrics and maternal-fetal care, as well as state or local public health officials, epidemiologists, statisticians, community organizations, geographic regions, and other individuals or organizations that are most affected by maternal deaths and lack of access to maternal health care services.

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

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

(2) Identifying factors associated with maternal deaths;

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

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

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

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

(4) Consulting with relevant experts, as needed;

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Upon request by the department, health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, law enforcement agencies, driver's license bureaus, other state agencies, and facilities licensed by the department shall provide to the department data related to maternal deaths from sources such as medical records, autopsy reports, medical examiner's reports, coroner's reports, law enforcement reports, motor vehicle records, social services records, and other sources as appropriate. Such data requests shall be limited to maternal deaths which have occurred within the previous twenty-four months. No entity shall be held liable for civil damages or be subject to any criminal or disciplinary action when complying in good faith with a request from the department for information under the provisions of this subsection.

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

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

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

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

(3) Information, records, reports, statements, notes, memoranda, or other data collected under this section shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency, or person. Such information, records, reports, notes, memoranda, data obtained by the department or any other person, statements, notes, memoranda, or other data shall not be exhibited nor their contents disclosed in any way, in whole or in part, by any officer or representative of the department or any

other person. No person participating in such review shall disclose, in any manner, the information so obtained except in strict conformity with such review project. Such information shall not be subject to disclosure under chapter 610.

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

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

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

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

Further amend the title and enacting clause accordingly.

In which the concurrence of the House is respectfully requested.

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate has taken up and passed **SS HCS#2 HB 499** entitled:

An act to repeal sections 136.055, 301.010, 301.067, 302.574, 304.580, 304.585, 304.590, 304.894, 479.500, 643.300, 643.303, 643.305, 643.310, 643.315, 643.320, 643.325, 643.330, 643.335, 643.337, 643.340, 643.345, 643.350, 643.353, and 643.355, RSMo, and to enact in lieu thereof twenty-six new sections relating to transportation, with penalty provisions and an effective date for certain sections.

In which the concurrence of the House is respectfully requested.

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate refuses to concur in **HCS SB 36, as amended**, and requests the House to recede from its position and failing to do so grant the Senate a conference thereon.

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate refuses to concur in **HCS SB 54, as amended**, and requests the House to recede from its position and failing to do so grant the Senate a conference thereon.

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate has taken up and adopted **HCS** for **SB 68, as amended**, and has taken up and passed **HCS SB 68, as amended**.

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate conferees be allowed to exceed the differences on **House Amendment No. 1 to House Amendment No. 2** to **SCS SB 83**, relating to grandparent visitation, to make the language consistent with what the Senate Committee adopted in **SCS HCS HB 700**.

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate refuses to concur in **HCS SCS SB 174, as amended**, and requests the House to recede from its position and failing to do so grant the Senate a conference thereon.

REFERRAL OF HOUSE BILLS

The following House Bills were referred to the Committee indicated:

SS#2 HB 219, as amended - Fiscal Review
SS SCS HCS HB 399, as amended - Fiscal Review
SCS HCS HB 447, as amended - Fiscal Review
SS HCS #2 HB 499 - Fiscal Review

HOUSE BILLS WITH SENATE AMENDMENTS

SS HCS HB 677, relating to certain tourism infrastructure facilities, was taken up by Representative Patterson.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 095

Anderson	Andrews	Baker	Basye	Black 137
Black 7	Bromley	Busick	Chappelle-Nadal	Chipman
Christofanelli	Coleman 32	Coleman 97	Deaton	DeGroot
Dinkins	Dogan	Eggleston	Evans	Falkner III
Fishel	Fitzwater	Francis	Gregory	Grier
Griesheimer	Griffith	Haden	Haffner	Hannegan
Hansen	Helms	Henderson	Hill	Houx
Hovis	Hudson	Hurst	Justus	Kelley 127
Kelly 141	Kidd	Knight	Kolkmeyer	Lovasco
Love	Lynch	Mayhew	McGirl	Miller
Moon	Morris 140	Morse 151	Muntzel	Neely
O'Donnell	Patterson	Pfautsch	Pike	Plocher
Pogue	Pollitt 52	Pollock 123	Porter	Reedy
Rehder	Toalson Reisch	Remole	Richey	Riggs
Roberts 161	Rone	Ross	Ruth	Schnelting
Schroer	Sharpe	Shaul 113	Shawan	Shields
Simmons	Smith	Solon	Sommer	Spencer
Stacy	Swan	Taylor	Trent	Veit
Walsh	Wiemann	Wilson	Wood	Mr. Speaker

NOES: 040

Appelbaum	Bangert	Baringer	Barnes	Beck
Bland Manlove	Brown 27	Burnett	Burns	Butz
Carpenter	Clemens	Ellebracht	Franks Jr.	Green
Ingle	Kendrick	Lavender	Mackey	McCreery
McDaniel	Merideth	Mitten	Morgan	Mosley
Murphy	Pierson Jr.	Proudie	Quade	Razer
Roberts 77	Rogers	Rowland	Runions	Sain
Sauls	Stevens 46	Unsicker	Walker	Windham

PRESENT: 001

Roden

ABSENT WITH LEAVE: 024

Allred	Bailey	Billington	Bondon	Bosley
Brown 70	Carter	Dohrman	Ellington	Eslinger
Gannon	Gray	Hicks	McGaugh	Messenger
Pietzman	Price	Roeber	Shull 16	Stephens 128
Tate	Vescovo	Washington	Wright	

VACANCIES: 003

On motion of Representative Patterson, **SS HCS HB 677** was adopted by the following vote:

AYES: 088

Allred	Andrews	Appelbaum	Bangert	Baringer
Barnes	Beck	Bland Manlove	Bondon	Brown 27
Burnett	Burns	Butz	Carpenter	Clemens
Coleman 32	Coleman 97	Dinkins	Dohrman	Ellebracht
Evans	Falkner III	Fishel	Francis	Franks Jr.
Gannon	Gray	Green	Gregory	Griesheimer
Griffith	Haden	Haffner	Hannegan	Henderson
Hicks	Houx	Hovis	Ingle	Justus
Kelly 141	Kendrick	Kidd	Kolkmeyer	Lavender
Love	Mackey	Merideth	Miller	Mitten
Morgan	Morse 151	Mosley	O'Donnell	Patterson
Pfautsch	Pierson Jr.	Pike	Plocher	Porter
Price	Proudie	Quade	Razer	Roberts 161
Roberts 77	Rogers	Rone	Rowland	Runions
Ruth	Sain	Sauls	Sharpe	Shaul 113
Shawan	Shields	Solon	Sommer	Stevens 46
Swan	Tate	Unsicker	Veit	Walker
Washington	Windham	Mr. Speaker		

NOES: 057

Anderson	Baker	Basye	Billington	Black 137
Black 7	Bromley	Busick	Chappelle-Nadal	Chipman
Christofanelli	Deaton	DeGroot	Dogan	Eggleston
Fitzwater	Grier	Hansen	Helms	Hill
Hudson	Hurst	Kelley 127	Lovasco	Lynch

Mayhew	McCreery	McDaniel	Moon	Morris 140
Muntzel	Murphy	Neely	Pogue	Pollitt 52
Pollock 123	Reedy	Rehder	Toalson Reisch	Remole
Richey	Riggs	Ross	Schnelting	Schroer
Simmons	Smith	Spencer	Stacy	Stephens 128
Taylor	Trent	Walsh	Wiemann	Wilson
Wood	Wright			

PRESENT: 001

Roden

ABSENT WITH LEAVE: 014

Bailey	Bosley	Brown 70	Carter	Ellington
Eslinger	Knight	McGaugh	McGirl	Messenger
Pietzman	Roeber	Shull 16	Vescovo	

VACANCIES: 003

On motion of Representative Patterson, **SS HCS HB 677** was truly agreed to and finally passed by the following vote:

AYES: 089

Allred	Appelbaum	Bangert	Baringer	Barnes
Beck	Bland Manlove	Bondon	Brown 27	Burnett
Burns	Butz	Carpenter	Clemens	Coleman 32
Coleman 97	Dinkins	Dohrman	Ellebracht	Evans
Falkner III	Fishel	Francis	Franks Jr.	Gannon
Gray	Green	Gregory	Griesheimer	Griffith
Haden	Haffner	Hannegan	Henderson	Hicks
Houx	Hovis	Ingle	Justus	Kelly 141
Kendrick	Kidd	Knight	Kolkmeyer	Lavender
Love	Mackey	McGirl	Merideth	Miller
Mitten	Morgan	Morse 151	Mosley	O'Donnell
Patterson	Pfautsch	Pierson Jr.	Pike	Plocher
Porter	Price	Proudie	Quade	Razer
Roberts 161	Roberts 77	Roden	Rogers	Rone
Rowland	Runions	Ruth	Sain	Sauls
Sharpe	Shaul 113	Shawan	Shields	Solon
Sommer	Stevens 46	Swan	Tate	Unsicker
Walker	Washington	Windham	Mr. Speaker	

NOES: 058

Anderson	Andrews	Baker	Basye	Billington
Black 137	Black 7	Bromley	Busick	Chappelle-Nadal
Chipman	Christofanelli	Deaton	DeGroot	Dogan
Eggleston	Fitzwater	Grier	Hansen	Helms
Hill	Hudson	Hurst	Kelley 127	Lovasco
Lynch	Mayhew	McCreery	McDaniel	Moon
Morris 140	Muntzel	Murphy	Neely	Pogue
Pollitt 52	Pollock 123	Reedy	Rehder	Toalson Reisch
Remole	Richey	Riggs	Ross	Schnelting
Schroer	Simmons	Smith	Spencer	Stacy
Stephens 128	Taylor	Trent	Walsh	Wiemann
Wilson	Wood	Wright		

PRESENT: 000

ABSENT WITH LEAVE: 013

Bailey	Bosley	Brown 70	Carter	Ellington
Eslinger	McGaugh	Messenger	Pietzman	Roeber
Shull 16	Veit	Vescovo		

VACANCIES: 003

Speaker Haahr declared the bill passed.

THIRD READING OF SENATE BILLS - INFORMAL

HCS SB 21, relating to taxation, was taken up by Representative Rone.

Representative Rone moved that the title of **HCS SB 21** be agreed to.

Representative Merideth offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Substitute for Senate Bill No. 21, Page 1, In the Title, Line 5, by deleting the word "taxation" and inserting in lieu thereof the phrase "laws, generally"; and

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

Speaker Pro Tem Wiemann assumed the Chair.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 102

Allred	Anderson	Andrews	Baker	Basye
Billington	Black 137	Black 7	Bondon	Bromley
Busick	Chipman	Christofanelli	Coleman 32	Coleman 97
Deaton	DeGroot	Dinkins	Dogan	Eggleston
Evans	Falkner III	Fishel	Fitzwater	Francis
Gannon	Gregory	Griesheimer	Griffith	Haden
Haffner	Hannegan	Hansen	Helms	Henderson
Hicks	Houx	Hovis	Hudson	Hurst
Justus	Kelley 127	Kelly 141	Kidd	Knight
Kolkmeyer	Lovasco	Love	Lynch	Mayhew
McGirl	Miller	Moon	Morris 140	Morse 151
Muntzel	Murphy	Neely	O'Donnell	Patterson
Pfautsch	Pike	Plocher	Pogue	Pollitt 52
Pollock 123	Porter	Price	Reedy	Rehder
Toalson Reisch	Remole	Richey	Riggs	Roberts 161
Rone	Ross	Ruth	Schnelting	Schroer
Sharpe	Shaul 113	Shawan	Shields	Simmons

Smith	Solon	Sommer	Spencer	Stacy
Stephens 128	Swan	Tate	Taylor	Trent
Veit	Walsh	Wiemann	Wilson	Wood
Wright	Mr. Speaker			

NOES: 041

Appelbaum	Bangert	Baringer	Barnes	Beck
Bland Manlove	Bosley	Brown 27	Burnett	Burns
Butz	Carpenter	Chappelle-Nadal	Clemens	Ellebracht
Gray	Green	Ingle	Kendrick	Lavender
Mackey	McDaniel	Merideth	Mitten	Morgan
Mosley	Pierson Jr.	Proudie	Quade	Razer
Roberts 77	Rogers	Rowland	Runions	Sain
Sauls	Stevens 46	Unsicker	Walker	Washington
Windham				

PRESENT: 001

Roden

ABSENT WITH LEAVE: 016

Bailey	Brown 70	Carter	Dohrman	Ellington
Eslinger	Franks Jr.	Grier	Hill	McCreery
McGaugh	Messenger	Pietzman	Roeber	Shull 16
Vescovo				

VACANCIES: 003

House Amendment No. 1 was withdrawn.

On motion of Representative Rone, the title of **HCS SB 21** was agreed to.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 103

Allred	Anderson	Andrews	Baker	Basye
Billington	Black 137	Black 7	Bondon	Bromley
Busick	Chipman	Christofanelli	Coleman 32	Coleman 97
Deaton	DeGroot	Dinkins	Dogan	Dohrman
Eggleston	Evans	Falkner III	Fishel	Fitzwater
Francis	Gannon	Gregory	Grier	Griesheimer
Griffith	Haden	Haffner	Hannegan	Hansen
Helms	Henderson	Hicks	Hill	Houx
Hovis	Hudson	Hurst	Justus	Kelley 127
Kelly 141	Knight	Kolkmeyer	Lovasco	Love
Lynch	Mayhew	McGirl	Miller	Moon
Morris 140	Morse 151	Muntzel	Murphy	Neely
O'Donnell	Patterson	Pfautsch	Pike	Plocher
Pogue	Pollitt 52	Pollock 123	Porter	Reedy
Rehder	Toalson Reisch	Remole	Richey	Riggs
Roberts 161	Rone	Ross	Ruth	Schnelting

Schroer	Sharpe	Shaul 113	Shawan	Shields
Simmons	Smith	Solon	Sommer	Spencer
Stacy	Stephens 128	Swan	Tate	Taylor
Trent	Veit	Vescovo	Walsh	Wiemann
Wilson	Wood	Wright		

NOES: 043

Appelbaum	Bangert	Baringer	Barnes	Beck
Bland Manlove	Bosley	Brown 27	Burnett	Burns
Butz	Carpenter	Chappelle-Nadal	Clemens	Ellebracht
Gray	Green	Ingle	Kendrick	Lavender
Mackey	McCreery	McDaniel	Merideth	Mitten
Morgan	Mosley	Pierson Jr.	Price	Proudie
Quade	Razer	Roberts 77	Rogers	Rowland
Runions	Sain	Sauls	Stevens 46	Unsicker
Walker	Washington	Windham		

PRESENT: 001

Roden

ABSENT WITH LEAVE: 013

Bailey	Brown 70	Carter	Ellington	Eslinger
Franks Jr.	Kidd	McGaugh	Messenger	Pietzman
Roeber	Shull 16	Mr. Speaker		

VACANCIES: 003

Representative Rone moved that **HCS SB 21** be adopted.

Which motion was defeated.

On motion of Representative Rone, the title of **SB 21**, relating to local sales taxes, was agreed to.

On motion of Representative Rone, **SB 21** was truly agreed to and finally passed by the following vote:

AYES: 139

Allred	Anderson	Andrews	Appelbaum	Baker
Bangert	Baringer	Barnes	Basye	Beck
Billington	Black 137	Black 7	Bland Manlove	Bondon
Bosley	Bromley	Brown 27	Burnett	Burns
Busick	Butz	Carpenter	Chappelle-Nadal	Chipman
Christofanelli	Clemens	Coleman 32	Coleman 97	Deaton
DeGroot	Dinkins	Dogan	Dohrman	Eggleston
Ellebracht	Evans	Falkner III	Fishel	Fitzwater
Francis	Gannon	Gray	Green	Gregory
Grier	Griesheimer	Griffith	Haden	Haffner
Hannegan	Hansen	Helms	Henderson	Hill
Houx	Hovis	Hudson	Ingle	Justus

Kelley 127	Kelly 141	Kendrick	Kidd	Knight
Kolkmeyer	Lavender	Love	Lynch	Mackey
Mayhew	McCreery	McGirl	Merideth	Miller
Morgan	Morris 140	Morse 151	Mosley	Muntzel
Murphy	Neely	O'Donnell	Patterson	Pfautsch
Pierson Jr.	Pike	Plocher	Pollitt 52	Pollock 123
Porter	Price	Proudie	Quade	Razer
Reedy	Rehder	Toalson Reisch	Remole	Richey
Riggs	Roberts 161	Roberts 77	Rogers	Rone
Ross	Rowland	Runions	Ruth	Sain
Sauls	Schnelting	Schroer	Sharpe	Shaul 113
Shawan	Shields	Simmons	Smith	Solon
Sommer	Spencer	Stacy	Stephens 128	Stevens 46
Swan	Tate	Taylor	Trent	Unsicker
Veit	Walker	Walsh	Washington	Wiemann
Wilson	Windham	Wood	Wright	

NOES: 005

Hurst	Lovasco	McDaniel	Moon	Pogue

PRESENT: 000

ABSENT WITH LEAVE: 016

Bailey	Brown 70	Carter	Ellington	Eslinger
Franks Jr.	Hicks	McGaugh	Messenger	Mitten
Pietzman	Roden	Roeber	Shull 16	Vescovo
Mr. Speaker				

VACANCIES: 003

Speaker Pro Tem Wiemann declared the bill passed.

The emergency clause was adopted by the following vote:

AYES: 116

Allred	Anderson	Andrews	Baker	Bangert
Baringer	Basye	Billington	Black 137	Black 7
Bondon	Bromley	Brown 27	Burns	Busick
Butz	Chipman	Christofanelli	Coleman 32	Coleman 97
Deaton	DeGroot	Dinkins	Dogan	Dohrman
Eggleston	Ellebracht	Evans	Falkner III	Fishel
Fitzwater	Francis	Gannon	Green	Gregory
Grier	Griesheimer	Griffith	Haden	Haffner
Hannegan	Hansen	Helms	Henderson	Hicks
Hill	Houx	Hovis	Hudson	Justus
Kelley 127	Kelly 141	Kidd	Knight	Kolkmeyer
Love	Lynch	Mayhew	McGirl	Miller
Morris 140	Morse 151	Muntzel	Murphy	Neely
O'Donnell	Patterson	Pfautsch	Pike	Plocher
Pollitt 52	Pollock 123	Porter	Proudie	Razer
Reedy	Rehder	Toalson Reisch	Remole	Richey
Riggs	Roberts 161	Rogers	Rone	Ross
Rowland	Runions	Ruth	Sauls	Schnelting
Schroer	Sharpe	Shaul 113	Shawan	Shields

Simmons	Smith	Solon	Sommer	Spencer
Stacy	Stephens 128	Swan	Tate	Taylor
Trent	Unsicker	Veit	Vescovo	Walsh
Washington	Wiemann	Wilson	Windham	Wood
Wright				

NOES: 030

Appelbaum	Barnes	Beck	Bosley	Burnett
Carpenter	Chappelle-Nadal	Clemens	Gray	Hurst
Ingle	Kendrick	Lavender	Lovasco	Mackey
McCreery	McDaniel	Merideth	Moon	Morgan
Mosley	Pierson Jr.	Pogue	Price	Quade
Roberts 77	Roden	Sain	Stevens 46	Walker

PRESENT: 001

Bland Manlove

ABSENT WITH LEAVE: 013

Bailey	Brown 70	Carter	Ellington	Eslinger
Franks Jr.	McGaugh	Messenger	Mitten	Pietzman
Roeber	Shull 16	Mr. Speaker		

VACANCIES: 003

THIRD READING OF SENATE BILLS

HCS SB 282, **SCS SBs 12 & 123**, **SB 88**, **SB 185**, **HCS SS#4 SB 224**, **SB 228**, **HCS SB 333**, and **HCS SB 514** were placed on the Informal Calendar.

THIRD READING OF SENATE BILLS - INFORMAL

HCS SB 514, relating health care, was taken up by Representative Wood.

On motion of Representative Wood, the title of **HCS SB 514** was agreed to.

Speaker Haahr resumed the Chair.

Representative Wood moved that **HCS SB 514** be adopted.

Which motion was defeated.

Representative Wood moved that the title of **SB 514**, relating to MO HealthNet benefits for persons in foster care, be agreed to.

Representative Wood offered **House Amendment No. 1**.

House Amendment No. 1

AMEND Senate Bill No. 514, Page 1, In the Title, Line 3, by deleting said line and inserting in lieu thereof the words "to health care."; and

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

On motion of Representative Wood, **House Amendment No. 1** was adopted.

Representative Wood offered **House Amendment No. 2**.

House Amendment No. 2

AMEND Senate Bill No. 514, Page 1, Section A, Line 2, by inserting after said section and line the following:

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

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

3. The task force shall:

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

(2) Explore solutions to substance abuse issues; and

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Residence in the state of Missouri;

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

(4) Enrollment as a full-time dental student in the final year of course study offered by an approved educational institution or licensed to practice general dentistry pursuant to chapter 332;

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

(6) Application for loan repayment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) "Prior authorization", the process by which the health insurer or the pharmacy benefits manager determines the medical necessity of otherwise covered health care services prior to the rendering of such health care services. "Prior authorization" also includes any health insurer's or utilization review entity's requirement that a subscriber or health care provider notify the health insurer or utilization review entity prior to receiving or providing a health care service;

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

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

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

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

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

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

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

(1) Buprenorphine tablets;

(2) Methadone;

(3) Naloxone;

(4) Extended-release injectable naltrexone; and

(5) Buprenorphine/naloxone combination.

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

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

(1) Any annual or lifetime dollar limitations;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

comply with the health care-associated infection data reporting requirements of subsections 2 to 17 of this section applicable to hospitals, except that the department shall post a link on its website to publicly reported data by hospitals on the Centers for Medicare and Medicaid Services' Hospital Compare website, or its successor.

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

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

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

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

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

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

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

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

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

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

5. After considering the recommendations of the infection control advisory panel, and provided that the requirements of subsection 13 of this section can be met, the department shall implement guidelines from the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor. It shall be a condition of licensure for hospitals that meet the minimum public reporting requirements of the National Healthcare Safety Network and the Centers for Medicare and Medicaid Services to participate in the National Healthcare Safety Network, or its successor. Such hospitals shall permit the National Healthcare Safety Network, or its successor, to disclose facility-specific infection data to the department as required under this section, and as necessary to provide the public reports required by the department. It shall be a condition of licensure for any ambulatory surgical center or abortion facility which does not voluntarily participate in the National Healthcare Safety Network, or its successor, to submit facility-specific data to the department as required under this section, and as necessary to provide the public reports required by the department.

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

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

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

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

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

8. The department shall undertake a reasonable number of studies and publish information, including at least an annual consumer guide, in collaboration with health care providers, business coalitions and consumers based upon the information obtained pursuant to the provisions of section 192.665 and this section. The department shall allow all health care providers and associations and related organizations who have submitted data which will be used in any publication to review and comment on the publication prior to its publication or release for general use. The publication shall be made available to the public for a reasonable charge.

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

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

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

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

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

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

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

(c) Are infections for which reports are collected by the National Healthcare Safety Network or its successor;

(2) Central line-related bloodstream infections;

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

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

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

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

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

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

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

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

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

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

20. Hospitals described in subsection 19 of this section shall meet the National Healthcare Safety Network requirements for reporting antimicrobial usage or resistance by using the Centers for Disease Control and Prevention's Antimicrobial Use and Resistance (AUR) Module when **[**~~regulations concerning Stage 3 of the Medicare and Medicaid Electronic Health Records Incentive Programs promulgated by the Centers for Medicare and Medicaid Services that enable the electronic interface for such reporting are effective~~**] conditions of participation promulgated by the Centers for Medicare and Medicaid Services requiring the electronic reporting of antibiotic use or antibiotic resistance by hospitals become effective**. When such antimicrobial usage or resistance reporting takes effect, hospitals shall authorize the National Healthcare Safety Network, or its successor, to disclose to the department facility-specific information reported to the AUR Module. Facility-specific data on antibiotic usage and resistance collected under this subsection shall not be disclosed to the public, but the department may release case-specific information to other facilities, physicians, and the public if the department determines on a case-by-case basis that the release of such information is necessary to protect persons in a public health emergency. **Nothing in this section shall prohibit a hospital from voluntarily reporting antibiotic use or antibiotic resistance data through the National Healthcare Safety Network, or its successor, prior to the effective date of the conditions of participation requiring the reporting.**

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

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

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

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

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

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

4. The board shall have a multidisciplinary and diverse membership that represents a variety of medical and nursing specialties, including, but not limited to, obstetrics and maternal-fetal care, as well as state or local public health officials, epidemiologists, statisticians, community organizations, geographic regions, and other individuals or organizations that are most affected by maternal deaths and lack of access to maternal health care services.

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

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

(2) Identifying factors associated with maternal deaths;

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

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

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

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

(4) Consulting with relevant experts, as needed;

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Upon request by the department, health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, law enforcement agencies, driver's license bureaus, other state agencies, and facilities licensed by the department shall provide to the department data related to maternal deaths from sources such as medical records, autopsy reports, medical examiner's reports, coroner's reports, law enforcement reports, motor vehicle records, social services records, and other sources as appropriate. Such data requests shall be limited to maternal deaths which have occurred within the previous twenty-four months. No entity shall be held liable for civil damages or be subject to any criminal or disciplinary action when complying in good faith with a request from the department for information under the provisions of this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

195.060. 1. Except as provided in subsection 4 of this section, a pharmacist, in good faith, may sell and dispense controlled substances to any person only upon a prescription of a practitioner as authorized by statute, provided that the controlled substances listed in Schedule V may be sold without prescription in accordance with regulations of the department of health and senior services. All written prescriptions shall be signed by the person prescribing the same**, except for electronic prescriptions**. All prescriptions shall be dated on the day when issued and bearing the full name and address of the patient for whom, or of the owner of the animal for which, the drug is prescribed, and the full name, address, and the registry number under the federal controlled substances laws of the person prescribing, if he or she is required by those laws to be so registered. If the prescription is for an animal, it shall state the species of the animal for which the drug is prescribed. The person filling the prescription shall either write the date of filling and his or her own signature on the prescription or retain the date of filling and the identity of the dispenser as electronic prescription information. The prescription or electronic prescription information shall be retained on file by the proprietor of the pharmacy in which it is filled for a period of two years, so as to be readily accessible for inspection by any public officer or employee engaged in the enforcement of this law. No prescription for a drug in Schedule I or II shall be filled more than six months after the date prescribed; no prescription for a drug in Schedule I or II shall be refilled; no prescription for a drug in Schedule III or IV shall be filled or refilled more than six months after the date of the original prescription or be refilled more than five times unless renewed by the practitioner.

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

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

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

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

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

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

195.080. 1. Except as otherwise provided in this chapter and chapter 579, this chapter and chapter 579 shall not apply to the following cases: prescribing, administering, dispensing or selling at retail of liniments, ointments, and other preparations that are susceptible of external use only and that contain controlled substances in such combinations of drugs as to prevent the drugs from being readily extracted from such liniments, ointments, or preparations, except that this chapter and chapter 579 shall apply to all liniments, ointments, and other preparations that contain coca leaves in any quantity or combination.

2. Unless otherwise provided in sections 334.037, 334.104, and 334.747, a practitioner, other than a veterinarian, shall not issue an initial prescription for more than a seven-day supply of any opioid controlled substance upon the initial consultation and treatment of a patient for acute pain. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription in compliance with

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

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

4. Unless otherwise provided in this section, the quantity of Schedule II controlled substances prescribed or dispensed at any one time shall be limited to a thirty-day supply. The quantity of Schedule III, IV or V controlled substances prescribed or dispensed at any one time shall be limited to a ninety-day supply and shall be prescribed and dispensed in compliance with the general provisions of this chapter and chapter 579. The supply limitations provided in this subsection may be increased up to three months if the physician describes on the prescription form or indicates via telephone, fax, or electronic communication to the pharmacy to be entered on or attached to the prescription form the medical reason for requiring the larger supply. The supply limitations provided in this subsection shall not apply if:

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

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

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

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

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

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

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

5. Whenever a pharmacist or practitioner sells or dispenses any controlled substance on a prescription issued by a physician, physician assistant, dentist, podiatrist, veterinarian, or advanced practice registered nurse, the pharmacist or practitioner shall affix to the container in which such drug is sold or dispensed a label showing his or her own name and address of the pharmacy or practitioner for whom he or she is lawfully acting; the name of the patient or, if the patient is an animal, the name of the owner of the animal and the species of the animal; the name of the physician, physician assistant, dentist, podiatrist, advanced practice registered nurse, or veterinarian by whom the prescription was written; the name of the collaborating physician if the prescription is written by an advanced practice registered nurse or **[**~~the supervising physician if the prescription is written by~~**]** a physician assistant, and such directions as may be stated on the prescription. No person shall alter, deface, or remove any label so affixed.

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

(1) Issued by veterinarians;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[~~4.~~**] 5. Certified** nursing assistants who have not successfully completed the nursing assistant training program prior to employment may begin duties as a **certified** nursing assistant **[**~~only after completing an initial twelve hours of basic orientation approved by the department~~**]** and may provide direct resident care only if under the **[**~~general~~**] direct** supervision of a licensed nurse prior to completion of the seventy-five classroom hours of the training program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) All earned income of the disabled worker;

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

(c) A twenty dollar standard deduction;

(d) Health insurance premiums;

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

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

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

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

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

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

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

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

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

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

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

Further amend said bill, Page 8, Section 208.151, Line 268, by inserting after all of said section and line the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. The structured family caregiver waiver shall include:

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

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

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

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

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

(6) A requirement that all organizations serving as structured family caregiving agencies are considered in-home service provider agencies and are accountable for documentation of services delivered, meeting the requirements set forth for these provider agencies, qualification and requalification of caregivers and homes, caregiver training, providing a case manager or registered nurse to create a service plan tailored to each participant's needs, professional staff support for eligible people, ongoing monitoring and support through monthly home visits, deployment of electronic daily notes, and remote consultation with families;

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

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

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

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

(2) Upon receipt of an approved waiver under subdivision (1) of this subsection, the department of health and senior services shall promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2019, shall be invalid and void.

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

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

(1) Makes application to the department;

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) Bank statements; and

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

5. A personal care assistance services plan shall be developed by the department pursuant to section 208.906 for each person who is determined to be eligible and in financial need under the provisions of this section.

The plan developed by the department shall include the maximum amount of financial assistance allowed by the department, subject to appropriation, for such services.

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

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

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

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

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

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

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

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

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

(2) A request for such hearing shall be made to the department of social services in writing in the form prescribed by the department of social services within ninety days after the mailing or delivery of the written decision of the department of health and senior services. The procedures for such requests and for the hearings shall be as set forth in section 208.080.

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

11. The department may promulgate rules and regulations, including emergency rules, to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. Any provisions of the existing rules regarding the personal care assistance program promulgated by the department of elementary and secondary education in title 5, code of state regulations, division 90, chapter 7, which are inconsistent with the provisions of this section are void and of no force and effect.

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

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

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

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

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

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

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

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

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

221.125. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than canceled or terminated, for a person who is an offender in a county jail, a city jail, or a private jail if:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Geographic areas to be covered;

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

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

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

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

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

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

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

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

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

9. No contract or other agreement shall require a physician to act as a collaborating physician for an assistant physician against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular assistant physician. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the

physician's authority to any assistant physician, but such requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) A hospital as defined in section 197.020;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[~~(6)~~**] (7)** "Physician assistant", a person who has graduated from a physician assistant program accredited by the **[**~~American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency~~**] Accreditation Review Commission on Education for the Physician Assistant or its successor agency, prior to 2001, or the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs**, who has passed the certifying examination administered by the National Commission on Certification of Physician Assistants and has active certification by the National Commission on Certification of Physician Assistants who provides health care services delegated by a licensed

physician. A person who has been employed as a physician assistant for three years prior to August 28, 1989, who has passed the National Commission on Certification of Physician Assistants examination, and has active certification of the National Commission on Certification of Physician Assistants;

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

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

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

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

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

(1) Taking patient histories;

(2) Performing physical examinations of a patient;

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

(4) Performing routine therapeutic procedures;

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

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

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

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

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

~~(10)~~**].**

3. Physician assistants shall not perform or prescribe abortions.

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

which is specific to the clinical conditions treated by the supervising physician and the physician assistant shall be subject to the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

334.747. 1. A physician assistant with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to prescribe controlled substances in a **[**~~supervision agreement~~**] collaborative practice arrangement**. Such authority shall be listed on the **[**~~supervision verification~~**] collaborating physician** form on file with the state board of healing arts. The **[**~~supervising~~**] collaborating** physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the physician assistant is permitted to prescribe. Any limitations shall be listed on the **[**~~supervision~~**] collaborating physician** form. Prescriptions for Schedule II medications prescribed by a physician assistant with authority to prescribe delegated in a **[**~~supervision agreement~~**] collaborative practice arrangement** are restricted to only those medications containing hydrocodone. Physician assistants shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall

be limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the **[**~~supervising~~**] collaborating** physician. Physician assistants who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

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

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

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

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

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

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

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

2. The commission shall be appointed no later than October 1, 1996, and shall consist of five members, one member of the board, two licensed physician assistants, one physician and one lay member. The two licensed physician assistant members, the physician member and the lay member shall be appointed by the director of the division of professional registration. Each licensed physician assistant member shall be a citizen of the United States and a resident of this state, and shall be licensed as a physician assistant by this state. The physician member shall be a United States citizen, a resident of this state, have an active Missouri license to practice medicine in this state and shall be a **[**~~supervising~~**] collaborating** physician, at the time of appointment, to a licensed physician assistant. The lay member shall be a United States citizen and a resident of this state. The licensed physician assistant members shall be appointed to serve three-year terms, except that the first commission appointed shall consist of one member whose term shall be for one year and one member whose term shall be for two years. The physician member and lay member shall each be appointed to serve a three-year term. No physician assistant member nor the physician member shall be appointed for more than two consecutive three-year terms. The president of the Missouri Academy of Physicians Assistants in office at the time shall, at least ninety days prior to the expiration of a term of a physician assistant member of a commission member or as soon as feasible after such a vacancy on the commission otherwise occurs, submit to the director of the division of professional registration a list of five physician assistants qualified and willing to fill the vacancy in question, with the request and recommendation that the director appoint one of the five persons so listed, and with the list so submitted, the president of the Missouri Academy of Physicians Assistants shall include in his or her letter of transmittal a description of the method by which the names were chosen by that association.

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

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

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

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

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

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

(2) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid and void.

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

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

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

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

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

337.712. 1. Applications for licensure as a marital and family therapist shall be in writing, submitted to the committee on forms prescribed by the committee and furnished to the applicant. **The form shall include a statement that the applicant has completed two hours of suicide assessment, referral, treatment, and management training.** The application shall contain the applicant's statements showing the applicant's education, experience and such other information as the committee may require. Each application shall contain a statement that it is made under oath or affirmation and that the information contained therein is true and correct to the best knowledge and belief of the applicant, subject to the penalties provided for the making of a false affidavit or declaration. Each application shall be accompanied by the fees required by the division.

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

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

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

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

338.010. 1. The "practice of pharmacy" means the interpretation, implementation, and evaluation of medical prescription orders, including any legend drugs under 21 U.S.C. Section 353; receipt, transmission, or handling of such orders or facilitating the dispensing of such orders; the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by the prescription order so long as the prescription order is specific to each patient for care by a pharmacist; the compounding, dispensing, labeling, and administration of drugs and devices pursuant to medical prescription orders and administration of viral influenza, pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, and meningitis vaccines by written protocol authorized by a physician for persons at least seven years of age or the age recommended by the Centers for Disease Control and Prevention, whichever is higher, or the administration of pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, meningitis, and viral influenza vaccines by written protocol authorized by a physician for a specific patient as authorized by rule; the participation in drug selection according to state law and participation in drug utilization reviews; the proper and safe storage of drugs and devices and the maintenance of proper records thereof; consultation with patients and other health care practitioners, and veterinarians and their clients about legend drugs, about the safe and effective use of drugs and devices; **the prescribing and dispensing of any nicotine replacement therapy product under section 338.665;** and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management and control of a pharmacy. No person shall engage in the practice of pharmacy unless he **or she** is licensed under the provisions of this chapter. This chapter shall not be construed to prohibit the use of auxiliary personnel under the direct supervision of a pharmacist from assisting the pharmacist in any of his or her duties. This assistance in no way is intended to relieve the pharmacist from his or her responsibilities for compliance with this chapter and he or she will be responsible for the actions of the auxiliary personnel acting in his or her assistance. This chapter shall also not be construed to prohibit or interfere with any legally registered practitioner of medicine, dentistry, or podiatry, or veterinary medicine only for use in animals, or the practice of optometry in accordance with and as provided in sections 195.070 and 336.220 in the compounding, administering, prescribing, or dispensing of his or her own prescriptions.

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

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

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

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

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

7. The state board of registration for the healing arts, under section 334.125, and the state board of pharmacy, under section 338.140, shall jointly promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Such rules shall require protocols to include provisions allowing for timely communication between the pharmacist and the referring physician, and any other patient protection provisions deemed appropriate by both boards. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither board shall separately promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Any rule or portion of a rule, as that term is defined in section 536.010,

that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

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

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

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

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

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

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

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

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

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

(1) The identity of the patient;

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

(3) The route of administration;

(4) The anatomic site of the administration;

(5) The dose administered; and

(6) The date of administration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) Violation of any professional trust or confidence;

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

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

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

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

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

singly or in combination, censure, placing the licensee, registrant, or permittee named in the complaint on additional probation on such terms and conditions as the board deems appropriate, which additional probation shall not exceed five years, or suspension for a period not to exceed three years, or revocation of the license, certificate, or permit.

4. If the board concludes that a licensee or registrant has committed an act or is engaging in a course of conduct which would be grounds for disciplinary action which constitutes a clear and present danger to the public health and safety, the board may file a complaint before the administrative hearing commission requesting an expedited hearing and specifying the activities which give rise to the danger and the nature of the proposed restriction or suspension of the licensee's or registrant's license. Within fifteen days after service of the complaint on the licensee or registrant, the administrative hearing commission shall conduct a preliminary hearing to determine whether the alleged activities of the licensee or registrant appear to constitute a clear and present danger to the public health and safety which justify that the licensee's or registrant's license or registration be immediately restricted or suspended. The burden of proving that the actions of a licensee or registrant constitute a clear and present danger to the public health and safety shall be upon the state board of pharmacy. The administrative hearing commission shall issue its decision immediately after the hearing and shall either grant to the board the authority to suspend or restrict the license or dismiss the action.

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

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

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

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

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

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

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

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

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

6. Violations of this section are infractions.

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

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

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

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

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

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

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

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

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

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

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

4. The provisions of this subsection shall expire on August 28, 2023. The board shall provide a final report on approved projects and related data or findings to the general assembly on or before December 31, 2022. The name, location, approval dates, general description of and responsible pharmacist for an approved pilot or research project shall be deemed an open record.

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

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

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

4. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2019, shall be invalid and void.

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

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

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

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

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

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

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

(a) An agency of the federal government;

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

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

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

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

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

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

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

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

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

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

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

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

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

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

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

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

(5) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within one hundred twenty days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the final offer by each party. A claim for unanticipated out-of-network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for

purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with subdivisions (3) to (5) of this subsection.

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

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

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

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

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

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

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall be binding on all parties. The arbitrator shall provide a copy of the final decision to the director. The initial request for arbitration, all correspondence and documents received by the department and the final arbitration decision shall be considered a closed record under section 374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of section 536.010.

6. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare-allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

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

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

(2) The nature of the service provided;

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

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

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

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

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

~~10.~~**]** The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to procedural requirements for arbitration. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void.

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

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

(2) "Autism service provider":

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

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

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

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

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

(b) Manifests before the individual reaches age nineteen;

(c) Is likely to continue indefinitely; and

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

a. Self-care;

b. Understanding and use of language;

c. Learning;

d. Mobility;

e. Self-direction; or

f. Capacity for independent living;

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

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

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

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

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

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

[~~(10)~~**] (11)** "Psychiatric care", direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

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

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

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

(a) Psychiatric care;

(b) Psychological care;

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

(d) Therapeutic care;

(e) Pharmacy care.

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

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

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

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

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

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

[~~6.~~**] (2)** The maximum benefit limitation for applied behavior analysis described in **[**~~subsection 5~~**] subdivision (1)** of this **[**~~section~~**] subsection** shall be adjusted by the health carrier at least triennially for inflation to reflect the aggregate increase in the general price level as measured by the Consumer Price Index for All Urban Consumers for the United States, or its successor index, as defined and officially published by the United States Department of Labor, or its successor agency. Beginning January 1, 2012, and annually thereafter, the current value of the maximum benefit limitation for applied behavior analysis coverage adjusted for inflation in accordance with this subsection shall be calculated by the director of the department of insurance, financial institutions and professional registration. The director shall furnish the calculated value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021.

[~~7.~~**] (3)** Subject to the provisions set forth in subdivision (3) of subsection 4 of this section, coverage provided **for autism spectrum disorders** under this section shall not be subject to any limits on the number of visits an individual may make to an autism service provider, except that the maximum total benefit for applied behavior analysis set forth in **subdivision (1) of this** subsection **[**~~5 of this section~~**]** shall apply to this **[**~~subsection~~**] subdivision**.

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

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

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

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

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

Such payments or reimbursements under this subsection to an autism service provider or a board-certified behavior analyst shall include payments or reimbursements for services provided by a line therapist under the supervision of such provider or behavior analyst if such services provided by the line therapist are included in the treatment plan and are deemed medically necessary.

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

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

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

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

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

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

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

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

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

[~~15.~~**]** **13.** Any health carrier or other entity subject to the provisions of this section shall not be required to provide reimbursement for the applied behavior analysis delivered to a person insured by such health carrier or other entity to the extent such health carrier or other entity is billed for such services by any Part C early intervention program or any school district for applied behavior analysis rendered to the person covered by such health carrier or other entity. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education plan, or an individualized service plan. This section shall not be construed as affecting any obligation to provide reimbursement pursuant to section 376.1218.

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

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

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

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

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

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

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

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

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

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

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

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

376.1345. 1. As used in this section, unless the context clearly indicates otherwise, terms shall have the same meaning as ascribed to them in section 376.1350.

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

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

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

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

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

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

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

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

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

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

(1) "Adverse determination", a determination by a health carrier or **[**~~its designee~~**] a** utilization review **[**~~organization~~**] entity** that an admission, availability of care, continued stay or other health care service **furnished or proposed to be furnished to an enrollee** has been reviewed and, based upon the information provided, does not meet the **utilization review entity or** health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, **or are experimental or investigational,** and the payment for the requested service is therefore denied, reduced or terminated;

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

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

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

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

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

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

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

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

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

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

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

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

(b) Serious impairment to a bodily function;

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

(d) Inadequately controlled pain; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The United States Pharmacopoeia-Drug Information;

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

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

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

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

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

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

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within one working day of making the adverse determination.

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

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

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

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

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

6. A health carrier shall have written procedures to address the failure or inability of a provider or an enrollee to provide all necessary information for review. **These procedures shall be made available to health care providers on the health carrier's website or provider portal.** In cases where the provider or an enrollee will not release necessary information, the health carrier may deny certification of an admission, procedure or service.

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

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

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

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

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

4. No later than January 1, 2021, each health carrier utilizing prior authorization review shall develop a single secure electronic prior authorization cover page for all of its health benefit plans utilizing prior authorization review, which the carrier or its utilization review entity shall use to accept and respond to, and which providers shall use to submit, requests for prior authorization. Such cover page shall include, but not be limited to, fields for patient or enrollee information, referring or requesting provider information, rendering or attending provider information, and required clinical information, and shall be supplemented by additional clinical information as required by the health carrier or utilization review entity.

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

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

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

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

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

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

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

(1) Other enrollees; **and**

(2) Representatives of the health carrier that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance**[**~~; and~~**].**

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

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

630.175. 1. No person admitted on a voluntary or involuntary basis to any mental health facility or mental health program in which people are civilly detained pursuant to chapter 632 and no patient, resident or client of a residential facility or day program operated, funded or licensed by the department shall be subject to physical or chemical restraint, isolation or seclusion unless it is determined by the head of the facility, the attending licensed physician, or in the circumstances specifically set forth in this section, by an advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**~~supervision agreement~~**] collaborative practice arrangement**, with the attending licensed physician that the chosen intervention is imminently necessary to protect the health and safety of the patient, resident, client or others and that it provides the least restrictive environment. An advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**~~supervision agreement~~**] collaborative practice arrangement**, with the attending licensed physician may make a determination that the chosen intervention is necessary for patients, residents, or clients of facilities or programs operated by the department, in hospitals as defined in section 197.020 that only provide psychiatric care and in dedicated psychiatric units of general acute care hospitals as hospitals are defined in section 197.020. Any determination made by the advanced practice registered nurse, physician assistant, or assistant physician shall be documented as required in subsection 2 of this section and reviewed in person by the attending licensed physician if the episode of restraint is to extend beyond:

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

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

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

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

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

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

4. The use of security escort devices, including devices designed to restrict physical movement, which are used to maintain safety and security and to prevent escape during transport outside of a facility shall not be considered physical restraint within the meaning of this section. Individuals who have been civilly detained under sections 632.300 to 632.475 may be placed in security escort devices when transported outside of the facility if it is determined by the head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**~~supervision agreement~~**] collaborative practice arrangement**, with the attending licensed physician that the use of security escort devices is necessary to protect the health and safety of the patient, resident, client, or other persons or is necessary to prevent escape. Individuals who have been civilly detained under sections 632.480 to 632.513 or committed under chapter 552 shall be placed in security escort devices when transported outside of the facility

unless it is determined by the head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**~~supervision agreement~~**] collaborative practice arrangement**, with the attending licensed physician that security escort devices are not necessary to protect the health and safety of the patient, resident, client, or other persons or is not necessary to prevent escape.

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

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

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

630.875. 1. This section shall be known and may be cited as the "Improved Access to Treatment for Opioid Addictions Act" or "IATOA Act".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section B. Because immediate action is necessary to ensure vital health care services for Missouri citizens, the repeal and reenactment of section 208.930 of section A of this act is deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of section 208.930 of section A of this act shall be in full force and effect upon its passage and approval."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 099

Allred	Anderson	Andrews	Baker	Basye
Billington	Black 137	Black 7	Bondon	Bromley
Busick	Chipman	Christofanelli	Coleman 32	Coleman 97
Deaton	DeGroot	Dinkins	Dohrman	Eggleston
Evans	Falkner III	Fishel	Fitzwater	Francis
Gannon	Gregory	Grier	Griesheimer	Griffith
Haden	Haffner	Hannegan	Hansen	Helms
Henderson	Hicks	Houx	Hovis	Hudson
Hurst	Justus	Kelley 127	Kelly 141	Kidd
Knight	Kolkmeyer	Lovasco	Love	Lynch

Mayhew	McGirl	Moon	Morris 140	Morse 151
Muntzel	Murphy	Neely	O'Donnell	Patterson
Pfautsch	Pike	Plocher	Pogue	Pollitt 52
Pollock 123	Porter	Reedy	Rehder	Remole
Richey	Riggs	Roberts 161	Rone	Ross
Ruth	Schnelting	Schroer	Sharpe	Shaul 113
Shawan	Shields	Simmons	Smith	Solon
Sommer	Spencer	Stacy	Stephens 128	Swan
Tate	Taylor	Veit	Walsh	Wiemann
Wilson	Wood	Wright	Mr. Speaker	

NOES: 037

Appelbaum	Bangert	Baringer	Barnes	Beck
Bosley	Brown 27	Burnett	Burns	Butz
Carpenter	Chappelle-Nadal	Clemens	Ellebracht	Gray
Green	Ingle	Kendrick	Lavender	Mackey
McCreery	Merideth	Morgan	Mosley	Pierson Jr.
Proudie	Quade	Razer	Roberts 77	Rogers
Rowland	Sain	Sauls	Unsicker	Walker
Washington	Windham			

PRESENT: 000

ABSENT WITH LEAVE: 024

Bailey	Bland Manlove	Brown 70	Carter	Dogan
Ellington	Eslinger	Franks Jr.	Hill	McDaniel
McGaugh	Messenger	Miller	Mitten	Pietzman
Price	Toalson Reisch	Roden	Roeber	Runions
Shull 16	Stevens 46	Trent	Vescovo	

VACANCIES: 003

On motion of Representative Wood, **House Amendment No. 2** was adopted.

SB 514, as amended, was referred to the Committee on Fiscal Review pursuant to Rule 53.

BILLS CARRYING REQUEST MESSAGES

HCS SB 36, as amended, relating to real estate, was taken up by Representative Ross.

Representative Ross moved that the House refuse to recede from its position on **HCS SB 36, as amended**, and grant the Senate a conference.

Which motion was adopted.

HCS SB 54, as amended, relating to insurance companies, was taken up by Representative Muntzel.

Representative Muntzel moved that the House refuse to recede from its position on **HCS SB 54, as amended**, and grant the Senate a conference.

Which motion was adopted.

On motion of Representative Eggleston, the House recessed until 1:00 p.m.

AFTERNOON SESSION

The hour of recess having expired, the House was called to order by Speaker Haahr.

APPOINTMENT OF CONFERENCE COMMITTEES

The Speaker appointed the following Conference Committees to act with like committees from the Senate on the following bills:

HCS SB 36, as amended: Representatives Ross, Helms, Billington, Brown (27) and Lavender
HCS SB 54, as amended: Representatives Muntzel, Roden, Porter, Clemens and Chappelle-Nadal

COMMITTEE REPORTS

Committee on Fiscal Review, Chairman Houx reporting:

Mr. Speaker: Your Committee on Fiscal Review, to which was referred **SCS HCS HB 447, as amended**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (10): Anderson, Baringer, Burnett, Deaton, Gregory, Houx, Morgan, Walsh, Wiemann and Wood

Noes (0)

Absent (0)

Mr. Speaker: Your Committee on Fiscal Review, to which was returned **SS HCS#2 HB 499**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (10): Anderson, Baringer, Burnett, Deaton, Gregory, Houx, Morgan, Walsh, Wiemann and Wood

Noes (0)

Absent (0)

HOUSE BILLS WITH SENATE AMENDMENTS

SS HCS#2 HB 499, relating to transportation, was taken up by Representative Griesheimer.

Representative Griesheimer moved that the House refuse to adopt **SS HCS#2 HB 499** and request the Senate to recede from its position and, failing to do so, grant the House a conference.

Which motion was adopted.

BILLS IN CONFERENCE

CCR HCS SB 133, relating to agriculture, was taken up by Representative Shaul (113).

On motion of Representative Shaul (113), **CCR HCS SB 133** was adopted by the following vote:

AYES: 136

Anderson	Andrews	Appelbaum	Bailey	Baker
Bangert	Baringer	Barnes	Basye	Beck
Billington	Black 137	Black 7	Bland Manlove	Bondon
Bosley	Bromley	Brown 27	Burnett	Burns
Busick	Butz	Carpenter	Chappelle-Nadal	Chipman
Christofanelli	Clemens	Coleman 32	Coleman 97	Deaton
DeGroot	Dinkins	Dogan	Dohrman	Eggleston
Ellebracht	Evans	Falkner III	Fishel	Fitzwater
Francis	Franks Jr.	Gannon	Gray	Green
Gregory	Grier	Griffith	Haden	Haffner
Hannegan	Hansen	Helms	Henderson	Hicks
Hill	Houx	Hovis	Hudson	Justus
Kelley 127	Kelly 141	Kendrick	Kidd	Kolkmeyer
Lavender	Lovasco	Love	Lynch	Mackey
Mayhew	McCreery	McDaniel	McGirl	Merideth
Miller	Mitten	Morgan	Morris 140	Morse 151
Mosley	Murphy	Neely	O'Donnell	Patterson
Pfautsch	Pierson Jr.	Pike	Pollitt 52	Porter
Proudie	Quade	Razer	Reedy	Rehder
Toalson Reisch	Remole	Richey	Riggs	Roberts 161
Roberts 77	Roden	Rogers	Rone	Ross
Rowland	Runions	Ruth	Sain	Sauls
Schnelting	Schroer	Sharpe	Shaul 113	Shawan
Shields	Simmons	Smith	Solon	Sommer
Spencer	Stacy	Stephens 128	Stevens 46	Swan
Tate	Taylor	Trent	Unsicker	Vescovo
Walsh	Wiemann	Wilson	Wood	Wright
Mr. Speaker				

NOES: 003

Hurst	Moon	Pogue

PRESENT: 000

ABSENT WITH LEAVE: 021

Allred	Brown 70	Carter	Ellington	Eslinger
Griesheimer	Ingle	Knight	McGaugh	Messenger
Muntzel	Pietzman	Plocher	Pollock 123	Price
Roeber	Shull 16	Veit	Walker	Washington
Windham				

VACANCIES: 003

On motion of Representative Shaul (113), **CCS HCS SB 133** was truly agreed to and finally passed by the following vote:

AYES: 135

Anderson	Andrews	Appelbaum	Bailey	Baker
Bangert	Baringer	Barnes	Basye	Beck
Billington	Black 137	Black 7	Bland Manlove	Bondon
Bosley	Bromley	Brown 27	Burnett	Burns
Busick	Butz	Chappelle-Nadal	Chipman	Christofanelli
Clemens	Coleman 32	Coleman 97	Deaton	DeGroot
Dinkins	Dogan	Dohrman	Eggleston	Ellebracht
Evans	Falkner III	Fishel	Fitzwater	Francis
Franks Jr.	Gannon	Gray	Gregory	Griffith
Haden	Haffner	Hannegan	Hansen	Helms
Henderson	Hicks	Hill	Houx	Hovis
Hudson	Ingle	Justus	Kelley 127	Kelly 141
Kendrick	Kidd	Knight	Kolkmeyer	Lavender
Lovasco	Love	Lynch	Mackey	Mayhew
McCreery	McDaniel	McGirl	Merideth	Miller
Mitten	Morris 140	Morse 151	Mosley	Muntzel
Murphy	Neely	O'Donnell	Patterson	Pfautsch
Pierson Jr.	Pike	Pollitt 52	Pollock 123	Porter
Proudie	Quade	Reedy	Rehder	Toalson Reisch
Remole	Richey	Riggs	Roberts 161	Roberts 77
Roden	Rogers	Rone	Ross	Rowland
Runions	Ruth	Sain	Sauls	Schnelting
Schroer	Sharpe	Shaul 113	Shawan	Shields
Simmons	Smith	Solon	Sommer	Spencer
Stacy	Stevens 46	Swan	Tate	Taylor
Trent	Unsicker	Walsh	Washington	Wiemann
Wilson	Windham	Wood	Wright	Mr. Speaker

NOES: 004

Grier	Hurst	Moon	Pogue

PRESENT: 000

ABSENT WITH LEAVE: 021

Allred	Brown 70	Carpenter	Carter	Ellington
Eslinger	Green	Griesheimer	McGaugh	Messenger
Morgan	Pietzman	Plocher	Price	Razer
Roeber	Shull 16	Stephens 128	Veit	Vescovo
Walker				

VACANCIES: 003

Speaker Haahr declared the bill passed.

The emergency clause was adopted by the following vote:

AYES: 131

Anderson	Andrews	Appelbaum	Bailey	Baker
Bangert	Baringer	Barnes	Basye	Beck
Billington	Black 137	Black 7	Bondon	Bosley
Bromley	Brown 27	Burnett	Burns	Busick
Butz	Chappelle-Nadal	Chipman	Christofanelli	Clemens

Coleman 32	Coleman 97	Deaton	DeGroot	Dinkins
Dogan	Dohrman	Eggleston	Evans	Falkner III
Fishel	Fitzwater	Francis	Franks Jr.	Gannon
Gray	Green	Gregory	Grier	Griffith
Haden	Haffner	Hannegan	Hansen	Henderson
Hill	Houx	Hovis	Hudson	Ingle
Justus	Kelley 127	Kelly 141	Kendrick	Kidd
Knight	Kolkmeyer	Lavender	Lovasco	Love
Lynch	Mackey	Mayhew	McCreery	McGirl
Merideth	Miller	Morgan	Morris 140	Morse 151
Mosley	Muntzel	Murphy	Neely	O'Donnell
Patterson	Pfautsch	Pierson Jr.	Pike	Pollitt 52
Pollock 123	Porter	Proudie	Quade	Reedy
Rehder	Toalson Reisch	Remole	Richey	Riggs
Roberts 161	Roberts 77	Roden	Rogers	Rone
Ross	Rowland	Runions	Ruth	Sain
Sauls	Schnelting	Schroer	Sharpe	Shaul 113
Shawan	Shields	Simmons	Smith	Solon
Sommer	Spencer	Stacy	Stevens 46	Swan
Tate	Taylor	Trent	Unsicker	Walsh
Washington	Wiemann	Windham	Wood	Wright
Mr. Speaker				

NOES: 006

Bland Manlove	Hurst	McDaniel	Moon	Pogue
Wilson				

PRESENT: 000

ABSENT WITH LEAVE: 023

Allred	Brown 70	Carpenter	Carter	Ellebracht
Ellington	Eslinger	Griesheimer	Helms	Hicks
McGaugh	Messenger	Mitten	Pietzman	Plocher
Price	Razer	Roeber	Shull 16	Stephens 128
Veit	Vescovo	Walker		

VACANCIES: 003

THIRD READING OF SENATE BILLS - INFORMAL

SCS SB 330, relating to special license plates, was taken up by Representative Sharpe.

Representative Sharpe offered **House Amendment No. 1**.

House Amendment No. 1

AMEND Senate Committee Substitute for Senate Bill No. 330, Page 1, In the Title, Lines 2-3, by deleting the phrase "special license plates" and inserting in lieu thereof the word "utilities"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Sharpe, **House Amendment No. 1** was adopted.

Representative Hansen offered **House Amendment No. 2**.

House Amendment No. 2

AMEND Senate Committee Substitute for Senate Bill No. 330, Page 3, Section 301.3067, Line 37, by inserting after all of said section and line the following:

"523.262. 1. Except as set forth in subsection 2 of this section, the power of eminent domain shall only be vested in governmental bodies or agencies whose governing body is elected or whose governing body is appointed by elected officials or in an urban redevelopment corporation operating pursuant to a redevelopment agreement with the municipality for a particular redevelopment area, which agreement was executed prior to or on December 31, 2006.

2. A private utility company, public utility, rural electric cooperative, municipally owned utility, pipeline, railroad or common carrier shall have the power of eminent domain as may be granted pursuant to the provisions of other sections of the revised statutes of Missouri. For the purposes of this section, the term "common carrier" shall not include motor carriers, contract carriers, or express companies. Where a condemnation by such an entity results in a displaced person, as defined in section 523.200, the provisions of subsections 3 and 6 to 10 of section 523.205 shall apply unless the condemning entity is subject to the relocation assistance provisions of the federal Uniform Relocation Assistance Act.

3. Any entity with the power of eminent domain and pursuing the acquisition of property for the purpose of constructing a power generation facility after December 31, 2006, after providing notice in a newspaper of general circulation in the county where the facility is to be constructed, shall conduct a public meeting disclosing the purpose of the proposed facility prior to making any offer to purchase property in pursuit thereof or, alternatively, shall provide the property owner with notification of the identity of the condemning authority and the proposed purpose for which the condemned property shall be used at the time of making the initial offer.

4. (1) Private entities shall not have the power of eminent domain under the provisions of this section for the purposes of constructing above-ground merchant lines.

(2) For the purpose of this subsection, the following terms mean:

(a) "Merchant line", a high-voltage direct current electric transmission line that does not provide for the erection of electric substations at intervals of less than fifty miles, which substations are necessary to accommodate both the purchase and sale to persons located in this state of electricity generated or transmitted by the private entity; and

(b) "Private entity", a utility company that does not provide service to end-use customers, provide retail service in Missouri, or collect its costs to provide service under a regional transmission organization tariff, regardless of whether it has received a certificate of convenience and necessity from the public service commission under section 393.170."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Hansen, **House Amendment No. 2** was adopted.

Representative Knight offered **House Amendment No. 3**.

House Amendment No. 3

AMEND Senate Committee Substitute for Senate Bill No. 330, Page 3, Section 301.3067, Line 37, by inserting after said section and line the following:

"**569.086. 1. As used in this section, "critical infrastructure facility" means any of the following facilities that are under construction or operational: a petroleum or alumina refinery; critical electric infrastructure, as defined in 18 CFR Section 118.113(c)(3) including, but not limited to, an electrical power generating facility, substation, switching station, electrical control center, or electric power lines and associated equipment infrastructure; a chemical, polymer, or rubber manufacturing facility; a water intake structure, water storage facility, water treatment facility, wastewater treatment plant, wastewater pumping facility, or pump station; a natural gas compressor station; a liquid natural gas terminal or storage facility; a telecommunications central switching office; wireless telecommunications infrastructure, including cell**

towers, telephone poles and lines, including fiber optic lines; a port, railroad switching yard, railroad tracks, trucking terminal, or other freight transportation facility; a gas processing plant, including a plant used in the processing, treatment, or fractionation of natural gas or natural gas liquids; a transmission facility used by a federally licensed radio or television station; a steelmaking facility that uses an electric arc furnace to make steel; a facility identified and regulated by the United States Department of Homeland Security Chemical Facility Anti-Terrorism Standards (CFATS) program; a dam that is regulated by the state or federal government; a natural gas distribution utility facility including, but not limited to, natural gas distribution and transmission mains and services, pipeline interconnections, a city gate or town border station, metering station, aboveground piping, a regulator station, and a natural gas storage facility; a crude oil or refined products storage and distribution facility including, but not limited to, valve sites, pipeline interconnection, pump station, metering station, below or aboveground pipeline or piping and truck loading or offloading facility, a grain mill or processing facility; a generation, transmission, or distribution system of broadband internet access; or any aboveground portion of an oil, gas, hazardous liquid or chemical pipeline, tank, railroad facility, or other storage facility that is enclosed by a fence, other physical barrier, or is clearly marked with signs prohibiting trespassing, that are obviously designed to exclude intruders.

2. A person commits the offense of trespass on a critical infrastructure facility if he or she purposely trespasses or enters property containing a critical infrastructure facility without the permission of the owner of the property or lawful occupant thereof. The offense of trespass on a critical infrastructure facility is a class B misdemeanor. If it is determined that the intent of the trespasser is to damage, destroy, vandalize, deface, tamper with equipment, or impede or inhibit operations of the facility, the person shall be guilty of a class A misdemeanor.

3. A person commits the offense of damage of a critical infrastructure facility if he or she purposely damages, destroys, or tampers with equipment in a critical infrastructure facility. The offense of damage of a critical infrastructure facility is a class D felony.

4. If an organization is found to be a conspirator with persons who are found to have committed any of the offenses set forth in subsection 2 or 3 of this section, the conspiring organization shall be punished by a fine that is ten times the amount of the fine attached to the offense set forth in subsection 2 or 3 of this section.

5. This section shall not apply to conduct protected under the Constitution of the United States, the Constitution of the state of Missouri, or a state or federal law or rule."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Ingle offered **House Amendment No. 1 to House Amendment No. 3**.

House Amendment No. 1
to
House Amendment No. 3

AMEND House Amendment No. 3 to Senate Committee Substitute for Senate Bill No. 330, Page 2, Lines 2-5, by deleting said lines; and

Further amend said amendment and page, Line 6, by deleting the number "**5.**" and inserting in lieu thereof the number "**4.**"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 095

Allred	Anderson	Andrews	Bailey	Baker
Basye	Billington	Black 137	Black 7	Bromley
Busick	Coleman 32	Coleman 97	Deaton	DeGroot

Dinkins	Dogan	Dohrman	Eggleston	Falkner III
Fishel	Fitzwater	Gannon	Gregory	Grier
Griesheimer	Haden	Haffner	Hannegan	Hansen
Helms	Henderson	Hill	Houx	Hovis
Hudson	Hurst	Justus	Kelley 127	Kelly 141
Kidd	Knight	Kolkmeyer	Lovasco	Love
Lynch	Mayhew	McGirl	Miller	Moon
Morris 140	Morse 151	Muntzel	Neely	O'Donnell
Patterson	Pietzman	Pike	Plocher	Pogue
Pollitt 52	Pollock 123	Porter	Reedy	Rehder
Toalson Reisch	Remole	Richey	Riggs	Roberts 161
Roden	Rone	Ross	Ruth	Schnelting
Sharpe	Shaul 113	Shawan	Shields	Simmons
Smith	Solon	Sommer	Spencer	Stacy
Swan	Tate	Taylor	Vescovo	Walsh
Wiemann	Wilson	Wood	Wright	Mr. Speaker

NOES: 042

Appelbaum	Bangert	Baringer	Barnes	Beck
Bland Manlove	Bosley	Brown 27	Burnett	Burns
Butz	Carpenter	Chappelle-Nadal	Clemens	Ellebracht
Franks Jr.	Gray	Green	Ingle	Kendrick
Lavender	Mackey	McCreery	McDaniel	Merideth
Mitten	Morgan	Mosley	Pierson Jr.	Proudie
Quade	Razer	Roberts 77	Rogers	Runions
Sain	Sauls	Stevens 46	Unsicker	Walker
Washington	Windham			

PRESENT: 000

ABSENT WITH LEAVE: 023

Bondon	Brown 70	Carter	Chipman	Christofanelli
Ellington	Eslinger	Evans	Francis	Griffith
Hicks	McGaugh	Messenger	Murphy	Pfautsch
Price	Roeber	Rowland	Schroer	Shull 16
Stephens 128	Trent	Veit		

VACANCIES: 003

Representative Ingle moved that **House Amendment No. 1 to House Amendment No. 3** be adopted.

Which motion was defeated by the following vote, the ayes and noes having been demanded by Representative Ingle:

AYES: 043

Appelbaum	Bangert	Baringer	Barnes	Beck
Bland Manlove	Bosley	Brown 27	Burnett	Burns
Butz	Chappelle-Nadal	Clemens	Ellebracht	Franks Jr.
Gray	Green	Ingle	Kendrick	Lavender
Lovasco	Mackey	McCreery	McDaniel	Merideth
Mitten	Morgan	Mosley	Pierson Jr.	Proudie
Quade	Razer	Roberts 77	Rogers	Rowland
Runions	Sain	Sauls	Stevens 46	Unsicker
Walker	Washington	Windham		

NOES: 098

Allred	Anderson	Andrews	Bailey	Baker
Basye	Billington	Black 137	Black 7	Bromley
Busick	Coleman 32	Coleman 97	Deaton	DeGroot
Dinkins	Dogan	Dohrman	Eggleston	Evans
Falkner III	Fishel	Fitzwater	Gannon	Gregory
Grier	Griesheimer	Griffith	Haden	Haffner
Hannegan	Hansen	Helms	Henderson	Hill
Houx	Hovis	Hudson	Hurst	Justus
Kelley 127	Kelly 141	Kidd	Knight	Kolkmeyer
Love	Lynch	Mayhew	McGirl	Miller
Moon	Morris 140	Morse 151	Muntzel	Neely
O'Donnell	Patterson	Pietzman	Pike	Plocher
Pogue	Pollitt 52	Pollock 123	Porter	Reedy
Rehder	Toalson Reisch	Remole	Richey	Riggs
Roberts 161	Roden	Rone	Ross	Ruth
Schnelting	Sharpe	Shaul 113	Shawan	Shields
Simmons	Smith	Solon	Sommer	Spencer
Stacy	Stephens 128	Swan	Tate	Taylor
Veit	Vescovo	Walsh	Wiemann	Wilson
Wood	Wright	Mr. Speaker		

PRESENT: 000

ABSENT WITH LEAVE: 019

Bondon	Brown 70	Carpenter	Carter	Chipman
Christofanelli	Ellington	Eslinger	Francis	Hicks
McGaugh	Messenger	Murphy	Pfautsch	Price
Roeber	Schroer	Shull 16	Trent	

VACANCIES: 003

Representative Roden offered **House Amendment No. 2 to House Amendment No. 3**.

House Amendment No. 2
to
House Amendment No. 3

AMEND House Amendment No. 3 to Senate Committee Substitute for Senate Bill No. 330, Page 1, Line 1, by inserting after the number "330," the following:

"Page 1, Section A, Line 2, by inserting after said section and line the following:

"247.200. **1.** The district shall have the right to lay its mains in public highways, roads, streets and alleys included in the district, but the same shall be done under reasonable rules and regulations of governmental bodies having jurisdiction of such public places. This shall apply to maintenance and repair jobs. In the construction of ditches, laying of mains, filling of ditches after mains are laid, connection of service pipes and repairing of lines, due regard must be taken of the rights of the public in its use of thoroughfares and the equal rights of other utilities thereto.

2. No district shall require a secondary deposit from commercial property owners. For the purposes of this subsection, a commercial property is a property that is zoned for commercial use by the zoning authority that has jurisdiction over the property.

3. If a water meter has been removed from a property or if services to a property have been discontinued, no future charges may be made to the customer for service to that property.

247.285. 1. No metropolitan water supply district shall require a secondary deposit from commercial property owners. For the purposes of this subsection, a commercial property is a property that is zoned for commercial use by the zoning authority that has jurisdiction over the property.

2. If a water meter has been removed from a property or if services to a property have been discontinued, no future charges shall be made to the customer for service to that property. Any charges made after service is discontinued or the water meter is removed shall be credited to the customer and applied toward any future charges to such customer by the metropolitan water supply district."; and

Further amend said bill,"; and

Further amend said amendment and page, Line 27, by deleting the word "**storage**" and inserting in lieu thereof the words "**critical infrastructure**"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Ross assumed the Chair.

On motion of Representative Roden, **House Amendment No. 2 to House Amendment No. 3** was adopted.

Representative Kidd offered **House Amendment No. 3 to House Amendment No. 3**.

House Amendment No. 3
to
House Amendment No. 3

AMEND House Amendment No. 3 to Senate Committee Substitute for Senate Bill No. 330, Page 1, Line 4, by inserting before the number "**569.086.**" the following:

"386.135. 1. The commission shall have an independent technical advisory staff of up to six full-time employees. The advisory staff shall have expertise in accounting, economics, finance, engineering/utility operations, law, or public policy.

2. In addition, each commissioner shall also have the authority to retain one personal advisor, who shall be deemed a member of the technical advisory staff. The personal advisors will serve at the pleasure of the individual commissioner whom they serve and shall possess expertise in one or more of the following fields: accounting, economics, finance, engineering/utility operations, law, or public policy.

3. The commission shall only hire technical advisory staff pursuant to subsections 1 and 2 of this section if there is a corresponding elimination in comparable staff positions for commission staff to offset the hiring of such technical advisory staff on a cost-neutral basis. **[**~~Such technical advisory staff shall be hired on or before July 1, 2005.~~**]**

4. It shall be the duty of the technical advisory staff to render advice and assistance to the commissioners and the commission's administrative law judges on technical matters within their respective areas of expertise that may arise during the course of proceedings before the commission.

5. The technical advisory staff shall also update the commission and the commission's administrative law judges periodically on developments and trends in public utility regulation, including updates comparing the use, nature, and effect of various regulatory practices and procedures as employed by the commission and public utility commissions in other jurisdictions.

6. Each member of the technical advisory staff shall be subject to any applicable ex parte or conflict of interest requirements in the same manner and to the same degree as any commissioner, provided that neither any person regulated by, appearing before, or employed by the commission shall be permitted to offer such member a different appointment or position during that member's tenure on the technical advisory staff.

7. No employee of a company or corporation regulated by the public service commission, no employee of the office of public counsel or the public counsel, and no staff members of either the utility operations division or utility services division who were an employee or staff member on, during the two years immediately preceding, or anytime after August 28, 2003, may be a member of the commission's technical advisory staff for two years following the termination of their employment with the corporation, office of public counsel or commission staff member.

8. The technical advisory staff shall never be a party to any case before the commission."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 102

Allred	Anderson	Andrews	Bailey	Baker
Basye	Billington	Black 137	Black 7	Bromley
Busick	Chipman	Christofanelli	Coleman 32	Coleman 97
Deaton	DeGroot	Dinkins	Dogan	Dohrman
Eggleston	Evans	Falkner III	Fishel	Fitzwater
Gannon	Gregory	Grier	Griesheimer	Griffith
Haden	Haffner	Hannegan	Hansen	Helms
Henderson	Hicks	Hill	Houx	Hovis
Hudson	Hurst	Justus	Kelley 127	Kelly 141
Kidd	Knight	Kolkmeyer	Lovasco	Love
Lynch	Mayhew	McGirl	Miller	Moon
Morris 140	Morse 151	Muntzel	Neely	O'Donnell
Patterson	Pfautsch	Pietzman	Pike	Plocher
Pogue	Pollitt 52	Pollock 123	Porter	Reedy
Rehder	Toalson Reisch	Remole	Richey	Riggs
Roberts 161	Roden	Rone	Ross	Ruth
Schnelting	Sharpe	Shaul 113	Shawan	Shields
Simmons	Smith	Solon	Sommer	Spencer
Stacy	Swan	Tate	Taylor	Trent
Veit	Vescovo	Walsh	Wiemann	Wilson
Wright	Mr. Speaker			

NOES: 042

Appelbaum	Bangert	Baringer	Barnes	Beck
Bland Manlove	Brown 27	Burnett	Burns	Butz
Carpenter	Chappelle-Nadal	Clemens	Ellebracht	Ellington
Franks Jr.	Gray	Green	Ingle	Kendrick
Lavender	Mackey	McCreery	McDaniel	Merideth
Mitten	Morgan	Mosley	Pierson Jr.	Proudie
Quade	Razer	Roberts 77	Rogers	Rowland
Runions	Sain	Sauls	Stevens 46	Unsicker
Walker	Windham			

PRESENT: 000

ABSENT WITH LEAVE: 016

Bondon	Bosley	Brown 70	Carter	Eslinger
Francis	McGaugh	Messenger	Murphy	Price
Roeber	Schroer	Shull 16	Stephens 128	Washington
Wood				

VACANCIES: 003

On motion of Representative Kidd, **House Amendment No. 3 to House Amendment No. 3** was adopted.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 101

Allred	Anderson	Andrews	Bailey	Baker
Basye	Billington	Black 137	Black 7	Bromley
Busick	Chipman	Christofanelli	Coleman 32	Coleman 97
Deaton	DeGroot	Dinkins	Dogan	Dohrman
Eggleston	Evans	Falkner III	Fishel	Fitzwater
Gannon	Gregory	Grier	Griesheimer	Griffith
Haden	Haffner	Hannegan	Hansen	Helms
Henderson	Hicks	Hill	Houx	Hovis
Hudson	Hurst	Justus	Kelley 127	Kelly 141
Kidd	Knight	Kolkmeyer	Lovasco	Love
Mayhew	McGirl	Miller	Moon	Morris 140
Morse 151	Muntzel	Neely	O'Donnell	Patterson
Pfautsch	Pietzman	Pike	Plocher	Pogue
Pollitt 52	Pollock 123	Porter	Reedy	Rehder
Toalson Reisch	Remole	Richey	Riggs	Roberts 161
Roden	Rone	Ross	Ruth	Schnelting
Sharpe	Shaul 113	Shawan	Shields	Simmons
Smith	Solon	Sommer	Spencer	Stacy
Swan	Tate	Taylor	Trent	Veit
Vescovo	Walsh	Wiemann	Wilson	Wright
Mr. Speaker				

NOES: 042

Appelbaum	Bangert	Baringer	Barnes	Beck
Bland Manlove	Brown 27	Burnett	Burns	Butz
Carpenter	Chappelle-Nadal	Clemens	Ellebracht	Ellington
Franks Jr.	Gray	Green	Ingle	Kendrick
Lavender	Mackey	McCreery	McDaniel	Merideth
Mitten	Morgan	Mosley	Pierson Jr.	Proudie
Quade	Razer	Roberts 77	Rogers	Rowland
Runions	Sain	Stevens 46	Unsicker	Walker
Washington	Windham			

PRESENT: 000

ABSENT WITH LEAVE: 017

Bondon	Bosley	Brown 70	Carter	Eslinger
Francis	Lynch	McGaugh	Messenger	Murphy
Price	Roeber	Sauls	Schroer	Shull 16
Stephens 128	Wood			

VACANCIES: 003

On motion of Representative Knight, **House Amendment No. 3, as amended**, was adopted.

Representative Black (137) offered **House Amendment No. 4**.

House Amendment No. 4

AMEND Senate Committee Substitute for Senate Bill No. 330, Page 3, Section 301.3067, Line 37, by inserting after all of said section and line the following:

"537.340. 1. If any person shall cut down, injure or destroy or carry away any tree placed or growing for use, shade or ornament, or any timber, rails or wood standing, being or growing on the land of any other person, including any governmental entity, or shall dig up, quarry or carry away any stones, ore or mineral, gravel, clay or mold, or any ice or other substance or material being a part of the realty, or any roots, fruits or plants, or cut down or carry away grass, grain, corn, flax or hemp in which such person has no interest or right, standing, lying or being on land not such person's own, or shall knowingly break the glass or any part of it in any building not such person's own, the person so offending shall pay to the party injured treble the value of the things so injured, broken, destroyed or carried away, with costs. Any person filing a claim for damages pursuant to this section need not prove negligence or intent.

2. Notwithstanding the provisions of subsection 1 of this section, the following rules shall apply to the trimming, removing, and controlling of trees and other vegetation by any electric supplier:

(1) Every electric supplier that operates electric transmission or distribution lines shall have the authority to maintain the same by trimming, removing, and controlling trees and other vegetation posing a hazard to the continued safe and reliable operation thereof;

(2) An electric supplier may exercise its authority under subdivision (1) of this subsection if the trees and other vegetation are within the legal description of any recorded easement or, in the absence of a recorded easement, the following:

(a) Within ten feet, plus one-half the length of any attached cross arm, of either side of the centerline of electricity lines potentially energized at or below 34.5 kilovolts measured line to line and located within the limits of any city; or

(b) Within thirty feet of either side of the centerline of electricity lines potentially energized at or below 34.5 kilovolts measured line to line and located outside the limits of any city; or

(c) Within fifty feet of either side of the centerline of electricity lines potentially energized between 34.5 and one hundred kilovolts measured line to line; or

(d) Within the greater of the following for any electricity lines potentially energized at one hundred kilovolts or more measured line to line:

a. Seventy-five feet to either side of the centerline; or

b. Any required clearance distance adopted by either the Federal Energy Regulatory Commission or an Electric Reliability Organization authorized by the Energy Policy Act of 2005, 16 U.S.C. Section 824o. Such exercise shall be considered reasonable and necessary for the proper and reliable operation of electric service and shall create a rebuttable presumption, in claims for property damage, that the electric supplier acted with reasonable care, operated within its rights regarding the operation and maintenance of its electricity lines, and has not committed a trespass;

(3) An electric supplier may trim, remove, and control trees and other vegetation outside the provisions in subdivision (2) of this subsection if such actions are necessary to maintain the continued safe and reliable operation of its electric lines;

(4) An electric supplier may secure from the owner or occupier of land greater authority to trim, remove, and control trees and other vegetation than the provisions set forth in subdivision (2) of this subsection and may exercise any and all rights regarding the trimming, removing, and controlling of trees and other vegetation granted in any easement held by the electric supplier;

(5) An electric supplier may trim or remove any tree of sufficient height outside the provisions of subdivision (2) of this subsection when such tree, if it were to fall, would threaten the integrity and safety of any electric transmission or distribution line and would pose a hazard to the continued safe and reliable operation thereof;

(6) Prior to the removal of any tree under the provisions of subdivision (5) of this subsection, an electric supplier shall notify the owner or occupier of land, if available, at least fourteen days prior to such removal unless either the electric supplier deems the removal to be immediately necessary to continue the safe and reliable

operation of its electricity lines, or the electric supplier is trimming or removing trees and other vegetation following a major weather event or other emergency situation;

(7) If any tree which is partially trimmed by an electric supplier dies within three months as a result of said trimming, the owner or occupier of land upon which the tree was trimmed may request in writing that the electric supplier remove said tree at the electric supplier's expense. The electric supplier shall respond to such request within ninety days;

(8) Nothing in this subsection shall be interpreted as requiring any electric supplier to fully exercise the authorities granted in this subsection.

3. For purposes of this section, the term "electric supplier" means any rural electric cooperative that is subject to the provisions of chapter 394**[**~~, and~~**];** any electrical corporation which is required by its bylaws to operate on the not-for-profit cooperative business plan, with its consumers who receive service as the stockholders of such corporation, and which holds a certificate of public convenience and necessity to serve a majority of its customer-owners in counties of the third classification as of August 28, 2003**; any municipally owned or operated electric power system that is subject to the provisions of chapter 91; and any municipally owned utility whose service area is set by state statute, service agreement, or other authority to include areas which are not incorporated into city limits**."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Miller offered **House Amendment No. 1 to House Amendment No. 4**.

House Amendment No. 1
to
House Amendment No. 4

AMEND House Amendment No. 4 to Senate Committee Substitute for Senate Bill No. 330, Page 1, Line 4, by inserting before the number "537.340." the following:

"393.1009. As used in sections 393.1009 to 393.1015, the following terms mean:

(1) "Appropriate pretax revenues", the revenues necessary to produce net operating income equal to:

(a) The gas corporation's weighted cost of capital multiplied by the net original cost of eligible infrastructure system replacements, including recognition of accumulated deferred income taxes and accumulated depreciation associated with eligible infrastructure system replacements which are included in a currently effective ISRS; and

(b) Recover state, federal, and local income or excise taxes applicable to such income; and

(c) Recover all other ISRS costs;

(2) "Commission", the Missouri public service commission;

(3) "Eligible infrastructure system replacements", gas utility plant projects that:

(a) Do not increase revenues by directly connecting the infrastructure replacement to new customers;

(b) Are in service and used and useful;

(c) Were not included in the gas corporation's rate base in its most recent general rate case; and

(d) Replace or extend the useful life of an existing infrastructure;

(4) "Gas corporation", every corporation, company, association, joint stock company or association, partnership and person, their lessees, trustees or receivers appointed by any court whatsoever, owning, operating, controlling, or managing any gas plant operating for public use under privilege, license, or franchise now or hereafter granted by the state or any political subdivision, county, or municipality thereof as defined in section 386.020;

(5) "Gas utility plant projects" may consist only of the following:

(a) Mains, valves, service lines, regulator stations, vaults, and other pipeline system components installed to comply with state or federal safety requirements as replacements for existing facilities that have worn out or are in deteriorated condition **and such replacement of connected or associated facilities, when done as part of a qualifying replacement project and that adds no incremental cost to a project compared to tying into or reusing existing facilities**;

(b) Main relining projects, service line insertion projects, joint encapsulation projects, and other similar projects extending the useful life or enhancing the integrity of pipeline system components undertaken to comply with state or federal safety requirements; and

(c) Facilities relocations required due to construction or improvement of a highway, road, street, public way, or other public work by or on behalf of the United States, this state, a political subdivision of this state, or another entity having the power of eminent domain provided that the costs related to such projects have not been reimbursed to the gas corporation;

(6) "ISRS", infrastructure system replacement surcharge;

(7) "ISRS costs", depreciation expense and property taxes that will be due within twelve months of the ISRS filing;

(8) "ISRS revenues", revenues produced through an ISRS exclusive of revenues from all other rates and charges."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

House Amendment No. 1 to House Amendment No. 4 was withdrawn.

On motion of Representative Black (137), **House Amendment No. 4** was adopted.

Representative McCreery offered **House Amendment No. 5**.

House Amendment No. 5

AMEND Senate Committee Substitute for Senate Bill No. 330, Page 1, Section A, Line 2, by inserting after all of said section and line the following:

"249.422. 1. If approved by a majority of the voters voting on the proposal, any city, town, village or county on behalf of the unincorporated area, located either within the boundaries of a sewer district established pursuant to Article VI, Section 30(a) of the Missouri Constitution or within any county of the first classification having a charter form of government with a population of more than two hundred ten thousand inhabitants but less than three hundred thousand inhabitants, may by city, town, village or county ordinance levy and impose annually for the repair of lateral sewer service lines on or connecting residential property having six or less dwelling units a fee not to exceed fifty dollars per year. Any city, town, village, or county that establishes or increases the fee used to repair any portion of the lateral sewer service line shall include all defective portions of the lateral sewer service line from the residential structure to its connection with the public sewer system line. Notwithstanding any provision of chapter 448, the fee imposed pursuant to this chapter shall be imposed upon condominiums that have six or less condominium units per building and each condominium unit shall be responsible for its proportionate share of any fee charged pursuant to this chapter**[**~~, and~~**]**.** In addition, any condominium unit shall, if determined to be responsible for and served by its own individual lateral sewer line **and notified of the determination in writing each time a notification of change of assessment is sent to the property owner under section 137.180**, be treated as an individual residence regardless of the number of units in the development. It shall be the responsibility of the condominium owner or condominium association who are of the opinion that they are not properly classified as provided in this section to notify the county **or municipal** office administering the program. Where an existing sewer lateral program was in effect prior to August 28, 2003, condominium and apartment units not previously enrolled may be ineligible for enrollment if it is determined that the sewer lateral serving the unit is defective.

2. The question shall be submitted in substantially the following form:

Shall a maximum charge not to exceed fifty dollars be assessed annually on residential property for each lateral sewer service line serving six or less dwelling units on that property and condominiums that have six or less condominium units per building and any condominium responsible for its own individual lateral sewer line to provide funds to pay the cost of certain repairs of those lateral sewer service lines which may be billed quarterly or annually?

☐ YES ☐ NO

3. If a majority of the voters voting thereon approve the proposal provided for in subsection 2 of this section, the governing body of the city, town, village or county may enact an ordinance for the collection and administration of such fee in order to protect the public health, welfare, peace and safety. The funds collected pursuant to such ordinance shall be deposited in a special account to be used solely for the purpose of paying for all

or a portion of the costs reasonably associated with and necessary to administer and carry out the defective lateral sewer service line repairs. All interest generated on deposited funds shall be accrued to the special account established for the repair of lateral sewer service lines.

4. Fee payments that are authorized by this section shall be exempt from the requirements of section 139.031, and class action challenges are authorized, including challenges under Article X, Sections 22 and 23 of the Constitution of Missouri, as well as other measures approved by law."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 098

Allred	Anderson	Andrews	Bailey	Baker
Basye	Billington	Black 137	Black 7	Bondon
Bromley	Busick	Chipman	Christofanelli	Coleman 32
Coleman 97	Deaton	DeGroot	Dinkins	Eggleston
Evans	Falkner III	Fishel	Francis	Gannon
Gregory	Grier	Griesheimer	Griffith	Haden
Hannegan	Hansen	Helms	Henderson	Hicks
Hill	Hovis	Hudson	Hurst	Justus
Kelley 127	Kelly 141	Kidd	Knight	Kolkmeyer
Lovasco	Love	Lynch	Mayhew	McGirl
Miller	Moon	Morris 140	Morse 151	Muntzel
Murphy	Neely	O'Donnell	Patterson	Pfautsch
Pietzman	Pike	Plocher	Pogue	Pollitt 52
Pollock 123	Reedy	Rehder	Toalson Reisch	Remole
Richey	Riggs	Roberts 161	Roden	Rone
Ross	Ruth	Sharpe	Shaul 113	Shawan
Shields	Simmons	Solon	Sommer	Spencer
Stacy	Stephens 128	Swan	Tate	Taylor
Trent	Veit	Walsh	Wiemann	Wilson
Wood	Wright	Mr. Speaker		

NOES: 038

Appelbaum	Bangert	Baringer	Barnes	Beck
Bland Manlove	Bosley	Brown 27	Burnett	Burns
Butz	Carpenter	Clemens	Ellebracht	Ellington
Franks Jr.	Ingle	Kendrick	Lavender	Mackey
McCreery	Merideth	Mitten	Morgan	Mosley
Pierson Jr.	Proudie	Quade	Roberts 77	Rogers
Rowland	Runions	Sain	Sauls	Stevens 46
Unsicker	Walker	Windham		

PRESENT: 000

ABSENT WITH LEAVE: 024

Brown 70	Carter	Chappelle-Nadal	Dogan	Dohrman
Eslinger	Fitzwater	Gray	Green	Haffner
Houx	McDaniel	McGaugh	Messenger	Porter
Price	Razer	Roeber	Schnelting	Schroer
Shull 16	Smith	Vescovo	Washington	

VACANCIES: 003

Representative McCreery moved that **House Amendment No. 5** be adopted.

Which motion was defeated.

On motion of Representative Sharpe, **SCS SB 330, as amended**, was read the third time and passed by the following vote:

AYES: 103

Allred	Anderson	Andrews	Bailey	Baker
Basye	Billington	Black 137	Black 7	Bondon
Bromley	Brown 27	Busick	Chipman	Christofanelli
Coleman 32	Coleman 97	Deaton	DeGroot	Dinkins
Dogan	Dohrman	Eggleston	Ellebracht	Evans
Falkner III	Fishel	Francis	Gannon	Gregory
Grier	Griesheimer	Griffith	Haden	Hannegan
Hansen	Helms	Henderson	Hicks	Hill
Houx	Hovis	Hudson	Justus	Kelley 127
Kelly 141	Kidd	Knight	Kolkmeyer	Lovasco
Love	Lynch	Mayhew	McDaniel	McGirl
Miller	Morris 140	Morse 151	Muntzel	Murphy
Neely	O'Donnell	Patterson	Pfautsch	Pietzman
Pike	Plocher	Pollitt 52	Pollock 123	Reedy
Rehder	Toalson Reisch	Remole	Richey	Riggs
Roberts 161	Roden	Rone	Ross	Rowland
Runions	Ruth	Schnelting	Schroer	Sharpe
Shaul 113	Shawan	Shields	Simmons	Solon
Sommer	Spencer	Stephens 128	Swan	Tate
Trent	Veit	Walsh	Wiemann	Wilson
Wood	Wright	Mr. Speaker		

NOES: 043

Appelbaum	Bangert	Baringer	Barnes	Beck
Bland Manlove	Bosley	Burnett	Burns	Butz
Carpenter	Clemens	Ellington	Franks Jr.	Gray
Green	Hurst	Ingle	Kendrick	Lavender
Mackey	McCreery	Merideth	Mitten	Moon
Morgan	Mosley	Pierson Jr.	Pogue	Price
Proudie	Quade	Razer	Roberts 77	Rogers
Sain	Sauls	Stacy	Stevens 46	Taylor
Unsicker	Walker	Windham		

PRESENT: 000

ABSENT WITH LEAVE: 014

Brown 70	Carter	Chappelle-Nadal	Eslinger	Fitzwater
Haffner	McGaugh	Messenger	Porter	Roeber
Shull 16	Smith	Vescovo	Washington	

VACANCIES: 003

Representative Ross declared the bill passed.

Representative Plocher assumed the Chair.

SB 358, relating to the health professional student loan repayment program, was taken up by Representative Swan.

Representative Swan moved that the title of **SB 358** be agreed to.

Representative Patterson offered **House Amendment No. 1**.

House Amendment No. 1

AMEND Senate Bill No. 358, Page 1, In the Title, Lines 3-4, by deleting the words "the health professional student loan repayment program" and inserting in lieu thereof the words "health care"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Patterson, **House Amendment No. 1** was adopted.

Representative Swan offered **House Amendment No. 2**.

House Amendment No. 2

AMEND Senate Bill No. 358, Page 2, Section 191.605, Line 16, by inserting after said section and line the following:

"192.067. 1. The department of health and senior services, for purposes of conducting epidemiological studies to be used in promoting and safeguarding the health of the citizens of Missouri under the authority of this chapter is authorized to receive information from patient medical records. The provisions of this section shall also apply to the collection, analysis, and disclosure of nosocomial infection data from patient records collected pursuant to section 192.667 **and to the collection of data under section 192.990**.

2. The department shall maintain the confidentiality of all medical record information abstracted by or reported to the department. Medical information secured pursuant to the provisions of subsection 1 of this section may be released by the department only in a statistical aggregate form that precludes and prevents the identification of patient, physician, or medical facility except that medical information may be shared with other public health authorities and coinvestigators of a health study if they abide by the same confidentiality restrictions required of the department of health and senior services and except as otherwise authorized by the provisions of sections 192.665 to 192.667**, or section 192.990**. The department of health and senior services, public health authorities and coinvestigators shall use the information collected only for the purposes provided for in this section **[**~~and~~**],** section 192.667**, or section 192.990**.

3. No individual or organization providing information to the department in accordance with this section shall be deemed to be or be held liable, either civilly or criminally, for divulging confidential information unless such individual organization acted in bad faith or with malicious purpose.

4. The department of health and senior services is authorized to reimburse medical care facilities, within the limits of appropriations made for that purpose, for the costs associated with abstracting data for special studies.

5. Any department of health and senior services employee, public health authority or coinvestigator of a study who knowingly releases information which violates the provisions of this section shall be guilty of a class A misdemeanor and, upon conviction, shall be punished as provided by law.

192.385. 1. There is hereby established in the department of health and senior services the "Senior Services Growth and Development Program" to provide additional funding for senior services provided through the area agencies on aging in this state.

2. Beginning January 1, 2020, two and one-half percent, and beginning January 1, 2021, and each year thereafter, five percent of the premium tax collected under sections 148.320 and 148.370, excluding any moneys to be transferred to the state school moneys fund as described in section 148.360, shall be deposited in the fund created in subsection 3 of this section.

3. (1) There is hereby created in the state treasury the "Senior Services Growth and Development Program Fund", which shall consist of moneys collected under this section. The director of the department of revenue shall collect the moneys described in subsection 2 of this section and shall remit such moneys to the state treasurer for deposit in the fund, less one percent for the cost of collection. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and moneys in the fund shall be used solely by the department of health and senior services for enhancing senior services provided by area agencies on aging in this state.

(2) Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund. This fund is not intended to supplant general revenue provided for senior services.

(3) The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

4. The department of health and senior services shall disburse the moneys from the fund to the area agencies on aging in accordance with the funding formula used by the department to disburse other federal and state moneys to the area agencies on aging.

5. At least fifty percent of all moneys distributed under this section shall be applied by area agencies on aging to the development and expansion of senior center programs, facilities, and services.

6. All area agencies on aging shall report, either individually or as an association, annually to the department of health and senior services, the department of insurance, financial institutions and professional registration, and the general assembly on the distribution and use of moneys under this section. The board of directors and the advisory board of each area agency on aging shall be responsible for ensuring the proper use and distribution of such moneys.

7. The department of health and senior services may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2019, shall be invalid and void.

192.990. 1. There is hereby established within the department of health and senior services the "Pregnancy-Associated Mortality Review Board" to improve data collection and reporting with respect to maternal deaths. The department may collaborate with localities and with other states to meet the goals of the initiative.

2. For purposes of this section, the following terms shall mean:

(1) "Department", the Missouri department of health and senior services;

(2) "Maternal death", the death of a woman while pregnant or during the one-year period following the date of the end of pregnancy, regardless of the cause of death and regardless of whether a delivery, miscarriage, or death occurs inside or outside of a hospital.

3. The board shall be composed of no more than eighteen members, with a chair elected from among its membership. The board shall meet at least twice per year and shall approve the strategic priorities, funding allocations, work processes, and products of the board. Members of the board shall be appointed by the director of the department. Members shall serve four-year terms, except that the initial terms shall be staggered so that approximately one-third serve three, four, and five-year terms.

4. The board shall have a multidisciplinary and diverse membership that represents a variety of medical and nursing specialties, including, but not limited to, obstetrics and maternal-fetal care, as well as state or local public health officials, epidemiologists, statisticians, community organizations, geographic regions, and other individuals or organizations that are most affected by maternal deaths and lack of access to maternal health care services.

5. The duties of the board shall include, but not be limited to:

(1) Conducting ongoing comprehensive, multidisciplinary reviews of all maternal deaths;

(2) Identifying factors associated with maternal deaths;

(3) Reviewing medical records and other relevant data, which shall include, to the extent available:

(a) A description of the maternal deaths determined by matching each death record of a maternal death to a birth certificate of an infant or fetal death record, as applicable, and an indication of whether the delivery, miscarriage, or death occurred inside or outside of a hospital;

(b) Data collected from medical examiner and coroner reports, as appropriate; and

(c) Using other appropriate methods or information to identify maternal deaths, including deaths from pregnancy outcomes not identified under paragraph (a) of this subdivision;

(4) Consulting with relevant experts, as needed;

(5) Analyzing cases to produce recommendations for reducing maternal mortality;

(6) Disseminating recommendations to policy makers, health care providers and facilities, and the general public;

(7) Recommending and promoting preventative strategies and making recommendations for systems changes;

(8) Protecting the confidentiality of the hospitals and individuals involved in any maternal deaths;

(9) Examining racial and social disparities in maternal deaths;

(10) Subject to appropriation, providing for voluntary and confidential case reporting of maternal deaths to the appropriate state health agency by family members of the deceased, and other appropriate individuals, for purposes of review by the board;

(11) Making publicly available the contact information of the board for use in such reporting;

(12) Conducting outreach to local professional organizations, community organizations, and social services agencies regarding the availability of the review board; and

(13) Ensuring that data collected under this section is made available, as appropriate and practicable, for research purposes, in a manner that protects individually identifiable or potentially identifiable information and that is consistent with state and federal privacy laws.

6. The board may contract with other entities consistent with the duties of the board.

7. (1) Before June 30, 2020, and annually thereafter, the board shall submit to the Director of the Centers for Disease Control and Prevention, the director of the department, the governor, and the general assembly a report on maternal mortality in the state based on data collected through ongoing comprehensive, multidisciplinary reviews of all maternal deaths, and any other projects or efforts funded by the board. The data shall be collected using best practices to reliably determine and include all maternal deaths, regardless of the outcome of the pregnancy and shall include data, findings, and recommendations of the committee, and, as applicable, information on the implementation during such year of any recommendations submitted by the board in a previous year.

(2) The report shall be made available to the public on the department's website and the director shall disseminate the report to all health care providers and facilities that provide women's health services in the state.

8. The director of the department, or his or her designee, shall provide the board with the copy of the death certificate and any linked birth or fetal death certificate for any maternal death occurring within the state.

9. Upon request by the department, health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, law enforcement agencies, driver's license bureaus, other state agencies, and facilities licensed by the department shall provide to the department data related to maternal deaths from sources such as medical records, autopsy reports, medical examiner's reports, coroner's reports, law enforcement reports, motor vehicle records, social services records, and other sources as appropriate. Such data requests shall be limited to maternal deaths which have occurred within the previous twenty-four months. No entity shall be held liable for civil damages or be subject to any criminal or disciplinary action when complying in good faith with a request from the department for information under the provisions of this subsection.

10. (1) The board shall protect the privacy and confidentiality of all patients, decedents, providers, hospitals, or any other participants involved in any maternal deaths. In no case shall any individually identifiable health information be provided to the public or submitted to an information clearinghouse.

(2) Nothing in this subsection shall prohibit the board or department from publishing statistical compilations and research reports that:

(a) Are based on confidential information relating to mortality reviews under this section; and

(b) Do not contain identifying information or any other information that could be used to ultimately identify the individuals concerned.

(3) Information, records, reports, statements, notes, memoranda, or other data collected under this section shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency, or person. Such information, records, reports, notes, memoranda, data obtained by the department or any other person, statements, notes, memoranda, or other data shall not be exhibited nor their contents disclosed in any way, in whole or in part, by any officer or representative of the department or any other person. No person participating in such review shall disclose, in any manner, the information so obtained except in strict conformity with such review project. Such information shall not be subject to disclosure under chapter 610.

(4) All information, records of interviews, written reports, statements, notes, memoranda, or other data obtained by the department, the board, and other persons, agencies, or organizations so authorized by the department under this section shall be confidential.

(5) All proceedings and activities of the board, opinions of members of such board formed as a result of such proceedings and activities, and records obtained, created, or maintained under this section, including records of interviews, written reports, statements, notes, memoranda, or other data obtained by the department or any other person, agency, or organization acting jointly or under contract with the department in connection with the requirements of this section, shall be confidential and shall not be subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding; provided, however, that nothing in this section shall be construed to limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another source and entirely independent of the board's proceedings.

(6) Members of the board shall not be questioned in any civil or criminal proceeding regarding the information presented in or opinions formed as a result of a meeting or communication of the board; provided, however, that nothing in this section shall be construed to prevent a member of the board from testifying to information obtained independently of the board or which is public information.

11. The department may use grant program funds to support the efforts of the board and may apply for additional federal government and private foundation grants as needed. The department may also accept private, foundation, city, county, or federal moneys to implement the provisions of this section.

193.015. As used in sections 193.005 to 193.325, unless the context clearly indicates otherwise, the following terms shall mean:

(1) "Advanced practice registered nurse", a person licensed to practice as an advanced practice registered nurse under chapter 335, and who has been delegated tasks outlined in section 193.145 by a physician with whom they have entered into a collaborative practice arrangement under chapter 334;

(2) "Assistant physician", as such term is defined in section 334.036, and who has been delegated tasks outlined in section 193.145 by a physician with whom they have entered into a collaborative practice arrangement under chapter 334;

(3) "Dead body", a human body or such parts of such human body from the condition of which it reasonably may be concluded that death recently occurred;

(4) "Department", the department of health and senior services;

(5) "Final disposition", the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or fetus;

(6) "Institution", any establishment, public or private, which provides inpatient or outpatient medical, surgical, or diagnostic care or treatment or nursing, custodian, or domiciliary care, or to which persons are committed by law;

(7) "Live birth", the complete expulsion or extraction from its mother of a child, irrespective of the duration of pregnancy, which after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached;

(8) "Physician", a person authorized or licensed to practice medicine or osteopathy pursuant to chapter 334;

(9) "Physician assistant", a person licensed to practice as a physician assistant pursuant to chapter 334, and who has been delegated tasks outlined in section 193.145 by a physician with whom they have entered into a **[**~~supervision agreement~~**] collaborative practice arrangement** under chapter 334;

(10) "Spontaneous fetal death", a noninduced death prior to the complete expulsion or extraction from its mother of a fetus, irrespective of the duration of pregnancy; the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles;

(11) "State registrar", state registrar of vital statistics of the state of Missouri;

(12) "System of vital statistics", the registration, collection, preservation, amendment and certification of vital records; the collection of other reports required by sections 193.005 to 193.325 and section 194.060; and activities related thereto including the tabulation, analysis and publication of vital statistics;

(13) "Vital records", certificates or reports of birth, death, marriage, dissolution of marriage and data related thereto;

(14) "Vital statistics", the data derived from certificates and reports of birth, death, spontaneous fetal death, marriage, dissolution of marriage and related reports.

198.082. 1. Each **certified** nursing assistant hired to work in a skilled nursing or intermediate care facility after January 1, 1980, shall have successfully completed a nursing assistant training program approved by the department or shall enroll in and begin the first available approved training program which is scheduled to commence within ninety days of the date of the **certified** nursing assistant's employment and which shall be completed within four months of employment. Training programs shall be offered at any facility licensed **[**~~or approved~~**]** by the department of health and senior services**; any skilled nursing or intermediate care unit in a Missouri veterans home, as defined in section 42.002; or any hospital, as defined in section 197.020. Training programs shall be [**~~which is most~~**]** reasonably accessible to the enrollees in each class. The program may be established by **[**~~the~~**] a** skilled nursing or intermediate care facility, **unit, or hospital;** by a professional organization**[**~~,~~**];** or by the department, and training shall be given by the personnel of the facility, **unit, or hospital;** by a professional organization**[**~~,~~**];** by the department**[**~~,~~**];** by any community college**;** or by the vocational education department of any high school.

2. As used in this section the term "**certified** nursing assistant" means an employee**[**~~,~~**]** **who has completed the training required under subsection 1 of this section, who has passed the certification exam, and [**~~including a nurse's aide or an orderly,~~**]** who is assigned by a skilled nursing or intermediate care facility**, unit, or hospital** to provide or assist in the provision of direct resident health care services under the supervision of a nurse licensed under the nursing practice law, chapter 335.

3. This section shall not apply to any person otherwise **regulated or** licensed to perform health care services under the laws of this state. It shall not apply to volunteers or to members of religious or fraternal orders which operate and administer the facility, if such volunteers or members work without compensation.

[~~3.~~**] 4.** The training program **[**~~after January 1, 1989, shall consist of at least the following:~~

~~(1) A training program consisting~~**] requirements shall be defined in regulation by the department and shall require [**~~of~~**]** at least seventy-five classroom hours of training **[**~~on basic nursing skills, clinical practice, resident safety and rights, the social and psychological problems of residents, and the methods of handling and caring for mentally confused residents such as those with Alzheimer's disease and related disorders,~~**]** and one hundred hours supervised and on-the-job training. **On-the-job training sites shall include supervised practical training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse.** The **[**~~one hundred hours~~**] training** shall be completed within four months of employment and may consist of normal employment as nurse assistants **or hospital nursing support staff** under the supervision of a licensed nurse**[**~~; and~~

~~(2) Continuing in-service training to assure continuing competency in existing and new nursing skills. All nursing assistants trained prior to January 1, 1989, shall attend, by August 31, 1989, an entire special retraining program established by rule or regulation of the department which shall contain information on methods of handling mentally confused residents and which may be offered on premises by the employing facility~~**]**.

[~~4.~~**] 5. Certified** nursing assistants who have not successfully completed the nursing assistant training program prior to employment may begin duties as a **certified** nursing assistant **[**~~only after completing an initial twelve hours of basic orientation approved by the department~~**]** and may provide direct resident care only if under the **[**~~general~~**] direct** supervision of a licensed nurse prior to completion of the seventy-five classroom hours of the training program.

6. The competency evaluation shall be performed in a facility, as defined in 42 CFR Sec. 483.5, or laboratory setting comparable to the setting in which the individual shall function as a certified nursing assistant.

7. Persons completing the training requirements of unlicensed assistive personnel under 19 CSR 30-20.125 or its successor regulation, and who have completed the competency evaluation, shall be allowed to sit for the certified nursing assistant examination and be deemed to have fulfilled the classroom and clinical standards for designation as a certified nursing assistant.

8. The department of health and senior services may offer additional training programs and certifications to students who are already certified as nursing assistants according to regulations promulgated by the department and curriculum approved by the board.

334.037. 1. A physician may enter into collaborative practice arrangements with assistant physicians. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which shall be in writing, may delegate to an assistant physician the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the assistant physician and is consistent with that assistant physician's skill, training, and competence and the skill and training of the collaborating physician.

2. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the assistant physician;

(2) A list of all other offices or locations besides those listed in subdivision (1) of this subsection where the collaborating physician authorized the assistant physician to prescribe;

(3) A requirement that there shall be posted at every office where the assistant physician is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by an assistant physician and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the assistant physician;

(5) The manner of collaboration between the collaborating physician and the assistant physician, including how the collaborating physician and the assistant physician shall:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity; except, the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar year for rural health clinics as defined by Pub. L. 95-210 (42 U.S.C. Section 1395x), as amended, as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. Such exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics if the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics if the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician shall maintain documentation related to such requirement and present it to the state board of registration for the healing arts when requested; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(6) A description of the assistant physician's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the assistant physician to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(7) A list of all other written practice agreements of the collaborating physician and the assistant physician;

(8) The duration of the written practice agreement between the collaborating physician and the assistant physician;

(9) A description of the time and manner of the collaborating physician's review of the assistant physician's delivery of health care services. The description shall include provisions that the assistant physician shall submit a minimum of ten percent of the charts documenting the assistant physician's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days; and

(10) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the assistant physician prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (9) of this subsection.

3. The state board of registration for the healing arts under section 334.125 shall promulgate rules regulating the use of collaborative practice arrangements for assistant physicians. Such rules shall specify:

(1) Geographic areas to be covered;

(2) The methods of treatment that may be covered by collaborative practice arrangements;

(3) In conjunction with deans of medical schools and primary care residency program directors in the state, the development and implementation of educational methods and programs undertaken during the collaborative practice service which shall facilitate the advancement of the assistant physician's medical knowledge and

capabilities, and which may lead to credit toward a future residency program for programs that deem such documented educational achievements acceptable; and

(4) The requirements for review of services provided under collaborative practice arrangements, including delegating authority to prescribe controlled substances.

Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. Any rules relating to dispensing or distribution of controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the department of health and senior services and the state board of pharmacy. The state board of registration for the healing arts shall promulgate rules applicable to assistant physicians that shall be consistent with guidelines for federally funded clinics. The rulemaking authority granted in this subsection shall not extend to collaborative practice arrangements of hospital employees providing inpatient care within hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150- 5.100 as of April 30, 2008.

4. The state board of registration for the healing arts shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to an assistant physician provided the provisions of this section and the rules promulgated thereunder are satisfied.

5. Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice arrangement, including collaborative practice arrangements delegating the authority to prescribe controlled substances, and also report to the board the name of each assistant physician with whom the physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that arrangements are carried out for compliance under this chapter.

6. A collaborating physician **[**~~or supervising physician~~**]** shall not enter into a collaborative practice arrangement **[**~~or supervision agreement~~**]** with more than six full-time equivalent assistant physicians, full-time equivalent physician assistants, or full-time equivalent advance practice registered nurses, or any combination thereof. Such limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of section 334.104.

7. The collaborating physician shall determine and document the completion of at least a one-month period of time during which the assistant physician shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. No rule or regulation shall require the collaborating physician to review more than ten percent of the assistant physician's patient charts or records during such one-month period. Such limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

8. No agreement made under this section shall supersede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital as defined in section 197.020 if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

9. No contract or other agreement shall require a physician to act as a collaborating physician for an assistant physician against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular assistant physician. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any assistant physician, but such requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff.

10. No contract or other agreement shall require any assistant physician to serve as a collaborating assistant physician for any collaborating physician against the assistant physician's will. An assistant physician shall have the right to refuse to collaborate, without penalty, with a particular physician.

11. All collaborating physicians and assistant physicians in collaborative practice arrangements shall wear identification badges while acting within the scope of their collaborative practice arrangement. The identification badges shall prominently display the licensure status of such collaborating physicians and assistant physicians.

12. (1) An assistant physician with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to prescribe controlled substances in a collaborative practice arrangement. Prescriptions for Schedule II medications prescribed by an assistant physician who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone. Such authority shall be filed with the state board of registration for the healing arts. The collaborating physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the assistant physician is permitted to prescribe. Any limitations shall be listed in the collaborative practice arrangement. Assistant physicians shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician. Assistant physicians who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

(2) The collaborating physician shall be responsible to determine and document the completion of at least one hundred twenty hours in a four-month period by the assistant physician during which the assistant physician shall practice with the collaborating physician on-site prior to prescribing controlled substances when the collaborating physician is not on-site. Such limitation shall not apply to assistant physicians of population-based public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009, or assistant physicians providing opioid addiction treatment.

(3) An assistant physician shall receive a certificate of controlled substance prescriptive authority from the state board of registration for the healing arts upon verification of licensure under section 334.036.

13. Nothing in this section or section 334.036 shall be construed to limit the authority of hospitals or hospital medical staff to make employment or medical staff credentialing or privileging decisions.

334.104. 1. A physician may enter into collaborative practice arrangements with registered professional nurses. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which shall be in writing, may delegate to a registered professional nurse the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the registered professional nurse and is consistent with that nurse's skill, training and competence.

2. Collaborative practice arrangements, which shall be in writing, may delegate to a registered professional nurse the authority to administer, dispense or prescribe drugs and provide treatment if the registered professional nurse is an advanced practice registered nurse as defined in subdivision (2) of section 335.016. Collaborative practice arrangements may delegate to an advanced practice registered nurse, as defined in section 335.016, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017, and Schedule II - hydrocodone; except that, the collaborative practice arrangement shall not delegate the authority to administer any controlled substances listed in Schedules III, IV, and V of section 195.017, or Schedule II - hydrocodone for the purpose of inducing sedation or general anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic controlled substance and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill. Such collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols or standing orders for the delivery of health care services. An advanced practice registered nurse may prescribe buprenorphine for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician.

3. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the advanced practice registered nurse;

(2) A list of all other offices or locations besides those listed in subdivision (1) of this subsection where the collaborating physician authorized the advanced practice registered nurse to prescribe;

(3) A requirement that there shall be posted at every office where the advanced practice registered nurse is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by an advanced practice registered nurse and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the advanced practice registered nurse;

(5) The manner of collaboration between the collaborating physician and the advanced practice registered nurse, including how the collaborating physician and the advanced practice registered nurse will:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity, except the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar year for rural health clinics as defined by P.L. 95-210, as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. This exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics where the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics where the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician is required to maintain documentation related to this requirement and to present it to the state board of registration for the healing arts when requested; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(6) A description of the advanced practice registered nurse's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the nurse to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(7) A list of all other written practice agreements of the collaborating physician and the advanced practice registered nurse;

(8) The duration of the written practice agreement between the collaborating physician and the advanced practice registered nurse;

(9) A description of the time and manner of the collaborating physician's review of the advanced practice registered nurse's delivery of health care services. The description shall include provisions that the advanced practice registered nurse shall submit a minimum of ten percent of the charts documenting the advanced practice registered nurse's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days; and

(10) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the advanced practice registered nurse prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (9) of this subsection.

4. The state board of registration for the healing arts pursuant to section 334.125 and the board of nursing pursuant to section 335.036 may jointly promulgate rules regulating the use of collaborative practice arrangements. Such rules shall be limited to specifying geographic areas to be covered, the methods of treatment that may be covered by collaborative practice arrangements and the requirements for review of services provided pursuant to collaborative practice arrangements including delegating authority to prescribe controlled substances. Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. Any rules relating to dispensing or distribution of controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the department of health and senior services and the state board of pharmacy. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither the state board of registration for the healing arts nor the board of nursing may separately promulgate rules relating to collaborative practice arrangements. Such jointly promulgated rules shall be consistent with guidelines for federally funded clinics. The rulemaking authority granted in this subsection shall not extend to collaborative practice arrangements of hospital employees providing inpatient care within hospitals as defined pursuant to chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

5. The state board of registration for the healing arts shall not deny, revoke, suspend or otherwise take disciplinary action against a physician for health care services delegated to a registered professional nurse provided the provisions of this section and the rules promulgated thereunder are satisfied. Upon the written request of a physician subject to a disciplinary action imposed as a result of an agreement between a physician and a registered professional nurse or registered physician assistant, whether written or not, prior to August 28, 1993, all records of such disciplinary licensure action and all records pertaining to the filing, investigation or review of an alleged violation of this chapter incurred as a result of such an agreement shall be removed from the records of the state board of registration for the healing arts and the division of professional registration and shall not be disclosed to any public or private entity seeking such information from the board or the division. The state board of registration

for the healing arts shall take action to correct reports of alleged violations and disciplinary actions as described in this section which have been submitted to the National Practitioner Data Bank. In subsequent applications or representations relating to his medical practice, a physician completing forms or documents shall not be required to report any actions of the state board of registration for the healing arts for which the records are subject to removal under this section.

6. Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice agreement, including collaborative practice agreements delegating the authority to prescribe controlled substances, or physician assistant agreement and also report to the board the name of each licensed professional with whom the physician has entered into such agreement. The board may make this information available to the public. The board shall track the reported information and may routinely conduct random reviews of such agreements to ensure that agreements are carried out for compliance under this chapter.

7. Notwithstanding any law to the contrary, a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016 shall be permitted to provide anesthesia services without a collaborative practice arrangement provided that he or she is under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed. Nothing in this subsection shall be construed to prohibit or prevent a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016 from entering into a collaborative practice arrangement under this section, except that the collaborative practice arrangement may not delegate the authority to prescribe any controlled substances listed in Schedules III, IV, and V of section 195.017, or Schedule II - hydrocodone.

8. A collaborating physician **[**~~or supervising physician~~**]** shall not enter into a collaborative practice arrangement **[**~~or supervision agreement~~**]** with more than six full-time equivalent advanced practice registered nurses, full-time equivalent licensed physician assistants, or full-time equivalent assistant physicians, or any combination thereof. This limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of this section.

9. It is the responsibility of the collaborating physician to determine and document the completion of at least a one-month period of time during which the advanced practice registered nurse shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. This limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

10. No agreement made under this section shall supersede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital as defined in section 197.020 if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

11. No contract or other agreement shall require a physician to act as a collaborating physician for an advanced practice registered nurse against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular advanced practice registered nurse. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any advanced practice registered nurse, but this requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by hospital's medical staff.

12. No contract or other agreement shall require any advanced practice registered nurse to serve as a collaborating advanced practice registered nurse for any collaborating physician against the advanced practice registered nurse's will. An advanced practice registered nurse shall have the right to refuse to collaborate, without penalty, with a particular physician.

334.108. 1. Prior to prescribing any drug, controlled substance, or other treatment through telemedicine, as defined in section 191.1145, or the internet, a physician shall establish a valid physician-patient relationship as described in section 191.1146. This relationship shall include:

(1) Obtaining a reliable medical history and performing a physical examination of the patient, adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions or contraindications to the treatment recommended or provided;

(2) Having sufficient dialogue with the patient regarding treatment options and the risks and benefits of treatment or treatments;

(3) If appropriate, following up with the patient to assess the therapeutic outcome;

(4) Maintaining a contemporaneous medical record that is readily available to the patient and, subject to the patient's consent, to the patient's other health care professionals; and

(5) Maintaining the electronic prescription information as part of the patient's medical record.

2. The requirements of subsection 1 of this section may be satisfied by the prescribing physician's designee when treatment is provided in:

(1) A hospital as defined in section 197.020;

(2) A hospice program as defined in section 197.250;

(3) Home health services provided by a home health agency as defined in section 197.400;

(4) Accordance with a collaborative practice agreement as defined in section 334.104;

(5) Conjunction with a physician assistant licensed pursuant to section 334.738;

(6) Conjunction with an assistant physician licensed under section 334.036;

(7) Consultation with another physician who has an ongoing physician-patient relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications; or

(8) On-call or cross-coverage situations.

3. No health care provider, as defined in section 376.1350, shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an evaluation over the telephone; except that, a physician**[**~~,~~**] or** such physician's on-call designee, **or** an advanced practice registered nurse**, a physician assistant, or an assistant physician** in a collaborative practice arrangement with such physician, **[**~~a physician assistant in a supervision agreement with such physician, or an assistant physician in a supervision agreement with such physician~~**]** may prescribe any drug, controlled substance, or other treatment that is within his or her scope of practice to a patient based solely on a telephone evaluation if a previously established and ongoing physician-patient relationship exists between such physician and the patient being treated.

4. No health care provider shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an internet request or an internet questionnaire.

334.735. 1. As used in sections 334.735 to 334.749, the following terms mean:

(1) "Applicant", any individual who seeks to become licensed as a physician assistant;

(2) "Certification" or "registration", a process by a certifying entity that grants recognition to applicants meeting predetermined qualifications specified by such certifying entity;

(3) "Certifying entity", the nongovernmental agency or association which certifies or registers individuals who have completed academic and training requirements;

(4) **"Collaborative practice arrangement", written agreements, jointly agreed upon protocols, or standing orders, all of which shall be in writing, for the delivery of health care services;**

(5) "Department", the department of insurance, financial institutions and professional registration or a designated agency thereof;

[~~(5)~~**] (6)** "License", a document issued to an applicant by the board acknowledging that the applicant is entitled to practice as a physician assistant;

[~~(6)~~**] (7)** "Physician assistant", a person who has graduated from a physician assistant program accredited by the **[**~~American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency~~**] Accreditation Review Commission on Education for the Physician Assistant or its successor agency, prior to 2001, or the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs**, who has passed the certifying examination administered by the National Commission on Certification of Physician Assistants and has active certification by the National Commission on Certification of Physician Assistants who provides health care services delegated by a licensed physician. A person who has been employed as a physician assistant for three years prior to August 28, 1989, who has passed the National Commission on Certification of Physician Assistants examination, and has active certification of the National Commission on Certification of Physician Assistants;

[~~(7)~~**] (8)** "Recognition", the formal process of becoming a certifying entity as required by the provisions of sections 334.735 to 334.749;

[~~(8) "Supervision", control exercised over a physician assistant working with a supervising physician and oversight of the activities of and accepting responsibility for the physician assistant's delivery of care. The physician assistant shall only practice at a location where the physician routinely provides patient care, except existing patients of the supervising physician in the patient's home and correctional facilities. The supervising physician must be immediately available in person or via telecommunication during the time the physician assistant is providing~~

~~patient care. Prior to commencing practice, the supervising physician and physician assistant shall attest on a form provided by the board that the physician shall provide supervision appropriate to the physician assistant's training and that the physician assistant shall not practice beyond the physician assistant's training and experience. Appropriate supervision shall require the supervising physician to be working within the same facility as the physician assistant for at least four hours within one calendar day for every fourteen days on which the physician assistant provides patient care as described in subsection 3 of this section. Only days in which the physician assistant provides patient care as described in subsection 3 of this section shall be counted toward the fourteen-day period. The requirement of appropriate supervision shall be applied so that no more than thirteen calendar days in which a physician assistant provides patient care shall pass between the physician's four hours working within the same facility. The board shall promulgate rules pursuant to chapter 536 for documentation of joint review of the physician assistant activity by the supervising physician and the physician assistant.~~

~~2. (1) A supervision agreement shall limit the physician assistant to practice only at locations described in subdivision (8) of subsection 1 of this section, within a geographic proximity to be determined by the board of registration for the healing arts.~~

~~(2) For a physician-physician assistant team working in a certified community behavioral health clinic as defined by P.L. 113-93 and a rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended, or a federally qualified health center as defined in 42 U.S.C. Section 1395 of the Public Health Service Act, as amended, no supervision requirements in addition to the minimum federal law shall be required.~~

~~3.~~**] 2.** The scope of practice of a physician assistant shall consist only of the following services and procedures:

(1) Taking patient histories;

(2) Performing physical examinations of a patient;

(3) Performing or assisting in the performance of routine office laboratory and patient screening procedures;

(4) Performing routine therapeutic procedures;

(5) Recording diagnostic impressions and evaluating situations calling for attention of a physician to institute treatment procedures;

(6) Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by a **[**~~licensed~~**] collaborating** physician;

(7) Assisting the supervising physician in institutional settings, including reviewing of treatment plans, ordering of tests and diagnostic laboratory and radiological services, and ordering of therapies, using procedures reviewed and approved by a licensed physician;

(8) Assisting in surgery; **and**

(9) Performing such other tasks not prohibited by law under the **[**~~supervision of~~**] collaborative practice arrangement with** a licensed physician as the physician**[**~~'s~~**]** assistant has been trained and is proficient to perform**[**~~; and~~

~~(10)~~**].**

3. Physician assistants shall not perform or prescribe abortions.

4. Physician assistants shall not prescribe any drug, medicine, device or therapy unless pursuant to a **[**~~physician supervision agreement~~**] collaborative practice arrangement** in accordance with the law, nor prescribe lenses, prisms or contact lenses for the aid, relief or correction of vision or the measurement of visual power or visual efficiency of the human eye, nor administer or monitor general or regional block anesthesia during diagnostic tests, surgery or obstetric procedures. Prescribing of drugs, medications, devices or therapies by a physician assistant shall be pursuant to a **[**~~physician assistant supervision agreement~~**] collaborative practice arrangement** which is specific to the clinical conditions treated by the supervising physician and the physician assistant shall be subject to the following:

(1) A physician assistant shall only prescribe controlled substances in accordance with section 334.747;

(2) The types of drugs, medications, devices or therapies prescribed by a physician assistant shall be consistent with the scopes of practice of the physician assistant and the **[**~~supervising~~**] collaborating** physician;

(3) All prescriptions shall conform with state and federal laws and regulations and shall include the name, address and telephone number of the physician assistant and the supervising physician;

(4) A physician assistant, or advanced practice registered nurse as defined in section 335.016 may request, receive and sign for noncontrolled professional samples and may distribute professional samples to patients; and

(5) A physician assistant shall not prescribe any drugs, medicines, devices or therapies the **[**~~supervising~~**]** **collaborating** physician is not qualified or authorized to prescribe.

5. A physician assistant shall clearly identify himself or herself as a physician assistant and shall not use or permit to be used in the physician assistant's behalf the terms "doctor", "Dr." or "doc" nor hold himself or herself out in any way to be a physician or surgeon. No physician assistant shall practice or attempt to practice without physician **[**~~supervision~~**]** **collaboration** or in any location where the **[**~~supervising~~**]** **collaborating** physician is not immediately available for consultation, assistance and intervention, except as otherwise provided in this section, and in an emergency situation, nor shall any physician assistant bill a patient independently or directly for any services or procedure by the physician assistant; except that, nothing in this subsection shall be construed to prohibit a physician assistant from enrolling with **a third party plan or** the department of social services as a MO HealthNet or Medicaid provider while acting under a **[**~~supervision agreement~~**]** **collaborative practice arrangement** between the physician and physician assistant.

6. **[**~~For purposes of this section, the~~**]** **The** licensing of physician assistants shall take place within processes established by the state board of registration for the healing arts through rule and regulation. The board of healing arts is authorized to establish rules pursuant to chapter 536 establishing licensing and renewal procedures, **[**~~supervision, supervision agreements~~**]** **collaboration, collaborative practice arrangements**, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensing may be denied or the license of a physician assistant may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule or regulation. Persons licensed pursuant to the provisions of chapter 335 shall not be required to be licensed as physician assistants. All applicants for physician assistant licensure who complete a physician assistant training program after January 1, 2008, shall have a master's degree from a physician assistant program.

7. **[**~~"Physician assistant supervision agreement" means a written agreement, jointly agreed upon protocols or standing order between a supervising physician and a physician assistant, which provides for the delegation of health care services from a supervising physician to a physician assistant and the review of such services. The agreement shall contain at least the following provisions:~~

~~(1) Complete names, home and business addresses, zip codes, telephone numbers, and state license numbers of the supervising physician and the physician assistant;~~

~~(2) A list of all offices or locations where the physician routinely provides patient care, and in which of such offices or locations the supervising physician has authorized the physician assistant to practice;~~

~~(3) All specialty or board certifications of the supervising physician;~~

~~(4) The manner of supervision between the supervising physician and the physician assistant, including how the supervising physician and the physician assistant shall:~~

~~(a) Attest on a form provided by the board that the physician shall provide supervision appropriate to the physician assistant's training and experience and that the physician assistant shall not practice beyond the scope of the physician assistant's training and experience nor the supervising physician's capabilities and training; and~~

~~(b) Provide coverage during absence, incapacity, infirmity, or emergency by the supervising physician;~~

~~(5) The duration of the supervision agreement between the supervising physician and physician assistant; and~~

~~(6) A description of the time and manner of the supervising physician's review of the physician assistant's delivery of health care services. Such description shall include provisions that the supervising physician, or a designated supervising physician listed in the supervision agreement review a minimum of ten percent of the charts of the physician assistant's delivery of health care services every fourteen days.~~

~~8. When a physician assistant supervision agreement is utilized to provide health care services for conditions other than acute self-limited or well-defined problems, the supervising physician or other physician designated in the supervision agreement shall see the patient for evaluation and approve or formulate the plan of treatment for new or significantly changed conditions as soon as practical, but in no case more than two weeks after the patient has been seen by the physician assistant.~~

~~9.~~**]** At all times the physician is responsible for the oversight of the activities of, and accepts responsibility for, health care services rendered by the physician assistant.

[~~10. It is the responsibility of the supervising physician to determine and document the completion of at least a one-month period of time during which the licensed physician assistant shall practice with a supervising physician continuously present before practicing in a setting where a supervising physician is not continuously present.~~

~~11.~~**] 8. A physician may enter into collaborative practice arrangements with physician assistants. Collaborative practice arrangements, which shall be in writing, may delegate to a physician assistant the authority to prescribe, administer, or dispense drugs and provide treatment which is within the skill,**

training, and competence of the physician assistant. Collaborative practice arrangements may delegate to a physician assistant, as defined in section 334.735, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017, and Schedule II - hydrocodone. Schedule III narcotic controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill. Such collaborative practice arrangements shall be in the form of a written arrangement, jointly agreed-upon protocols, or standing orders for the delivery of health care services.

9. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the physician assistant;

(2) A list of all other offices or locations, other than those listed in subdivision (1) of this subsection, where the collaborating physician has authorized the physician assistant to prescribe;

(3) A requirement that there shall be posted at every office where the physician assistant is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by a physician assistant and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the physician assistant;

(5) The manner of collaboration between the collaborating physician and the physician assistant, including how the collaborating physician and the physician assistant will:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity, as determined by the board of registration for the healing arts; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency of the collaborating physician;

(6) A list of all other written collaborative practice arrangements of the collaborating physician and the physician assistant;

(7) The duration of the written practice arrangement between the collaborating physician and the physician assistant;

(8) A description of the time and manner of the collaborating physician's review of the physician assistant's delivery of health care services. The description shall include provisions that the physician assistant shall submit a minimum of ten percent of the charts documenting the physician assistant's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days. Reviews may be conducted electronically;

(9) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the physician assistant prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (8) of this subsection; and

(10) A statement that no collaboration requirements in addition to the federal law shall be required for a physician-physician assistant team working in a certified community behavioral health clinic as defined by Pub.L. 113-93, or a rural health clinic under the federal Rural Health Services Act, Pub.L. 95-210, as amended, or a federally qualified health center as defined in 42 U.S.C. Section 1395 of the Public Health Service Act, as amended.

10. The state board of registration for the healing arts under section 334.125 may promulgate rules regulating the use of collaborative practice arrangements.

11. The state board of registration for the healing arts shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to a physician assistant, provided that the provisions of this section and the rules promulgated thereunder are satisfied.

12. Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice arrangement, including collaborative practice arrangements delegating the authority to prescribe controlled substances, and also report to the board the name of each physician assistant with whom the

physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that the arrangements are carried out in compliance with this chapter.

13. The collaborating physician shall determine and document the completion of a period of time during which the physician assistant shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. This limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2009.

14. No contract or other **[**~~agreement~~**] arrangement** shall require a physician to act as a **[**~~supervising~~**] collaborating** physician for a physician assistant against the physician's will. A physician shall have the right to refuse to act as a supervising physician, without penalty, for a particular physician assistant. No contract or other agreement shall limit the **[**~~supervising~~**] collaborating** physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any physician assistant**[**~~, but this requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by the hospital's medical staff~~**]**. **No contract or other arrangement shall require any physician assistant to collaborate with any physician against the physician assistant's will. A physician assistant shall have the right to refuse to collaborate, without penalty, with a particular physician.**

[~~12.~~**] 15.** Physician assistants shall file with the board a copy of their **[**~~supervising~~**] collaborating** physician form.

[~~13.~~**] 16.** No physician shall be designated to serve as **[**~~supervising physician or~~**] a** collaborating physician for more than six full-time equivalent licensed physician assistants, full-time equivalent advanced practice registered nurses, or full-time equivalent assistant physicians, or any combination thereof. This limitation shall not apply to physician assistant **[**~~agreements~~**] collaborative practice arrangements** of hospital employees providing inpatient care service in hospitals as defined in chapter 197, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of section 334.104.

17. No arrangement made under this section shall supercede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital, as defined in section 197.020, if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

334.736. Notwithstanding any other provision of sections 334.735 to 334.749, the board may issue without examination a temporary license to practice as a physician assistant. Upon the applicant paying a temporary license fee and the submission of all necessary documents as determined by the board, the board may grant a temporary license to any person who meets the qualifications provided in **[**~~section~~**] sections** 334.735 **to 334.749** which shall be valid until the results of the next examination are announced. The temporary license may be renewed at the discretion of the board and upon payment of the temporary license fee.

334.747. 1. A physician assistant with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to prescribe controlled substances in a **[**~~supervision agreement~~**] collaborative practice arrangement**. Such authority shall be listed on the **[**~~supervision verification~~**] collaborating physician** form on file with the state board of healing arts. The **[**~~supervising~~**] collaborating** physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the physician assistant is permitted to prescribe. Any limitations shall be listed on the **[**~~supervision~~**] collaborating physician** form. Prescriptions for Schedule II medications prescribed by a physician assistant with authority to prescribe delegated in a **[**~~supervision agreement~~**] collaborative practice arrangement** are restricted to only those medications containing hydrocodone. Physician assistants shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the **[**~~supervising~~**] collaborating** physician. Physician assistants who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

2. The **[**~~supervising~~**] collaborating** physician shall be responsible to determine and document the completion of at least one hundred twenty hours in a four-month period by the physician assistant during which the physician assistant shall practice with the **[**~~supervising~~**] collaborating** physician on-site prior to prescribing

controlled substances when the **[**~~supervising~~**]** **collaborating** physician is not on-site. Such limitation shall not apply to physician assistants of population-based public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009.

3. A physician assistant shall receive a certificate of controlled substance prescriptive authority from the board of healing arts upon verification of the completion of the following educational requirements:

(1) Successful completion of an advanced pharmacology course that includes clinical training in the prescription of drugs, medicines, and therapeutic devices. A course or courses with advanced pharmacological content in a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency shall satisfy such requirement;

(2) Completion of a minimum of three hundred clock hours of clinical training by the **[**~~supervising~~**]** **collaborating** physician in the prescription of drugs, medicines, and therapeutic devices;

(3) Completion of a minimum of one year of supervised clinical practice or supervised clinical rotations. One year of clinical rotations in a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency, which includes pharmacotherapeutics as a component of its clinical training, shall satisfy such requirement. Proof of such training shall serve to document experience in the prescribing of drugs, medicines, and therapeutic devices;

(4) A physician assistant previously licensed in a jurisdiction where physician assistants are authorized to prescribe controlled substances may obtain a state bureau of narcotics and dangerous drugs registration if a **[**~~supervising~~**]** **collaborating** physician can attest that the physician assistant has met the requirements of subdivisions (1) to (3) of this subsection and provides documentation of existing federal Drug Enforcement Agency registration.

334.749. 1. There is hereby established an "Advisory Commission for Physician Assistants" which shall guide, advise and make recommendations to the board. The commission shall also be responsible for the ongoing examination of the scope of practice and promoting the continuing role of physician assistants in the delivery of health care services. The commission shall assist the board in carrying out the provisions of sections 334.735 to 334.749.

2. The commission shall be appointed no later than October 1, 1996, and shall consist of five members, one member of the board, two licensed physician assistants, one physician and one lay member. The two licensed physician assistant members, the physician member and the lay member shall be appointed by the director of the division of professional registration. Each licensed physician assistant member shall be a citizen of the United States and a resident of this state, and shall be licensed as a physician assistant by this state. The physician member shall be a United States citizen, a resident of this state, have an active Missouri license to practice medicine in this state and shall be a **[**~~supervising~~**]** **collaborating** physician, at the time of appointment, to a licensed physician assistant. The lay member shall be a United States citizen and a resident of this state. The licensed physician assistant members shall be appointed to serve three-year terms, except that the first commission appointed shall consist of one member whose term shall be for one year and one member whose term shall be for two years. The physician member and lay member shall each be appointed to serve a three-year term. No physician assistant member nor the physician member shall be appointed for more than two consecutive three-year terms. The president of the Missouri Academy of Physicians Assistants in office at the time shall, at least ninety days prior to the expiration of a term of a physician assistant member of a commission member or as soon as feasible after such a vacancy on the commission otherwise occurs, submit to the director of the division of professional registration a list of five physician assistants qualified and willing to fill the vacancy in question, with the request and recommendation that the director appoint one of the five persons so listed, and with the list so submitted, the president of the Missouri Academy of Physicians Assistants shall include in his or her letter of transmittal a description of the method by which the names were chosen by that association.

3. Notwithstanding any other provision of law to the contrary, any appointed member of the commission shall receive as compensation an amount established by the director of the division of professional registration not to exceed seventy dollars per day for commission business plus actual and necessary expenses. The director of the division of professional registration shall establish by rule guidelines for payment. All staff for the commission shall be provided by the state board of registration for the healing arts.

4. The commission shall hold an open annual meeting at which time it shall elect from its membership a chairman and secretary. The commission may hold such additional meetings as may be required in the performance of its duties, provided that notice of every meeting shall be given to each member at least ten days prior to the date of the meeting. A quorum of the commission shall consist of a majority of its members.

5. On August 28, 1998, all members of the advisory commission for registered physician assistants shall become members of the advisory commission for physician assistants and their successor shall be appointed in the same manner and at the time their terms would have expired as members of the advisory commission for registered physician assistants.

334.1135. 1. There is hereby established a joint task force to be known as the "Joint Task Force on Radiologic Technologist Licensure".

2. The task force shall be composed of the following:

(1) Two members of the senate, one of whom shall be appointed by the president pro tempore and one by the minority leader of the senate;

(2) Two members of the house of representatives, one of whom shall be appointed by the speaker and one by the minority leader of the house of representatives;

(3) A clinic administrator, or his or her designee, appointed by the Missouri Association of Rural Health Clinics;

(4) A physician appointed by the Missouri State Medical Association;

(5) A pain management physician appointed by the Missouri Society of Anesthesiologists;

(6) A radiologic technologist appointed by the Missouri Society of Radiologic Technologists;

(7) A nuclear medicine technologist appointed by the Missouri Valley Chapter of the Society of Nuclear Medicine and Molecular Imaging;

(8) An administrator of an ambulatory surgical center appointed by the Missouri Ambulatory Surgical Center Association;

(9) A physician appointed by the Missouri Academy of Family Physicians;

(10) A certified registered nurse anesthetist appointed by the Missouri Association of Nurse Anesthetists;

(11) A physician appointed by the Missouri Radiological Society;

(12) The director of the Missouri state board of registration for the healing arts, or his or her designee; and

(13) The director of the Missouri state board of nursing, or his or her designee.

3. The joint task force shall review the current status of licensure of radiologic technologists in Missouri and shall develop a plan to address the most appropriate method to protect public safety when radiologic imaging and radiologic procedures are utilized. The plan shall include:

(1) An analysis of the risks associated if radiologic technologists are not licensed;

(2) The creation of a Radiologic Imaging and Radiation Therapy Advisory Commission;

(3) Procedures to address the specific needs of rural health care and the availability of licensed radiologic technologists;

(4) Requirements for licensure of radiographer, radiation therapist, nuclear medicine technologist, nuclear medicine advanced associate, radiologist assistant, limited x-ray machine operators;

(5) Reasonable exemptions to licensure;

(6) Continuing education and training;

(7) Penalty provisions; and

(8) Other items that the task force deems relevant for the proper determination of licensure of radiologic technologists in Missouri.

4. The task force shall meet within thirty days of its creation and select a chair and vice chair. A majority of the task force shall constitute a quorum, but the concurrence of a majority of total members shall be required for the determination of any matter within the joint task force's duties.

5. The task force shall be staffed by legislative personnel of as is deemed necessary to assist the task force in the performance of its duties.

6. The members of the task force shall serve without compensation, but may, subject to appropriation, be entitled to reimbursement for actual and necessary expenses incurred in the performance of their official duties.

7. The task force shall submit a full report of its activities, including the plan developed under subsection 3 of this section, to the general assembly on or before January 15, 2020. The task force shall send copies of the report to the director of the division of professional registration.

335.175. 1. No later than January 1, 2014, there is hereby established within the state board of registration for the healing arts and the state board of nursing the "Utilization of Telehealth by Nurses". An advanced practice registered nurse (APRN) providing nursing services under a collaborative practice arrangement under section 334.104 may provide such services outside the geographic proximity requirements of section 334.104 if the

collaborating physician and advanced practice registered nurse utilize telehealth in the care of the patient and if the services are provided in a rural area of need. Telehealth providers shall be required to obtain patient consent before telehealth services are initiated and ensure confidentiality of medical information.

2. As used in this section, "telehealth" shall have the same meaning as such term is defined in section 191.1145.

3. (1) The boards shall jointly promulgate rules governing the practice of telehealth under this section. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth.

(2) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid and void.

4. For purposes of this section, "rural area of need" means any rural area of this state which is located in a health professional shortage area as defined in section 354.650.

[~~5. Under section 23.253 of the Missouri sunset act:~~

~~(1) The provisions of the new program authorized under this section shall automatically sunset six years after August 28, 2013, unless reauthorized by an act of the general assembly; and~~

~~(2) If such program is reauthorized, the program authorized under this section shall automatically sunset twelve years after the effective date of the reauthorization of this section; and~~

~~(3) This section shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under this section is sunset.~~**]**

338.010. 1. The "practice of pharmacy" means the interpretation, implementation, and evaluation of medical prescription orders, including any legend drugs under 21 U.S.C. Section 353; receipt, transmission, or handling of such orders or facilitating the dispensing of such orders; the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by the prescription order so long as the prescription order is specific to each patient for care by a pharmacist; the compounding, dispensing, labeling, and administration of drugs and devices pursuant to medical prescription orders and administration of viral influenza, pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, and meningitis vaccines by written protocol authorized by a physician for persons at least seven years of age or the age recommended by the Centers for Disease Control and Prevention, whichever is higher, or the administration of pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, meningitis, and viral influenza vaccines by written protocol authorized by a physician for a specific patient as authorized by rule; the participation in drug selection according to state law and participation in drug utilization reviews; the proper and safe storage of drugs and devices and the maintenance of proper records thereof; consultation with patients and other health care practitioners, and veterinarians and their clients about legend drugs, about the safe and effective use of drugs and devices; and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management and control of a pharmacy. No person shall engage in the practice of pharmacy unless he **or she** is licensed under the provisions of this chapter. This chapter shall not be construed to prohibit the use of auxiliary personnel under the direct supervision of a pharmacist from assisting the pharmacist in any of his or her duties. This assistance in no way is intended to relieve the pharmacist from his or her responsibilities for compliance with this chapter and he or she will be responsible for the actions of the auxiliary personnel acting in his or her assistance. This chapter shall also not be construed to prohibit or interfere with any legally registered practitioner of medicine, dentistry, or podiatry, or veterinary medicine only for use in animals, or the practice of optometry in accordance with and as provided in sections 195.070 and 336.220 in the compounding, administering, prescribing, or dispensing of his or her own prescriptions.

2. Any pharmacist who accepts a prescription order for a medication therapeutic plan shall have a written protocol from the physician who refers the patient for medication therapy services. The written protocol and the prescription order for a medication therapeutic plan shall come from the physician only, and shall not come from a nurse engaged in a collaborative practice arrangement under section 334.104, or from a physician assistant engaged in a **[**~~supervision agreement~~**] collaborative practice arrangement** under section 334.735.

3. Nothing in this section shall be construed as to prevent any person, firm or corporation from owning a pharmacy regulated by sections 338.210 to 338.315, provided that a licensed pharmacist is in charge of such pharmacy.

4. Nothing in this section shall be construed to apply to or interfere with the sale of nonprescription drugs and the ordinary household remedies and such drugs or medicines as are normally sold by those engaged in the sale of general merchandise.

5. No health carrier as defined in chapter 376 shall require any physician with which they contract to enter into a written protocol with a pharmacist for medication therapeutic services.

6. This section shall not be construed to allow a pharmacist to diagnose or independently prescribe pharmaceuticals.

7. The state board of registration for the healing arts, under section 334.125, and the state board of pharmacy, under section 338.140, shall jointly promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Such rules shall require protocols to include provisions allowing for timely communication between the pharmacist and the referring physician, and any other patient protection provisions deemed appropriate by both boards. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither board shall separately promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

8. The state board of pharmacy may grant a certificate of medication therapeutic plan authority to a licensed pharmacist who submits proof of successful completion of a board-approved course of academic clinical study beyond a bachelor of science in pharmacy, including but not limited to clinical assessment skills, from a nationally accredited college or university, or a certification of equivalence issued by a nationally recognized professional organization and approved by the board of pharmacy.

9. Any pharmacist who has received a certificate of medication therapeutic plan authority may engage in the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by a prescription order from a physician that is specific to each patient for care by a pharmacist.

10. Nothing in this section shall be construed to allow a pharmacist to make a therapeutic substitution of a pharmaceutical prescribed by a physician unless authorized by the written protocol or the physician's prescription order.

11. "Veterinarian", "doctor of veterinary medicine", "practitioner of veterinary medicine", "DVM", "VMD", "BVSe", "BVMS", "BSe (Vet Science)", "VMB", "MRCVS", or an equivalent title means a person who has received a doctor's degree in veterinary medicine from an accredited school of veterinary medicine or holds an Educational Commission for Foreign Veterinary Graduates (EDFVG) certificate issued by the American Veterinary Medical Association (AVMA).

12. In addition to other requirements established by the joint promulgation of rules by the board of pharmacy and the state board of registration for the healing arts:

(1) A pharmacist shall administer vaccines by protocol in accordance with treatment guidelines established by the Centers for Disease Control and Prevention (CDC);

(2) A pharmacist who is administering a vaccine shall request a patient to remain in the pharmacy a safe amount of time after administering the vaccine to observe any adverse reactions. Such pharmacist shall have adopted emergency treatment protocols;

(3) In addition to other requirements by the board, a pharmacist shall receive additional training as required by the board and evidenced by receiving a certificate from the board upon completion, and shall display the certification in his or her pharmacy where vaccines are delivered.

13. A pharmacist shall inform the patient that the administration of the vaccine will be entered into the ShowMeVax system, as administered by the department of health and senior services. The patient shall attest to the inclusion of such information in the system by signing a form provided by the pharmacist. If the patient indicates that he or she does not want such information entered into the ShowMeVax system, the pharmacist shall provide a written report within fourteen days of administration of a vaccine to the patient's primary health care provider, if provided by the patient, containing:

(1) The identity of the patient;

(2) The identity of the vaccine or vaccines administered;

(3) The route of administration;

(4) The anatomic site of the administration;

(5) The dose administered; and

(6) The date of administration.

630.175. 1. No person admitted on a voluntary or involuntary basis to any mental health facility or mental health program in which people are civilly detained pursuant to chapter 632 and no patient, resident or client of a residential facility or day program operated, funded or licensed by the department shall be subject to physical or chemical restraint, isolation or seclusion unless it is determined by the head of the facility, the attending licensed physician, or in the circumstances specifically set forth in this section, by an advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**~~supervision agreement~~**] collaborative practice arrangement**, with the attending licensed physician that the chosen intervention is imminently necessary to protect the health and safety of the patient, resident, client or others and that it provides the least restrictive environment. An advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**~~supervision agreement~~**] collaborative practice arrangement**, with the attending licensed physician may make a determination that the chosen intervention is necessary for patients, residents, or clients of facilities or programs operated by the department, in hospitals as defined in section 197.020 that only provide psychiatric care and in dedicated psychiatric units of general acute care hospitals as hospitals are defined in section 197.020. Any determination made by the advanced practice registered nurse, physician assistant, or assistant physician shall be documented as required in subsection 2 of this section and reviewed in person by the attending licensed physician if the episode of restraint is to extend beyond:

(1) Four hours duration in the case of a person under eighteen years of age;

(2) Eight hours duration in the case of a person eighteen years of age or older; or

(3) For any total length of restraint lasting more than four hours duration in a twenty-four-hour period in the case of a person under eighteen years of age or beyond eight hours duration in the case of a person eighteen years of age or older in a twenty-four-hour period.

The review shall occur prior to the time limit specified under subsection 6 of this section and shall be documented by the licensed physician under subsection 2 of this section.

2. Every use of physical or chemical restraint, isolation or seclusion and the reasons therefor shall be made a part of the clinical record of the patient, resident or client under the signature of the head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**~~supervision agreement~~**] collaborative practice arrangement**, with the attending licensed physician.

3. Physical or chemical restraint, isolation or seclusion shall not be considered standard treatment or habilitation and shall cease as soon as the circumstances causing the need for such action have ended.

4. The use of security escort devices, including devices designed to restrict physical movement, which are used to maintain safety and security and to prevent escape during transport outside of a facility shall not be considered physical restraint within the meaning of this section. Individuals who have been civilly detained under sections 632.300 to 632.475 may be placed in security escort devices when transported outside of the facility if it is determined by the head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**~~supervision agreement~~**] collaborative practice arrangement**, with the attending licensed physician that the use of security escort devices is necessary to protect the health and safety of the patient, resident, client, or other persons or is necessary to prevent escape. Individuals who have been civilly detained under sections 632.480 to 632.513 or committed under chapter 552 shall be placed in security escort devices when transported outside of the facility unless it is determined by the head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**~~supervision agreement~~**] collaborative practice arrangement**, with the attending licensed physician that security escort devices are not necessary to protect the health and safety of the patient, resident, client, or other persons or is not necessary to prevent escape.

5. Extraordinary measures employed by the head of the facility to ensure the safety and security of patients, residents, clients, and other persons during times of natural or man-made disasters shall not be considered restraint, isolation, or seclusion within the meaning of this section.

6. Orders issued under this section by the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a **[**~~supervision agreement~~**] collaborative practice arrangement**, with the attending licensed physician shall be reviewed in person by the attending licensed

physician of the facility within twenty-four hours or the next regular working day of the order being issued, and such review shall be documented in the clinical record of the patient, resident, or client.

7. For purposes of this subsection, "division" shall mean the division of developmental disabilities. Restraint or seclusion shall not be used in habilitation centers or community programs that serve persons with developmental disabilities that are operated or funded by the division unless such procedure is part of an emergency intervention system approved by the division and is identified in such person's individual support plan. Direct-care staff that serve persons with developmental disabilities in habilitation centers or community programs operated or funded by the division shall be trained in an emergency intervention system approved by the division when such emergency intervention system is identified in a consumer's individual support plan.

630.875. 1. This section shall be known and may be cited as the "Improved Access to Treatment for Opioid Addictions Act" or "IATOA Act".

2. As used in this section, the following terms mean:

(1) "Department", the department of mental health;

(2) "IATOA program", the improved access to treatment for opioid addictions program created under subsection 3 of this section.

3. Subject to appropriations, the department shall create and oversee an "Improved Access to Treatment for Opioid Addictions Program", which is hereby created and whose purpose is to disseminate information and best practices regarding opioid addiction and to facilitate collaborations to better treat and prevent opioid addiction in this state. The IATOA program shall facilitate partnerships between assistant physicians, physician assistants, and advanced practice registered nurses practicing in federally qualified health centers, rural health clinics, and other health care facilities and physicians practicing at remote facilities located in this state. The IATOA program shall provide resources that grant patients and their treating assistant physicians, physician assistants, advanced practice registered nurses, or physicians access to knowledge and expertise through means such as telemedicine and Extension for Community Healthcare Outcomes (ECHO) programs established under section 191.1140.

4. Assistant physicians, physician assistants, and advanced practice registered nurses who participate in the IATOA program shall complete the necessary requirements to prescribe buprenorphine within at least thirty days of joining the IATOA program.

5. For the purposes of the IATOA program, a remote collaborating **[**~~or supervising~~**]** physician working with an on-site assistant physician, physician assistant, or advanced practice registered nurse shall be considered to be on-site. An assistant physician, physician assistant, or advanced practice registered nurse collaborating with a remote physician shall comply with all laws and requirements applicable to assistant physicians, physician assistants, or advanced practice registered nurses with on-site supervision before providing treatment to a patient.

6. An assistant physician, physician assistant, or advanced practice registered nurse collaborating with a physician who is waiver-certified for the use of buprenorphine may participate in the IATOA program in any area of the state and provide all services and functions of an assistant physician, physician assistant, or advanced practice registered nurse.

7. The department may develop curriculum and benchmark examinations on the subject of opioid addiction and treatment. The department may collaborate with specialists, institutions of higher education, and medical schools for such development. Completion of such a curriculum and passing of such an examination by an assistant physician, physician assistant, advanced practice registered nurse, or physician shall result in a certificate awarded by the department or sponsoring institution, if any.

8. An assistant physician, physician assistant, or advanced practice registered nurse participating in the IATOA program may also:

(1) Engage in community education;

(2) Engage in professional education outreach programs with local treatment providers;

(3) Serve as a liaison to courts;

(4) Serve as a liaison to addiction support organizations;

(5) Provide educational outreach to schools;

(6) Treat physical ailments of patients in an addiction treatment program or considering entering such a program;

(7) Refer patients to treatment centers;

(8) Assist patients with court and social service obligations;

(9) Perform other functions as authorized by the department; and

(10) Provide mental health services in collaboration with a qualified licensed physician.

The list of authorizations in this subsection is a nonexclusive list, and assistant physicians, physician assistants, or advanced practice registered nurses participating in the IATOA program may perform other actions.

9. When an overdose survivor arrives in the emergency department, the assistant physician, physician assistant, or advanced practice registered nurse serving as a recovery coach or, if the assistant physician, physician assistant, or advanced practice registered nurse is unavailable, another properly trained recovery coach shall, when reasonably practicable, meet with the overdose survivor and provide treatment options and support available to the overdose survivor. The department shall assist recovery coaches in providing treatment options and support to overdose survivors.

10. The provisions of this section shall supersede any contradictory statutes, rules, or regulations. The department shall implement the improved access to treatment for opioid addictions program as soon as reasonably possible using guidance within this section. Further refinement to the improved access to treatment for opioid addictions program may be done through the rules process.

11. The department shall promulgate rules to implement the provisions of the improved access to treatment for opioid addictions act as soon as reasonably possible. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Swan, **House Amendment No. 2** was adopted.

Representative Basye offered **House Amendment No. 3**.

House Amendment No. 3

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after all of said line the following:

"376.1224. 1. For purposes of this section, the following terms shall mean:

(1) "Applied behavior analysis", the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior;

(2) "Autism service provider":

(a) Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or

(b) Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst;

(3) "Autism spectrum disorders", a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;

(4) **"Developmental or physical disability", a severe chronic disability that:**

(a) Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services;

(b) Manifests before the individual reaches age nineteen;

(c) Is likely to continue indefinitely; and

(d) Results in substantial functional limitations in three or more of the following areas of major life activities:

a. Self-care;

b. Understanding and use of language;

c. Learning;

d. Mobility;

e. Self-direction; or

f. Capacity for independent living;

(5) "Diagnosis **[**~~of autism spectrum disorders~~**]**", medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder **or a developmental or physical disability**;

[~~(5)~~**] (6)** "Habilitative or rehabilitative care", professional, counseling, and guidance services and treatment programs, including applied behavior analysis **for those diagnosed with autism spectrum disorder**, that are necessary to develop the functioning of an individual;

[~~(6)~~**] (7)** "Health benefit plan", shall have the same meaning ascribed to it as in section 376.1350;

[~~(7)~~**] (8)** "Health carrier", shall have the same meaning ascribed to it as in section 376.1350;

[~~(8)~~**] (9)** "Line therapist", an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst;

[~~(9)~~**] (10)** "Pharmacy care", medications used to address symptoms of an autism spectrum disorder **or a developmental or physical disability** prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan;

[~~(10)~~**] (11)** "Psychiatric care", direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

[~~(11)~~**] (12)** "Psychological care", direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

[~~(12)~~**] (13)** "Therapeutic care", services provided by licensed speech therapists, occupational therapists, or physical therapists;

[~~(13)~~**] (14)** "Treatment **[**~~for autism spectrum disorders~~**]**", care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist**, or for an individual diagnosed with a developmental or physical disability by a licensed physician or licensed psychologist**, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

(a) Psychiatric care;

(b) Psychological care;

(c) Habilitative or rehabilitative care, including applied behavior analysis therapy **for those diagnosed with autism spectrum disorder**;

(d) Therapeutic care;

(e) Pharmacy care.

2. **Except as otherwise provided in subsection 12 of this section,** all **[**~~group~~**]** health benefit plans that are delivered, issued for delivery, continued, or renewed on or after January 1, **[**~~2011~~**] 2020**, if written inside the state of Missouri, or written outside the state of Missouri but insuring Missouri residents, shall provide coverage for the diagnosis and treatment of autism spectrum disorders **and for the diagnosis and treatment of developmental or physical disabilities** to the extent that such diagnosis and treatment is not already covered by the health benefit plan.

3. With regards to a health benefit plan, a health carrier shall not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual or their dependent because the individual is diagnosed with autism spectrum disorder **or developmental or physical disabilities**.

4. (1) Coverage provided under this section **for autism spectrum disorder or developmental or physical disabilities** is limited to medically necessary treatment that is ordered by the insured's treating licensed physician or licensed psychologist, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, in accordance with a treatment plan.

(2) The treatment plan, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

(3) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder **or developmental or physical disability**, a health carrier shall have the right to review the treatment plan not more than once every six months unless the health carrier and the individual's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual **[**~~being treated for an autism spectrum disorder~~**] receiving applied behavior analysis** and shall not apply to all individuals **[**~~being treated for autism spectrum disorders by a~~**] receiving applied behavior analysis from that autism service provider,** physician**,** or psychologist. The cost of obtaining any review or treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

5. **(1)** Coverage provided under this section for applied behavior analysis shall be subject to a maximum benefit of forty thousand dollars per calendar year for individuals through eighteen years of age. Such maximum benefit limit may be exceeded, upon prior approval by the health benefit plan, if the provision of applied behavior analysis services beyond the maximum limit is medically necessary for such individual. Payments made by a health carrier on behalf of a covered individual for any care, treatment, intervention, service or item, the provision of which was for the treatment of a health condition unrelated to the covered individual's autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection. Any coverage required under this section, other than the coverage for applied behavior analysis, shall not be subject to the age and dollar limitations described in this subsection.

[~~6.~~**] (2)** The maximum benefit limitation for applied behavior analysis described in **[**~~subsection 5~~**] subdivision (1)** of this **[**~~section~~**] subsection** shall be adjusted by the health carrier at least triennially for inflation to reflect the aggregate increase in the general price level as measured by the Consumer Price Index for All Urban Consumers for the United States, or its successor index, as defined and officially published by the United States Department of Labor, or its successor agency. Beginning January 1, 2012, and annually thereafter, the current value of the maximum benefit limitation for applied behavior analysis coverage adjusted for inflation in accordance with this subsection shall be calculated by the director of the department of insurance, financial institutions and professional registration. The director shall furnish the calculated value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021.

[~~7.~~**] (3)** Subject to the provisions set forth in subdivision (3) of subsection 4 of this section, coverage provided **for autism spectrum disorders** under this section shall not be subject to any limits on the number of visits an individual may make to an autism service provider, except that the maximum total benefit for applied behavior analysis set forth in **subdivision (1) of this** subsection **[**~~5 of this section~~**]** shall apply to this **[**~~subsection~~**] subdivision**.

6. Coverage for therapeutic care provided under this section for developmental or physical disabilities may be limited to a number of visits per calendar year, provided that upon prior approval by the health benefit plan, coverage shall be provided beyond the maximum calendar limit if such therapeutic care is medically necessary as determined by the health care plan.

[~~8.~~**] 7.** This section shall not be construed as limiting benefits which are otherwise available to an individual under a health benefit plan. The health care coverage required by this section shall not be subject to any greater deductible, coinsurance, or co-payment than other physical health care services provided by a health benefit plan. Coverage of services may be subject to other general exclusions and limitations of the contract or benefit plan, not in conflict with the provisions of this section, such as coordination of benefits, exclusions for services provided by family or household members, and utilization review of health care services, including review of medical necessity and care management; however, coverage for treatment under this section shall not be denied on the basis that it is educational or habilitative in nature.

[~~9.~~**] 8.** To the extent any payments or reimbursements are being made for applied behavior analysis, such payments or reimbursements shall be made to either:

(1) The autism service provider, as defined in this section; or

(2) The entity or group for whom such supervising person, who is certified as a board-certified behavior analyst by the Behavior Analyst Certification Board, works or is associated.

Such payments or reimbursements under this subsection to an autism service provider or a board-certified behavior analyst shall include payments or reimbursements for services provided by a line therapist under the supervision of such provider or behavior analyst if such services provided by the line therapist are included in the treatment plan and are deemed medically necessary.

[~~10.~~**] 9.** Notwithstanding any other provision of law to the contrary, health carriers shall not be held liable for the actions of line therapists in the performance of their duties.

[~~11.~~**]** **10.** The provisions of this section shall apply to any health care plans issued to employees and their dependents under the Missouri consolidated health care plan established pursuant to chapter 103 that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, **[**~~2011~~**] 2020**. The terms "employees" and "health care plans" shall have the same meaning ascribed to them in section 103.003.

[~~12.~~**]** **11.** The provisions of this section shall also apply to the following types of plans that are established, extended, modified, or renewed on or after January 1, **[**~~2011~~**] 2020**:

(1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section 1002(32);

(2) All self-insured group arrangements, to the extent not preempted by federal law;

(3) All plans provided through a multiple employer welfare arrangement, or plans provided through another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, or any waiver or exception to that act provided under federal law or regulation; and

(4) All self-insured school district health plans.

~~**[**13. The provisions of this section shall not automatically apply to an individually underwritten health benefit plan, but shall be offered as an option to any such plan.~~

~~14.~~**]** **12.** The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months or less duration, or any other supplemental policy. **The provisions of this section requiring coverage for autism spectrum disorders shall not apply to an individually underwritten health benefit plan issued prior to January 1, 2011. The provisions of this section requiring coverage for a developmental or physical disability shall not apply to a health benefit plan issued prior to January 1, 2014.**

[~~15.~~**]** **13.** Any health carrier or other entity subject to the provisions of this section shall not be required to provide reimbursement for the applied behavior analysis delivered to a person insured by such health carrier or other entity to the extent such health carrier or other entity is billed for such services by any Part C early intervention program or any school district for applied behavior analysis rendered to the person covered by such health carrier or other entity. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education plan, or an individualized service plan. This section shall not be construed as affecting any obligation to provide reimbursement pursuant to section 376.1218.

[~~16.~~**]** **14.** The provisions of sections 376.383, 376.384, and 376.1350 to 376.1399 shall apply to this section.

~~**[**17. The director of the department of insurance, financial institutions and professional registration shall grant a small employer with a group health plan, as that term is defined in section 379.930, a waiver from the provisions of this section if the small employer demonstrates to the director by actual claims experience over any consecutive twelve-month period that compliance with this section has increased the cost of the health insurance policy by an amount of two and a half percent or greater over the period of a calendar year in premium costs to the small employer.~~

~~18.~~**]** **15.** The provisions of this section shall not apply to the Mo HealthNet program as described in chapter 208.

~~**[**19. (1) By February 1, 2012, and every February first thereafter, the department of insurance, financial institutions and professional registration shall submit a report to the general assembly regarding the implementation of the coverage required under this section. The report shall include, but shall not be limited to, the following:~~

~~(a) The total number of insureds diagnosed with autism spectrum disorder;~~

~~(b) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this section;~~

~~(c) The cost of such coverage per insured per month; and~~

~~(d) The average cost per insured for coverage of applied behavior analysis;~~

~~(2) All health carriers and health benefit plans subject to the provisions of this section shall provide the department with the data requested by the department for inclusion in the annual report.~~**]**"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Basye, **House Amendment No. 3** was adopted.

Representative Solon offered **House Amendment No. 4**.

House Amendment No. 4

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after said section and line the following:

"338.010. 1. The "practice of pharmacy" means the interpretation, implementation, and evaluation of medical prescription orders, including any legend drugs under 21 U.S.C. Section 353; receipt, transmission, or handling of such orders or facilitating the dispensing of such orders; the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by the prescription order so long as the prescription order is specific to each patient for care by a pharmacist; the compounding, dispensing, labeling, and administration of drugs and devices pursuant to medical prescription orders and administration of viral influenza, pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, and meningitis vaccines by written protocol authorized by a physician for persons at least seven years of age or the age recommended by the Centers for Disease Control and Prevention, whichever is higher, or the administration of pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, meningitis, and viral influenza vaccines by written protocol authorized by a physician for a specific patient as authorized by rule; the participation in drug selection according to state law and participation in drug utilization reviews; the proper and safe storage of drugs and devices and the maintenance of proper records thereof; consultation with patients and other health care practitioners, and veterinarians and their clients about legend drugs, about the safe and effective use of drugs and devices; **the dispensing of self-administered oral hormonal contraceptives under section 338.720;** and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management and control of a pharmacy. No person shall engage in the practice of pharmacy unless he is licensed under the provisions of this chapter. This chapter shall not be construed to prohibit the use of auxiliary personnel under the direct supervision of a pharmacist from assisting the pharmacist in any of his or her duties. This assistance in no way is intended to relieve the pharmacist from his or her responsibilities for compliance with this chapter and he or she will be responsible for the actions of the auxiliary personnel acting in his or her assistance. This chapter shall also not be construed to prohibit or interfere with any legally registered practitioner of medicine, dentistry, or podiatry, or veterinary medicine only for use in animals, or the practice of optometry in accordance with and as provided in sections 195.070 and 336.220 in the compounding, administering, prescribing, or dispensing of his or her own prescriptions.

2. Any pharmacist who accepts a prescription order for a medication therapeutic plan shall have a written protocol from the physician who refers the patient for medication therapy services. The written protocol and the prescription order for a medication therapeutic plan shall come from the physician only, and shall not come from a nurse engaged in a collaborative practice arrangement under section 334.104, or from a physician assistant engaged in a supervision agreement under section 334.735.

3. Nothing in this section shall be construed as to prevent any person, firm or corporation from owning a pharmacy regulated by sections 338.210 to 338.315, provided that a licensed pharmacist is in charge of such pharmacy.

4. Nothing in this section shall be construed to apply to or interfere with the sale of nonprescription drugs and the ordinary household remedies and such drugs or medicines as are normally sold by those engaged in the sale of general merchandise.

5. No health carrier as defined in chapter 376 shall require any physician with which they contract to enter into a written protocol with a pharmacist for medication therapeutic services.

6. This section shall not be construed to allow a pharmacist to diagnose or independently prescribe pharmaceuticals.

7. The state board of registration for the healing arts, under section 334.125, and the state board of pharmacy, under section 338.140, shall jointly promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Such rules shall require protocols to include provisions allowing for timely communication between the pharmacist and the referring physician, and any other patient protection provisions deemed appropriate by both boards. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither board shall separately promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are

nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

8. The state board of pharmacy may grant a certificate of medication therapeutic plan authority to a licensed pharmacist who submits proof of successful completion of a board-approved course of academic clinical study beyond a bachelor of science in pharmacy, including but not limited to clinical assessment skills, from a nationally accredited college or university, or a certification of equivalence issued by a nationally recognized professional organization and approved by the board of pharmacy.

9. Any pharmacist who has received a certificate of medication therapeutic plan authority may engage in the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by a prescription order from a physician that is specific to each patient for care by a pharmacist.

10. Nothing in this section shall be construed to allow a pharmacist to make a therapeutic substitution of a pharmaceutical prescribed by a physician unless authorized by the written protocol or the physician's prescription order.

11. "Veterinarian", "doctor of veterinary medicine", "practitioner of veterinary medicine", "DVM", "VMD", "BVSe", "BVMS", "BSe (Vet Science)", "VMB", "MRCVS", or an equivalent title means a person who has received a doctor's degree in veterinary medicine from an accredited school of veterinary medicine or holds an Educational Commission for Foreign Veterinary Graduates (EDFVG) certificate issued by the American Veterinary Medical Association (AVMA).

12. In addition to other requirements established by the joint promulgation of rules by the board of pharmacy and the state board of registration for the healing arts:

(1) A pharmacist shall administer vaccines by protocol in accordance with treatment guidelines established by the Centers for Disease Control and Prevention (CDC);

(2) A pharmacist who is administering a vaccine shall request a patient to remain in the pharmacy a safe amount of time after administering the vaccine to observe any adverse reactions. Such pharmacist shall have adopted emergency treatment protocols;

(3) In addition to other requirements by the board, a pharmacist shall receive additional training as required by the board and evidenced by receiving a certificate from the board upon completion, and shall display the certification in his or her pharmacy where vaccines are delivered.

13. A pharmacist shall inform the patient that the administration of the vaccine will be entered into the ShowMeVax system, as administered by the department of health and senior services. The patient shall attest to the inclusion of such information in the system by signing a form provided by the pharmacist. If the patient indicates that he or she does not want such information entered into the ShowMeVax system, the pharmacist shall provide a written report within fourteen days of administration of a vaccine to the patient's primary health care provider, if provided by the patient, containing:

(1) The identity of the patient;

(2) The identity of the vaccine or vaccines administered;

(3) The route of administration;

(4) The anatomic site of the administration;

(5) The dose administered; and

(6) The date of administration.

338.720. 1. For purposes of this section, "self-administered oral hormonal contraceptive" shall mean a drug composed of a combination of hormones that is approved by the Food and Drug Administration to prevent pregnancy and that the patient to whom the drug is prescribed may take orally.

2. A pharmacist may dispense self-administered oral hormonal contraceptives to a person who is eighteen years of age or older under a prescription order for medication therapy services as described in section 338.010. A prescription order for a self-administered oral hormonal contraceptive shall have no expiration date.

3. The board of pharmacy, under section 338.140, and the board of registration for the healing arts, under section 334.125, shall jointly promulgate rules regulating the use of protocols for prescription orders for self-administered oral hormonal contraceptives. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2019, shall be invalid and void.

4. The rules adopted under this section shall require a pharmacist to:

(1) Complete a training program approved by the board of pharmacy that is related to prescribing self-administered oral hormonal contraceptives;

(2) Provide a self-screening risk assessment tool that the patient shall use prior to the pharmacist's prescribing the self-administered oral hormonal contraceptive;

(3) At least once every twelve months refer the patient to the patient's primary care practitioner or women's health care practitioner, or the physician with whom the pharmacist has a prescription order, before dispensing the self-administered oral hormonal contraceptive to the patient;

(4) Provide the patient with a written record of the self-administered oral hormonal contraceptive dispensed and advise the patient to consult with a primary care practitioner or women's health care practitioner; and

(5) Dispense the self-administered oral hormonal contraceptive to the patient as soon as practicable.

5. All state and federal laws governing insurance coverage of contraceptive drugs, devices, products, and services shall apply to self-administered oral hormonal contraceptives dispensed by a pharmacist under this section.

6. The provisions of this section shall terminate upon the enactment of any laws allowing the provision of oral hormonal contraceptives from a pharmacist without a prescription.

7. Nothing in this section shall be construed to allow a pharmacist to make a therapeutic substitution of a pharmaceutical prescribed by a physician unless authorized by the written protocol or the physician's written prescription order."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Solon, **House Amendment No. 4** was adopted.

Representative Shawan offered **House Amendment No. 5**.

House Amendment No. 5

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after said section and line the following:

"192.667. 1. All health care providers shall at least annually provide to the department charge data as required by the department. All hospitals shall at least annually provide patient abstract data and financial data as required by the department. Hospitals as defined in section 197.020 shall report patient abstract data for outpatients and inpatients. Ambulatory surgical centers and abortion facilities as defined in section 197.200 shall provide patient abstract data to the department. The department shall specify by rule the types of information which shall be submitted and the method of submission.

2. The department shall collect data on the incidence of health care-associated infections from hospitals, ambulatory surgical centers, abortion facilities, and other facilities as necessary to generate the reports required by this section. Hospitals, ambulatory surgical centers, abortion facilities, and other facilities shall provide such data in compliance with this section. **In order to streamline government and to eliminate duplicative reporting requirements, if the Centers for Medicare and Medicaid Services, or its successor entity, requires hospitals to submit health care-associated infection data, then hospitals and the department shall not be required to comply with the health care-associated infection data reporting requirements of subsections 2 to 17 of this section applicable to hospitals, except that the department shall post a link on its website to publicly reported data by hospitals on the Centers for Medicare and Medicaid Services' Hospital Compare website, or its successor.**

3. The department shall promulgate rules specifying the standards and procedures for the collection, analysis, risk adjustment, and reporting of the incidence of health care-associated infections and the types of infections and procedures to be monitored pursuant to subsection 13 of this section. In promulgating such rules, the department shall:

(1) Use methodologies and systems for data collection established by the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor; and

(2) Consider the findings and recommendations of the infection control advisory panel established pursuant to section 197.165.

4. By January 1, 2017, the infection control advisory panel created by section 197.165 shall make recommendations to the department regarding the Centers for Medicare and Medicaid Services' health care-associated infection data collection, analysis, and public reporting requirements for hospitals, ambulatory surgical centers, and other facilities in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, in lieu of all or part of the data collection, analysis, and public reporting requirements of this section. The advisory panel recommendations shall address which hospitals shall be required as a condition of licensure to use the National Healthcare Safety Network for data collection; the use of the National Healthcare Safety Network for risk adjustment and analysis of hospital submitted data; and the use of the Centers for Medicare and Medicaid Services' Hospital Compare website, or its successor, for public reporting of the incidence of health care-associated infection metrics. The advisory panel shall consider the following factors in developing its recommendation:

(1) Whether the public is afforded the same or greater access to facility-specific infection control indicators and metrics;

(2) Whether the data provided to the public is subject to the same or greater accuracy of risk adjustment;

(3) Whether the public is provided with the same or greater specificity of reporting of infections by type of facility infections and procedures;

(4) Whether the data is subject to the same or greater level of confidentiality of the identity of an individual patient;

(5) Whether the National Healthcare Safety Network, or its successor, has the capacity to receive, analyze, and report the required data for all facilities;

(6) Whether the cost to implement the National Healthcare Safety Network infection data collection and reporting system is the same or less.

5. After considering the recommendations of the infection control advisory panel, and provided that the requirements of subsection 13 of this section can be met, the department shall implement guidelines from the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor. It shall be a condition of licensure for hospitals that meet the minimum public reporting requirements of the National Healthcare Safety Network and the Centers for Medicare and Medicaid Services to participate in the National Healthcare Safety Network, or its successor. Such hospitals shall permit the National Healthcare Safety Network, or its successor, to disclose facility-specific infection data to the department as required under this section, and as necessary to provide the public reports required by the department. It shall be a condition of licensure for any ambulatory surgical center or abortion facility which does not voluntarily participate in the National Healthcare Safety Network, or its successor, to submit facility-specific data to the department as required under this section, and as necessary to provide the public reports required by the department.

6. The department shall not require the resubmission of data which has been submitted to the department of health and senior services or the department of social services under any other provision of law. The department of health and senior services shall accept data submitted by associations or related organizations on behalf of health care providers by entering into binding agreements negotiated with such associations or related organizations to obtain data required pursuant to section 192.665 and this section. A health care provider shall submit the required information to the department of health and senior services:

(1) If the provider does not submit the required data through such associations or related organizations;

(2) If no binding agreement has been reached within ninety days of August 28, 1992, between the department of health and senior services and such associations or related organizations; or

(3) If a binding agreement has expired for more than ninety days.

7. Information obtained by the department under the provisions of section 192.665 and this section shall not be public information. Reports and studies prepared by the department based upon such information shall be public information and may identify individual health care providers. The department of health and senior services may authorize the use of the data by other research organizations pursuant to the provisions of section 192.067. The department shall not use or release any information provided under section 192.665 and this section which would enable any person to determine any health care provider's negotiated discounts with specific preferred provider organizations or other managed care organizations. The department shall not release data in a form which could be used to identify a patient. Any violation of this subsection is a class A misdemeanor.

8. The department shall undertake a reasonable number of studies and publish information, including at least an annual consumer guide, in collaboration with health care providers, business coalitions and consumers based upon the information obtained pursuant to the provisions of section 192.665 and this section. The department shall

allow all health care providers and associations and related organizations who have submitted data which will be used in any publication to review and comment on the publication prior to its publication or release for general use. The publication shall be made available to the public for a reasonable charge.

9. Any health care provider which continually and substantially, as these terms are defined by rule, fails to comply with the provisions of this section shall not be allowed to participate in any program administered by the state or to receive any moneys from the state.

10. A hospital, as defined in section 197.020, aggrieved by the department's determination of ineligibility for state moneys pursuant to subsection 9 of this section may appeal as provided in section 197.071. An ambulatory surgical center or abortion facility as defined in section 197.200 aggrieved by the department's determination of ineligibility for state moneys pursuant to subsection 9 of this section may appeal as provided in section 197.221.

11. The department of health may promulgate rules providing for collection of data and publication of the incidence of health care-associated infections for other types of health facilities determined to be sources of infections; except that, physicians' offices shall be exempt from reporting and disclosure of such infections.

12. By January 1, 2017, the advisory panel shall recommend and the department shall adopt in regulation with an effective date of no later than January 1, 2018, the requirements for the reporting of the following types of infections as specified in this subsection:

(1) Infections associated with a minimum of four surgical procedures for hospitals and a minimum of two surgical procedures for ambulatory surgical centers that meet the following criteria:

(a) Are usually associated with an elective surgical procedure. An "elective surgical procedure" is a planned, nonemergency surgical procedure that may be either medically required such as a hip replacement or optional such as breast augmentation;

(b) Demonstrate a high priority aspect such as affecting a large number of patients, having a substantial impact for a smaller population, or being associated with substantial cost, morbidity, or mortality; or

(c) Are infections for which reports are collected by the National Healthcare Safety Network or its successor;

(2) Central line-related bloodstream infections;

(3) Health care-associated infections specified for reporting by hospitals, ambulatory surgical centers, and other health care facilities by the rules of the Centers for Medicare and Medicaid Services to the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor; and

(4) Other categories of infections that may be established by rule by the department.

The department, in consultation with the advisory panel, shall be authorized to collect and report data on subsets of each type of infection described in this subsection.

13. In consultation with the infection control advisory panel established pursuant to section 197.165, the department shall develop and disseminate to the public reports based on data compiled for a period of twelve months. Such reports shall be updated quarterly and shall show for each hospital, ambulatory surgical center, abortion facility, and other facility metrics on risk-adjusted health care-associated infections under this section.

14. The types of infections under subsection 12 of this section to be publicly reported shall be determined by the department by rule and shall be consistent with the infections tracked by the National Healthcare Safety Network, or its successor.

15. Reports published pursuant to subsection 13 of this section shall be published and readily accessible on the department's internet website. The reports shall be distributed at least annually to the governor and members of the general assembly. The department shall make such reports available to the public for a period of at least two years.

16. The Hospital Industry Data Institute shall publish a report of Missouri hospitals', ambulatory surgical centers', and abortion facilities' compliance with standardized quality of care measures established by the federal Centers for Medicare and Medicaid Services for prevention of infections related to surgical procedures. If the Hospital Industry Data Institute fails to do so by July 31, 2008, and annually thereafter, the department shall be authorized to collect information from the Centers for Medicare and Medicaid Services or from hospitals, ambulatory surgical centers, and abortion facilities and publish such information in accordance with this section.

17. The data collected or published pursuant to this section shall be available to the department for purposes of licensing hospitals, ambulatory surgical centers, and abortion facilities pursuant to chapter 197.

18. The department shall promulgate rules to implement the provisions of section 192.131 and sections 197.150 to 197.160. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the

provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

19. No later than August 28, 2017, each hospital, excluding mental health facilities as defined in section 632.005, and each ambulatory surgical center and abortion facility as defined in section 197.200, shall in consultation with its medical staff establish an antimicrobial stewardship program for evaluating the judicious use of antimicrobials, especially antibiotics that are the last line of defense against resistant infections. The hospital's stewardship program and the results of the program shall be monitored and evaluated by hospital quality improvement departments and shall be available upon inspection to the department. At a minimum, the antimicrobial stewardship program shall be designed to evaluate that hospitalized patients receive, in accordance with accepted medical standards of practice, the appropriate antimicrobial, at the appropriate dose, at the appropriate time, and for the appropriate duration.

20. Hospitals described in subsection 19 of this section shall meet the National Healthcare Safety Network requirements for reporting antimicrobial usage or resistance by using the Centers for Disease Control and Prevention's Antimicrobial Use and Resistance (AUR) Module when **[**~~regulations concerning Stage 3 of the Medicare and Medicaid Electronic Health Records Incentive Programs promulgated by the Centers for Medicare and Medicaid Services that enable the electronic interface for such reporting are effective~~**] conditions of participation promulgated by the Centers for Medicare and Medicaid Services requiring the electronic reporting of antibiotic use or antibiotic resistance by hospitals become effective**. When such antimicrobial usage or resistance reporting takes effect, hospitals shall authorize the National Healthcare Safety Network, or its successor, to disclose to the department facility-specific information reported to the AUR Module. Facility-specific data on antibiotic usage and resistance collected under this subsection shall not be disclosed to the public, but the department may release case-specific information to other facilities, physicians, and the public if the department determines on a case-by-case basis that the release of such information is necessary to protect persons in a public health emergency. **Nothing in this section shall prohibit a hospital from voluntarily reporting antibiotic use or antibiotic resistance data through the National Healthcare Safety Network, or its successor, prior to the effective date of the conditions of participation requiring the reporting.**

21. The department shall make a report to the general assembly beginning January 1, 2018, and on every January first thereafter on the incidence, type, and distribution of antimicrobial-resistant infections identified in the state and within regions of the state.

197.108. 1. The department of health and senior services shall not assign an individual to inspect or survey a hospital, for any purpose, if the inspector or surveyor was an employee of such hospital or another hospital within its organization or a competing hospital within fifty miles of the hospital to be inspected or surveyed in the preceding two years.

2. For any inspection or survey of a hospital, regardless of the purpose, the department shall require every newly hired inspector or surveyor at the time of hiring or any currently employed inspector or surveyor as of August 28, 2019, to disclose:

(1) The name of every hospital in which he or she has been employed in the last ten years and the approximate length of service and the job title at the hospital; and

(2) The name of any member of his or her immediate family who has been employed in the last ten years or is currently employed at a hospital and the approximate length of service and the job title at the hospital.

The disclosures under this subsection shall be made to the department whenever the event giving rise to disclosure first occurs.

3. For purposes of this section, the phrase "immediate family member" shall mean a husband, wife, natural or adoptive parent, child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, or grandchild.

4. The information provided under subsection 2 of this section shall be considered a public record under the provisions of section 610.010.

5. Any person may notify the department if facts exist that would lead a reasonable person to conclude that any inspector or surveyor has any personal or business affiliation that would result in a conflict of interest in conducting an inspection or survey for a hospital. Upon receiving such notice, the department, when assigning an inspector or surveyor to inspect or survey a hospital, for any purpose, shall take steps to verify the information and, if the department has reason to believe that such information is correct, the

department shall not assign the inspector or surveyor to the hospital or any hospital within its organization so as to avoid an appearance of prejudice or favor to the hospital or bias on the part of the inspector or surveyor."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Shawan, **House Amendment No. 5** was adopted.

Representative Patterson offered **House Amendment No. 6**.

House Amendment No. 6

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after all of said section and line the following:

"374.500. As used in sections 374.500 to 374.515, the following terms mean:

(1) "Certificate", a certificate of registration granted by the department of insurance, financial institutions and professional registration to a utilization review agent;

(2) "Director", the director of the department of insurance, financial institutions and professional registration;

(3) "Enrollee", an individual who has contracted for or who participates in coverage under a health insurance policy, an employee welfare benefit plan, a health services corporation plan or any other benefit program providing payment, reimbursement or indemnification for health care costs for himself or eligible dependents or both himself and eligible dependents. The term "enrollee" shall not include an individual who has health care coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(4) "Provider of record", the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment and services rendered to an enrollee;

(5) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques 58 may include ambulatory review, **[**~~prospective~~**] prior authorization** review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

(6) "Utilization review agent", any person or entity performing utilization review, except:

(a) An agency of the federal government;

(b) An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government; or

(c) Any individual person employed or used by a utilization review agent for the purpose of performing utilization review services, including, but not limited to, individual nurses and physicians, unless such individuals are providing utilization review services to the applicable benefit plan, pursuant to a direct contractual relationship with the benefit plan;

(d) An employee health benefit plan that is self-insured and qualified pursuant to the federal Employee Retirement Income Security Act of 1974, as amended;

(e) A property-casualty insurer or an employee or agent working on behalf of a property-casualty insurer;

(f) A health carrier, as defined in section 376.1350, that is performing a review of its own health plan;

(7) "Utilization review plan", a summary of the utilization review procedures of a utilization review agent.

376.690. 1. As used in this section, the following terms shall mean:

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

(2) "Facility", the same meaning given to such term in section 376.1350;

(3) "Health care professional", the same meaning given to such term in section 376.1350;

(4) "Health carrier", the same meaning given to such term in section 376.1350;

(5) "Unanticipated out-of-network care", health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged.

2. (1) Health care professionals **[**~~may~~**] shall** send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier within one hundred eighty days of the delivery of the unanticipated out-of-network care on a U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, or electronically using the 837 HIPAA format, or its successor.

(2) Within forty-five processing days, as defined in section 376.383, of receiving the health care professional's claim, the health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated out-of-network care based on the health care professional's services. If the health care professional participates in one or more of the carrier's commercial networks, the offer of reimbursement for unanticipated out-of-network care shall be the amount from the network which has the highest reimbursement.

(3) If the health care professional declines the health carrier's initial offer of reimbursement, the health carrier and health care professional shall have sixty days from the date of the initial offer of reimbursement to negotiate in good faith to attempt to determine the reimbursement for the unanticipated out-of-network care.

(4) If the health carrier and health care professional do not agree to a reimbursement amount by the end of the sixty-day negotiation period, the dispute shall be resolved through an arbitration process as specified in subsection 4 of this section.

(5) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within one hundred twenty days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the final offer by each party. A claim for unanticipated out-of-network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with subdivisions (3) to (5) of this subsection.

(6) No health care professional who sends a claim to a health carrier under subsection 2 of this section shall send a bill to the patient for any difference between the reimbursement rate as determined under this subsection and the health care professional's billed charge.

3. (1) When unanticipated out-of-network care is provided, the health care professional who sends a claim to a health carrier under subsection 2 of this section may bill a patient for no more than the cost-sharing requirements described under this section.

(2) Cost-sharing requirements shall be based on the reimbursement amount as determined under subsection 2 of this section.

(3) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within forty-five processing days of receiving a claim from the health care professional for services provided.

(4) The in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for the unanticipated out-of-network care.

4. The director shall ensure access to an external arbitration process when a health care professional and health carrier cannot agree to a reimbursement under subdivision (3) of subsection 2 of this section. In order to ensure access, when notified of a parties' intent to arbitrate, the director shall randomly select an arbitrator for each case from the department's approved list of arbitrators or entities that provide binding arbitration. The director shall specify the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared equally between and will be directly billed to the health care professional and health carrier. These costs will include, but are not limited to, reasonable time necessary for the arbitrator to review materials in preparation for the arbitration, travel expenses and reasonable time following the arbitration for drafting of the final decision.

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall be binding on all parties. The arbitrator shall provide a copy of the final decision to the director. The initial request for arbitration, all correspondence and documents received by the department and the final arbitration decision shall be considered a closed record under section 374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of section 536.010.

6. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare-allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

7. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, or experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

8. The enrollee shall not be required to participate in the arbitration process. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section.

9. **[**~~This section shall take effect on January 1, 2019.~~

~~10.~~**]** The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to procedural requirements for arbitration. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void.

376.1345. 1. As used in this section, unless the context clearly indicates otherwise, terms shall have the same meaning as ascribed to them in section 376.1350.

2. No health carrier, nor any entity acting on behalf of a health carrier, shall restrict methods of reimbursement to health care providers for health care services to a reimbursement method requiring the provider to pay a fee, discount the amount of their claim for reimbursement, or remit any other form of remuneration in order to redeem the amount of their claim for reimbursement.

3. If a health carrier initiates or changes the method used to reimburse a health care provider to a method of reimbursement that will require the health care provider to pay a fee, discount the amount of its claim for reimbursement, or remit any other form of remuneration to the health carrier or any entity acting on behalf of the health carrier in order to redeem the amount of its claim for reimbursement, the health carrier or an entity acting on its behalf shall:

(1) Notify such health care provider of the fee, discount, or other remuneration required to receive reimbursement through the new or different reimbursement method; and

(2) In such notice, provide clear instructions to the health care provider as to how to select an alternative payment method, and upon request such alternative payment method shall be used to reimburse the provider until the provider requests otherwise.

4. A health carrier shall allow the provider to select to be reimbursed by an electronic funds transfer through the Automated Clearing House Network as required pursuant to 45 C.F.R. Sections 162.925, 162.1601, and 162.1602, and if the provider makes such selection, the health carrier shall use such reimbursement method to reimburse the provider until the provider requests otherwise.

5. Violation of this section shall be deemed an unfair trade practice under sections 375.930 to 375.948.

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or **[**~~its designee~~**] a** utilization review **[**~~organization~~**] entity** that an admission, availability of care, continued stay or other health care service **furnished or proposed to be furnished to an enrollee** has been reviewed and, based upon the information provided, does not meet the **utilization review entity or** health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, **or are experimental or investigational,** and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

(4) "Certification", a determination by a health carrier or **[**~~its designee~~**]** **a** utilization review **[**~~organization~~**]** **entity** that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness**, and that payment will be made for that health care service provided the patient is an enrollee of the health benefit plan at the time the service is provided**;

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

(6) "Clinical review criteria", the **written policies,** written screening procedures, **drug formularies or lists of covered drugs, determination rules,** decision abstracts, clinical protocols **[**~~and~~**], medical protocols,** practice guidelines**, and any other criteria or rationale** used by the health carrier **or utilization review entity** to determine the necessity and appropriateness of health care services;

(7) "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

(9) "Director", the director of the department of insurance, financial institutions and professional registration;

(10) "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

(12) "Emergency medical condition", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(13) "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(14) "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(15) "FDA", the federal Food and Drug Administration;

(16) "Facility", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

(18) "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services; except that, health benefit plan shall not include any coverage pursuant to liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(19) "Health care professional", a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law;

(20) "Health care provider" or "provider", a health care professional or a facility;

(21) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease**, including but not limited to the provision of drugs or durable medical equipment**;

(22) "Health carrier", an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services; except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

(24) "Managed care plan", a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

(25) "Participating provider", a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier;

(26) "Peer-reviewed medical literature", a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the Social Security Act **(42 U.S.C. 1395x)**, as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier;

(27) "Person", an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing;

(28) **"Prior authorization", a certification made pursuant to a prior authorization review, or notice as required by a health carrier or utilization review entity prior to the provision of health care services;**

(29) "**[**~~Prospective review~~**] Prior authorization review**", utilization review conducted prior to an admission or a course of treatment**, including but not limited to pre-admission review, pre-treatment review, utilization review, and case management**;

[~~(29)~~**] (30)** "Retrospective review", utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

[~~(30)~~**] (31)** "Second opinion", an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

[~~(31)~~**] (32)** "Stabilize", with respect to an emergency medical condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred;

[~~(32)~~**] (33)** "Standard reference compendia":

(a) The American Hospital Formulary Service-Drug Information; or

(b) The United States Pharmacopoeia-Drug Information;

[~~(33)~~**] (34)** "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, **[**~~prospective~~**] prior authorization** review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

[~~(34)~~**] (35)** "Utilization review **[**~~organization~~**] entity**", a utilization review agent as defined in section 374.500**, or an individual or entity that performs prior authorization reviews for a health carrier or health care provider. A health carrier or health care provider is a utilization review entity if it performs prior authorization review**.

376.1356. Whenever a health carrier contracts to have a utilization review **[**~~organization or other~~**]** entity perform the utilization review functions required by sections 376.1350 to 376.1390 or applicable rules and regulations, the health carrier shall be responsible for monitoring the activities of the utilization review **[**~~organization~~

~~or~~**]** entity with which the health carrier contracts and for ensuring that the requirements of sections 376.1350 to 376.1390 and applicable rules and regulations are met.

376.1363. 1. A health carrier shall maintain written procedures for making utilization review decisions and for notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

2. For **[**~~initial~~**]** determinations, a health carrier shall make the determination within thirty-six hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

(1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the **[**~~initial~~**]** certification, and provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within two working days of making the **[**~~initial~~**]** certification;

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within one working day of making the adverse determination.

3. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information:

(1) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the enrollee and the provider within one working day after telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

(2) In the case of an adverse determination, the carrier shall notify by telephone or electronically the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the enrollee and the provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the enrollee until the enrollee has been notified of the determination.

4. For retrospective review determinations, a health carrier shall make the determination within thirty working days of receiving all necessary information. A carrier shall provide notice in writing of the carrier's determination to an enrollee within ten working days of making the determination.

5. A written notification of an adverse determination shall include the principal reason or reasons for the determination, **including the clinical rationale, and** the instructions for initiating an appeal or reconsideration of the determination**[**~~, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination~~**]**. A health carrier shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to **the health care provider and to** any party who received notice of the adverse determination **[**~~and who requests such information~~**]**.

6. A health carrier shall have written procedures to address the failure or inability of a provider or an enrollee to provide all necessary information for review. **These procedures shall be made available to health care providers on the health carrier's website or provider portal.** In cases where the provider or an enrollee will not release necessary information, the health carrier may deny certification of an admission, procedure or service.

7. Provided the patient is an enrollee of the health benefit plan, no utilization review entity shall revoke, limit, condition, or otherwise restrict a prior authorization within forty-five working days of the date the health care provider receives the prior authorization.

8. Provided the patient is an enrollee of the health benefit plan at the time the service is provided, no health carrier, utilization review entity, or health care provider shall bill an enrollee for any health care service for which a prior authorization was in effect at the time the health care service was provided, except as consistent with cost-sharing requirements applicable to a covered benefit under the enrollee's health benefit plan. Such cost-sharing shall be subject to and applied toward any in-network deductible or out-of-pocket maximum applicable to the enrollee's health benefit plan.

376.1364. 1. Any utilization review entity performing prior authorization review shall provide a unique confirmation number to a provider upon receipt from that provider of a request for prior authorization. Except as otherwise requested by the provider in writing, unique confirmation numbers shall be transmitted or otherwise communicated through the same medium through which the requests for prior authorization were made.

2. No later than January 1, 2021, utilization review entities shall accept and respond to requests for prior authorization of drug benefits through a secure electronic transmission using the National Council for Prescription Drugs SCRIPT Standard Version 2017071 or a backwards-compatible successor adopted by the United States Department of Health and Human Services. For purposes of this subsection, facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

3. No later than January 1, 2021, utilization review entities shall accept and respond to requests for prior authorization of health care services and mental health services electronically. For purposes of this subsection, facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

4. No later than January 1, 2021, each health carrier utilizing prior authorization review shall develop a single secure electronic prior authorization cover page for all of its health benefit plans utilizing prior authorization review, which the carrier or its utilization review entity shall use to accept and respond to, and which providers shall use to submit, requests for prior authorization. Such cover page shall include, but not be limited to, fields for patient or enrollee information, referring or requesting provider information, rendering or attending provider information, and required clinical information, and shall be supplemented by additional clinical information as required by the health carrier or utilization review entity.

376.1372. 1. In the certificate of coverage and the member handbook provided to enrollees, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of enrollees with respect to those procedures.

2. A health carrier shall include a summary of its utilization review procedures in material intended for prospective enrollees.

3. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

4. (1) A health carrier or utilization review entity shall make any current prior authorization requirements or restrictions, including written clinical review criteria, readily accessible on its website or provider portal. Requirements and restrictions, including step therapy protocols as such term is defined in section 376.2030, shall be described in detail.

(2) No health carrier or utilization review entity shall amend or implement a new prior authorization requirement or restriction prior to the change being reflected on the carrier or utilization review entity's website or provider portal as specified in subdivision (1) of this subsection.

(3) Health carriers and utilization review entities shall provide participating providers with written or electronic notice of the new or amended requirement not less than sixty days prior to implementing the requirement or restriction.

376.1385. 1. Upon receipt of a request for second-level review, a health carrier shall submit the grievance to a grievance advisory panel consisting of:

(1) Other enrollees;

(2) Representatives of the health carrier that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance; and

(3) Where the grievance involves an adverse determination, a majority of persons that are **[**~~appropriate~~**]** clinical peers **licensed to practice** in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

2. Review by the grievance advisory panel shall follow the same time frames as a first level review, except as provided for in section 376.1389 if applicable. Any decision of the grievance advisory panel shall include notice of the enrollee's or the health carrier's or plan sponsor's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice shall contain the toll-free telephone number and address of the director's office."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Patterson, **House Amendment No. 6** was adopted.

Representative Stephens (128) offered **House Amendment No. 7**.

House Amendment No. 7

AMEND Senate Bill No. 358, Page 1, Section A, Line 3, by inserting after said section and line the following:

"**21.790. 1. There is hereby established the "Task Force on Substance Abuse Prevention and Treatment". The task force shall be composed of six members from the house of representatives, six members from the senate, and four members appointed by the governor. The senate members of the task force shall be appointed by the president pro tempore of the senate and the house members by the speaker of the house of representatives. There shall be at least two members from the minority party of the senate and at least two members from the minority party of the house of representatives. The members appointed by the governor shall include one member from the health care industry, one member who is a first responder or law enforcement officer, one member who is a member of the judiciary or a prosecuting attorney, and one member representing a substance abuse prevention advocacy group.**

2. The task force shall select a chairperson and a vice-chairperson, one of whom shall be a member of the senate and one a member of the house of representatives. A majority of the members shall constitute a quorum. The task force shall meet at least once during each legislative session and at all other times as the chairperson may designate.

3. The task force shall:

(1) Conduct hearings on current and estimated future drug and substance use and abuse within the state;

(2) Explore solutions to substance abuse issues; and

(3) Draft or modify legislation as necessary to effectuate the goals of finding and funding education and treatment solutions to curb drug and substance use and abuse.

4. The task force may make reasonable requests for staff assistance from the research and appropriations staffs of the senate and house of representatives and the joint committee on legislative research. In the performance of its duties, the task force may request assistance or information from all branches of government and state departments, agencies, boards, commissions, and offices.

5. The task force shall report annually to the general assembly and the governor. The report shall include recommendations for legislation pertaining to substance abuse prevention and treatment."; and

Further amend said bill, Page 2, Section 191.607, Line 16, by inserting after said section and line the following:

"**191.1164. 1. Sections 191.1164 to 191.1168 shall be known and may be cited as the "Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act".**

2. As used in sections 191.1164 to 191.1168, the following terms shall mean:

(1) "Behavioral therapy", an individual, family, or group therapy designed to help patients engage in the treatment process, modify their attitudes and behaviors related to substance use, and increase healthy life skills;

(2) "Department of insurance", the department that has jurisdiction regulating health insurers;

(3) "Financial requirements", deductibles, co-payments, coinsurance, or out-of-pocket maximums;

(4) "Health care professional", a physician or other health care practitioner licensed, accredited, or certified by the state of Missouri to perform specified health services;

(5) "Health insurance plan", an individual or group plan that provides, or pays the cost of, health care items or services;

(6) "Health insurer", any person or entity that issues, offers, delivers, or administers a health insurance plan;

(7) "Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)", the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 found at 42 U.S.C. 300gg-26 and its implementing and related regulations found at 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115;

(8) "Nonquantitative treatment limitation" or "NQTL", any limitation on the scope or duration of treatment that is not expressed numerically;

(9) "Pharmacologic therapy", a prescribed course of treatment that may include methadone, buprenorphine, naltrexone, or other FDA-approved or evidence-based medications for the treatment of substance use disorder;

(10) "Pharmacy benefits manager", an entity that contracts with pharmacies on behalf of health carriers or any health plan sponsored by the state or a political subdivision of the state;

(11) "Prior authorization", the process by which the health insurer or the pharmacy benefits manager determines the medical necessity of otherwise covered health care services prior to the rendering of such health care services. "Prior authorization" also includes any health insurer's or utilization review entity's requirement that a subscriber or health care provider notify the health insurer or utilization review entity prior to receiving or providing a health care service;

(12) "Quantitative treatment limitation" or "QTL", numerical limits on the scope or duration of treatment, which include annual, episode, and lifetime day and visit limits;

(13) "Step therapy", a protocol or program that establishes the specific sequence in which prescription drugs for a medical condition that are medically appropriate for a particular patient are authorized by a health insurer or prescription drug management company;

(14) "Urgent health care service", a health care service with respect to which the application of the time period for making a non-expedited prior authorization, in the opinion of a physician with knowledge of the enrollee's medical condition:

(a) Could seriously jeopardize the life or health of the subscriber or the ability of the enrollee to regain maximum function; or

(b) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

3. For the purpose of this section, "urgent health care service" shall include services provided for the treatment of substance use disorders.

191.1165. 1. Medication-assisted treatment (MAT) shall include pharmacologic therapies. A formulary used by a health insurer or managed by a pharmacy benefits manager, or medical benefit coverage in the case of medications dispensed through an opioid treatment program, shall include:

(1) Buprenorphine tablets;

(2) Methadone;

(3) Naloxone;

(4) Extended-release injectable naltrexone; and

(5) Buprenorphine/naloxone combination.

2. All MAT medications required for compliance in this section shall be placed on the lowest cost-sharing tier of the formulary managed by the health insurer or the pharmacy benefits manager.

3. MAT medications provided for in this section shall not be subject to any of the following:

(1) Any annual or lifetime dollar limitations;

(2) Financial requirements and quantitative treatment limitations that do not comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), specifically 45 CFR 146.136(c)(3);

(3) Step therapy or other similar drug utilization strategy or policy when it conflicts or interferes with a prescribed or recommended course of treatment from a licensed health care professional; and

(4) Prior authorization for MAT medications as specified in this section.

4. MAT medications outlined in this section shall apply to all health insurance plans delivered in the state of Missouri.

5. Any entity that holds itself out as a treatment program or that applies for licensure by the state to provide clinical treatment services for substance use disorders shall be required to disclose the MAT services it provides, as well as which of its levels of care have been certified by an independent, national, or other organization that has competencies in the use of the applicable placement guidelines and level of care standards.

6. The MO HealthNet program shall cover the MAT medications and services provided for in this section and include those MAT medications in its preferred drug lists for the treatment of substance use disorders and prevention of overdose and death. The preferred drug list shall include all current and new formulations and medications that are approved by the U.S. Food and Drug Administration for the treatment of substance use disorders.

7. Drug courts or other diversion programs that provide for alternatives to jail or prison for persons with a substance use disorder shall be required to ensure all persons under their care are assessed for substance use disorders using standard diagnostic criteria by a licensed physician who actively treats patients with substance use disorders. The court or other diversion program shall make available the MAT services

covered under this section, consistent with a treatment plan developed by the physician, and shall not impose any limitations on the type of medication or other treatment prescribed or the dose or duration of MAT recommended by the physician.

8. Requirements under this section shall not be subject to a covered person's prior success or failure of the services provided.

191.1167. Any contract provision, written policy, or written procedure in violation of sections 191.1164 to 191.1168 shall be deemed to be unenforceable and shall be null and void.

191.1168. If any provision of sections 191.1164 to 191.1168 or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of sections 191.1164 to 191.1168 which may be given effect without the invalid provision or application, and to that end the provisions of sections 191.1164 to 191.1168 are severable.

195.060. 1. Except as provided in subsection 4 of this section, a pharmacist, in good faith, may sell and dispense controlled substances to any person only upon a prescription of a practitioner as authorized by statute, provided that the controlled substances listed in Schedule V may be sold without prescription in accordance with regulations of the department of health and senior services. All written prescriptions shall be signed by the person prescribing the same**, except for electronic prescriptions**. All prescriptions shall be dated on the day when issued and bearing the full name and address of the patient for whom, or of the owner of the animal for which, the drug is prescribed, and the full name, address, and the registry number under the federal controlled substances laws of the person prescribing, if he or she is required by those laws to be so registered. If the prescription is for an animal, it shall state the species of the animal for which the drug is prescribed. The person filling the prescription shall either write the date of filling and his or her own signature on the prescription or retain the date of filling and the identity of the dispenser as electronic prescription information. The prescription or electronic prescription information shall be retained on file by the proprietor of the pharmacy in which it is filled for a period of two years, so as to be readily accessible for inspection by any public officer or employee engaged in the enforcement of this law. No prescription for a drug in Schedule I or II shall be filled more than six months after the date prescribed; no prescription for a drug in Schedule I or II shall be refilled; no prescription for a drug in Schedule III or IV shall be filled or refilled more than six months after the date of the original prescription or be refilled more than five times unless renewed by the practitioner.

2. A pharmacist, in good faith, may sell and dispense controlled substances to any person upon a prescription of a practitioner located in another state, provided that the:

(1) Prescription was issued according to and in compliance with the applicable laws of that state and the United States; and

(2) Quantity limitations in subsection 4 of section 195.080 apply to prescriptions dispensed to patients located in this state.

3. The legal owner of any stock of controlled substances in a pharmacy, upon discontinuance of dealing in such drugs, may sell the stock to a manufacturer, wholesaler, or pharmacist, but only on an official written order.

4. A pharmacist, in good faith, may sell and dispense any Schedule II drug or drugs to any person in emergency situations as defined by rule of the department of health and senior services upon an oral prescription by an authorized practitioner.

5. Except where a bona fide physician-patient-pharmacist relationship exists, prescriptions for narcotics or hallucinogenic drugs shall not be delivered to or for an ultimate user or agent by mail or other common carrier.

195.080. 1. Except as otherwise provided in this chapter and chapter 579, this chapter and chapter 579 shall not apply to the following cases: prescribing, administering, dispensing or selling at retail of liniments, ointments, and other preparations that are susceptible of external use only and that contain controlled substances in such combinations of drugs as to prevent the drugs from being readily extracted from such liniments, ointments, or preparations, except that this chapter and chapter 579 shall apply to all liniments, ointments, and other preparations that contain coca leaves in any quantity or combination.

2. Unless otherwise provided in sections 334.037, 334.104, and 334.747, a practitioner, other than a veterinarian, shall not issue an initial prescription for more than a seven-day supply of any opioid controlled substance upon the initial consultation and treatment of a patient for acute pain. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription in compliance with the general provisions of this chapter and chapter 579. Prior to issuing an initial prescription for an opioid controlled substance, a practitioner shall consult with the patient regarding the quantity of the opioid and the patient's option to fill the prescription in a lesser quantity and shall inform the patient of the risks associated with the opioid prescribed. If, in the professional medical judgment of the practitioner, more than a seven-day supply is required to treat the patient's acute pain, the practitioner may issue a prescription for the quantity needed to treat the

patient; provided, that the practitioner shall document in the patient's medical record the condition triggering the necessity for more than a seven-day supply and that a nonopioid alternative was not appropriate to address the patient's condition. The provisions of this subsection shall not apply to prescriptions for opioid controlled substances for a patient who is currently undergoing treatment for cancer **or sickle cell disease**, is receiving hospice care from a hospice certified under chapter 197 or palliative care, is a resident of a long-term care facility licensed under chapter 198, or is receiving treatment for substance abuse or opioid dependence.

3. A pharmacist or pharmacy shall not be subject to disciplinary action or other civil or criminal liability for dispensing or refusing to dispense medication in good faith pursuant to an otherwise valid prescription that exceeds the prescribing limits established by subsection 2 of this section.

4. Unless otherwise provided in this section, the quantity of Schedule II controlled substances prescribed or dispensed at any one time shall be limited to a thirty-day supply. The quantity of Schedule III, IV or V controlled substances prescribed or dispensed at any one time shall be limited to a ninety-day supply and shall be prescribed and dispensed in compliance with the general provisions of this chapter and chapter 579. The supply limitations provided in this subsection may be increased up to three months if the physician describes on the prescription form or indicates via telephone, fax, or electronic communication to the pharmacy to be entered on or attached to the prescription form the medical reason for requiring the larger supply. The supply limitations provided in this subsection shall not apply if:

(1) The prescription is issued by a practitioner located in another state according to and in compliance with the applicable laws of that state and the United States and dispensed to a patient located in another state; or

(2) The prescription is dispensed directly to a member of the United States Armed Forces serving outside the United States.

5. The partial filling of a prescription for a Schedule II substance is permissible as defined by regulation by the department of health and senior services.

195.100. 1. It shall be unlawful to distribute any controlled substance in a commercial container unless such container bears a label containing an identifying symbol for such substance in accordance with federal laws.

2. It shall be unlawful for any manufacturer of any controlled substance to distribute such substance unless the labeling thereof conforms to the requirements of federal law and contains the identifying symbol required in subsection 1 of this section.

3. The label of a controlled substance in Schedule II, III or IV shall, when dispensed to or for a patient, contain a clear, concise warning that it is a criminal offense to transfer such narcotic or dangerous drug to any person other than the patient.

4. Whenever a manufacturer sells or dispenses a controlled substance and whenever a wholesaler sells or dispenses a controlled substance in a package prepared by him or her, the manufacturer or wholesaler shall securely affix to each package in which that drug is contained a label showing in legible English the name and address of the vendor and the quantity, kind, and form of controlled substance contained therein. No person except a pharmacist for the purpose of filling a prescription under this chapter, shall alter, deface, or remove any label so affixed.

5. Whenever a pharmacist or practitioner sells or dispenses any controlled substance on a prescription issued by a physician, physician assistant, dentist, podiatrist, veterinarian, or advanced practice registered nurse, the pharmacist or practitioner shall affix to the container in which such drug is sold or dispensed a label showing his or her own name and address of the pharmacy or practitioner for whom he or she is lawfully acting; the name of the patient or, if the patient is an animal, the name of the owner of the animal and the species of the animal; the name of the physician, physician assistant, dentist, podiatrist, advanced practice registered nurse, or veterinarian by whom the prescription was written; the name of the collaborating physician if the prescription is written by an advanced practice registered nurse or **[**~~the supervising physician if the prescription is written by~~**]** a physician assistant, and such directions as may be stated on the prescription. No person shall alter, deface, or remove any label so affixed.

195.550. 1. Notwithstanding any other provision of this section or any other law to the contrary, beginning January 1, 2021, no person shall issue any prescription in this state for any Schedule II, III, or IV controlled substance unless the prescription is made by electronic prescription from the person issuing the prescription to a pharmacy, except for prescriptions:

(1) Issued by veterinarians;

(2) Issued in circumstances where electronic prescribing is not available due to temporary technological or electrical failure;

(3) Issued by a practitioner to be dispensed by a pharmacy located outside the state;

(4) Issued when the prescriber and dispenser are the same entity;

(5) Issued that include elements that are not supported by the most recently implemented version of the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard;

(6) Issued by a practitioner for a drug that the federal Food and Drug Administration requires the prescription to contain certain elements that are not able to be accomplished with electronic processing;

(7) Issued by a practitioner allowing for the dispensing of a nonpatient specific prescription pursuant to a standing order, approved protocol for drug therapy, collaborative drug management or comprehensive medication management, in response to a public health emergency, or other circumstances where the practitioner may issue a nonpatient specific prescription;

(8) Issued by a practitioner prescribing a drug under a research protocol;

(9) Issued by practitioners who have received an annual waiver, or a renewal thereof, from the requirement to use electronic prescribing, pursuant to a process established in regulation by the department of health and senior services, due to economic hardship, technological limitations, or other exceptional circumstances demonstrated by the practitioner;

(10) Issued by a practitioner under circumstances where, notwithstanding the practitioner's present ability to make an electronic prescription as required by this subsection, such practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition; or

(11) Issued where the patient specifically requests a written prescription.

2. A pharmacist who receives a written, oral, or faxed prescription is not required to verify that the prescription properly falls under one of the exceptions from the requirement to electronically prescribe. Pharmacists may continue to dispense medications from otherwise valid written, oral, or fax prescriptions that are consistent with state and federal laws and regulations.

3. An individual who violates the provisions of this section may be subject to discipline by his or her professional licensing board.

196.100. 1. Any manufacturer, packer, distributor or seller of drugs or devices in this state shall comply with the current federal labeling requirements contained in the Federal Food, Drug and Cosmetic Act, as amended, and any federal regulations promulgated thereunder. Any drug or device which contains labeling that is not in compliance with the provisions of this section shall be deemed misbranded.

2. A drug dispensed on **an electronic prescription or** a written prescription signed by a licensed physician, dentist, or veterinarian, except a drug dispensed in the course of the conduct of a business of dispensing drugs pursuant to a diagnosis by mail, shall be exempt from the requirements of this section if such physician, dentist, or veterinarian is licensed by law to administer such drug, and such drug bears a label containing the name and place of business of the dispenser, the serial number and date of such prescription, and the name of such physician, dentist, or veterinarian.

3. The department is hereby directed to promulgate regulations exempting from any labeling or packaging requirement of sections 196.010 to 196.120, drugs and devices which are, in accordance with the practice of the trade, to be processed, labeled, or repacked in substantial quantities at establishments other than those where originally processed or packed, on condition that such drugs and devices are not adulterated or misbranded under the provisions of said sections upon removal from such processing, labeling, or repacking establishment.

208.790. 1. The applicant shall have or intend to have a fixed place of residence in Missouri, with the present intent of maintaining a permanent home in Missouri for the indefinite future. The burden of establishing proof of residence within this state is on the applicant. The requirement also applies to persons residing in long-term care facilities located in the state of Missouri.

2. The department shall promulgate rules outlining standards for documenting proof of residence in Missouri. Documents used to show proof of residence shall include the applicant's name and address in the state of Missouri.

3. Applicant household income limits for eligibility shall be subject to appropriations, but in no event shall applicants have household income that is greater than one hundred eighty-five percent of the federal poverty level for the applicable family size for the applicable year as converted to the MAGI equivalent net income standard. **[**~~The provisions of this subsection shall only apply to Medicaid dual eligible individuals.~~**]**

4. The department shall promulgate rules outlining standards for documenting proof of household income.

221.111. 1. A person commits the offense of possession of unlawful items in a prison or jail if such person knowingly delivers, attempts to deliver, possesses, deposits, or conceals in or about the premises of any correctional center as the term "correctional center" is defined under section 217.010, or any city, county, or private jail:

(1) Any controlled substance as that term is defined by law, except upon the written **or electronic** prescription of a licensed physician, dentist, or veterinarian;

(2) Any other alkaloid of any kind or any intoxicating liquor as the term intoxicating liquor is defined in section 311.020;

(3) Any article or item of personal property which a prisoner is prohibited by law, by rule made pursuant to section 221.060, or by regulation of the department of corrections from receiving or possessing, except as herein provided;

(4) Any gun, knife, weapon, or other article or item of personal property that may be used in such manner as to endanger the safety or security of the institution or as to endanger the life or limb of any prisoner or employee thereof.

2. The violation of subdivision (1) of subsection 1 of this section shall be a class D felony; the violation of subdivision (2) of this section shall be a class E felony; the violation of subdivision (3) of this section shall be a class A misdemeanor; and the violation of subdivision (4) of this section shall be a class B felony.

3. The chief operating officer of a county or city jail or other correctional facility or the administrator of a private jail may deny visitation privileges to or refer to the county prosecuting attorney for prosecution any person who knowingly delivers, attempts to deliver, possesses, deposits, or conceals in or about the premises of such jail or facility any personal item which is prohibited by rule or regulation of such jail or facility. Such rules or regulations, including a list of personal items allowed in the jail or facility, shall be prominently posted for viewing both inside and outside such jail or facility in an area accessible to any visitor, and shall be made available to any person requesting such rule or regulation. Violation of this subsection shall be an infraction if not covered by other statutes.

4. Any person who has been found guilty of a violation of subdivision (2) of subsection 1 of this section involving any alkaloid shall be entitled to expungement of the record of the violation. The procedure to expunge the record shall be pursuant to section 610.123. The record of any person shall not be expunged if such person has been found guilty of knowingly delivering, attempting to deliver, possessing, depositing, or concealing any alkaloid of any controlled substance in or about the premises of any correctional center, or city or county jail, or private prison or jail.

332.361. 1. **For purposes of this section, the following terms shall mean:**

(1) "Acute pain", shall have the same meaning as in section 195.010;

(2) "Long-acting or extended-release opioids", formulated in such a manner as to make the contained medicament available over an extended period of time following ingestion.

2. Any duly registered and currently licensed dentist in Missouri may write, and any pharmacist in Missouri who is currently licensed under the provisions of chapter 338 and any amendments thereto, may fill any prescription of a duly registered and currently licensed dentist in Missouri for any drug necessary or proper in the practice of dentistry, provided that no such prescription is in violation of either the Missouri or federal narcotic drug act.

[~~2.~~**] 3.** Any duly registered and currently licensed dentist in Missouri may possess, have under his control, prescribe, administer, dispense, or distribute a "controlled substance" as that term is defined in section 195.010 only to the extent that:

(1) The dentist possesses the requisite valid federal and state registration to distribute or dispense that class of controlled substance;

(2) The dentist prescribes, administers, dispenses, or distributes the controlled substance in the course of his professional practice of dentistry, and for no other reason;

(3) A bona fide dentist-patient relationship exists; and

(4) The dentist possesses, has under his control, prescribes, administers, dispenses, or distributes the controlled substance in accord with all pertinent requirements of the federal and Missouri narcotic drug and controlled substances acts, including the keeping of records and inventories when required therein.

4. Long-acting or extended-release opioids shall not be used for the treatment of acute pain. If in the professional judgement of the dentist, a long-acting or extended-release opioid is necessary to treat the patient, the dentist shall document and explain in the patient's dental record the reason for the necessity for the long-acting or extended-release opioid.

5. Dentists shall avoid prescribing doses greater than fifty morphine milligram equivalent (MME) per day for treatment of acute pain. If in the professional judgement of the dentist, doses greater than fifty MME are necessary to treat the patient, the dentist shall document and explain in the patient's dental record the reason for the necessity for the dose greater than fifty MME. The relative potency of opioids is represented by a value assigned to individual opioids known as a morphine milligram equivalent (MME). The MME value represents how many milligrams of a particular opioid is equivalent to one milligram of morphine. The Missouri dental board shall maintain a MME conversion chart and instructions for calculating MME on its website to assist licensees with calculating MME.

338.010. 1. The "practice of pharmacy" means the interpretation, implementation, and evaluation of medical prescription orders, including any legend drugs under 21 U.S.C. Section 353; receipt, transmission, or handling of such orders or facilitating the dispensing of such orders; the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by the prescription order so long as the prescription order is specific to each patient for care by a pharmacist; the compounding, dispensing, labeling, and administration of drugs and devices pursuant to medical prescription orders and administration of viral influenza, pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, and meningitis vaccines by written protocol authorized by a physician for persons at least seven years of age or the age recommended by the Centers for Disease Control and Prevention, whichever is higher, or the administration of pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, meningitis, and viral influenza vaccines by written protocol authorized by a physician for a specific patient as authorized by rule; the participation in drug selection according to state law and participation in drug utilization reviews; the proper and safe storage of drugs and devices and the maintenance of proper records thereof; consultation with patients and other health care practitioners, and veterinarians and their clients about legend drugs, about the safe and effective use of drugs and devices; **the prescribing and dispensing of any nicotine replacement therapy product under section 338.665;** and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management and control of a pharmacy. No person shall engage in the practice of pharmacy unless he **or she** is licensed under the provisions of this chapter. This chapter shall not be construed to prohibit the use of auxiliary personnel under the direct supervision of a pharmacist from assisting the pharmacist in any of his or her duties. This assistance in no way is intended to relieve the pharmacist from his or her responsibilities for compliance with this chapter and he or she will be responsible for the actions of the auxiliary personnel acting in his or her assistance. This chapter shall also not be construed to prohibit or interfere with any legally registered practitioner of medicine, dentistry, or podiatry, or veterinary medicine only for use in animals, or the practice of optometry in accordance with and as provided in sections 195.070 and 336.220 in the compounding, administering, prescribing, or dispensing of his or her own prescriptions.

2. Any pharmacist who accepts a prescription order for a medication therapeutic plan shall have a written protocol from the physician who refers the patient for medication therapy services. The written protocol and the prescription order for a medication therapeutic plan shall come from the physician only, and shall not come from a nurse engaged in a collaborative practice arrangement under section 334.104, or from a physician assistant engaged in a **[**~~supervision agreement~~**] collaborative practice arrangement** under section 334.735.

3. Nothing in this section shall be construed as to prevent any person, firm or corporation from owning a pharmacy regulated by sections 338.210 to 338.315, provided that a licensed pharmacist is in charge of such pharmacy.

4. Nothing in this section shall be construed to apply to or interfere with the sale of nonprescription drugs and the ordinary household remedies and such drugs or medicines as are normally sold by those engaged in the sale of general merchandise.

5. No health carrier as defined in chapter 376 shall require any physician with which they contract to enter into a written protocol with a pharmacist for medication therapeutic services.

6. This section shall not be construed to allow a pharmacist to diagnose or independently prescribe pharmaceuticals.

7. The state board of registration for the healing arts, under section 334.125, and the state board of pharmacy, under section 338.140, shall jointly promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Such rules shall require protocols to include provisions allowing for timely communication between the pharmacist and the referring physician, and any other patient protection provisions deemed appropriate by both boards. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither board shall separately promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

8. The state board of pharmacy may grant a certificate of medication therapeutic plan authority to a licensed pharmacist who submits proof of successful completion of a board-approved course of academic clinical study beyond a bachelor of science in pharmacy, including but not limited to clinical assessment skills, from a nationally accredited college or university, or a certification of equivalence issued by a nationally recognized professional organization and approved by the board of pharmacy.

9. Any pharmacist who has received a certificate of medication therapeutic plan authority may engage in the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by a prescription order from a physician that is specific to each patient for care by a pharmacist.

10. Nothing in this section shall be construed to allow a pharmacist to make a therapeutic substitution of a pharmaceutical prescribed by a physician unless authorized by the written protocol or the physician's prescription order.

11. "Veterinarian", "doctor of veterinary medicine", "practitioner of veterinary medicine", "DVM", "VMD", "BVSe", "BVMS", "BSe (Vet Science)", "VMB", "MRCVS", or an equivalent title means a person who has received a doctor's degree in veterinary medicine from an accredited school of veterinary medicine or holds an Educational Commission for Foreign Veterinary Graduates (EDFVG) certificate issued by the American Veterinary Medical Association (AVMA).

12. In addition to other requirements established by the joint promulgation of rules by the board of pharmacy and the state board of registration for the healing arts:

(1) A pharmacist shall administer vaccines by protocol in accordance with treatment guidelines established by the Centers for Disease Control and Prevention (CDC);

(2) A pharmacist who is administering a vaccine shall request a patient to remain in the pharmacy a safe amount of time after administering the vaccine to observe any adverse reactions. Such pharmacist shall have adopted emergency treatment protocols;

(3) In addition to other requirements by the board, a pharmacist shall receive additional training as required by the board and evidenced by receiving a certificate from the board upon completion, and shall display the certification in his or her pharmacy where vaccines are delivered.

13. A pharmacist shall inform the patient that the administration of the vaccine will be entered into the ShowMeVax system, as administered by the department of health and senior services. The patient shall attest to the inclusion of such information in the system by signing a form provided by the pharmacist. If the patient indicates that he or she does not want such information entered into the ShowMeVax system, the pharmacist shall provide a written report within fourteen days of administration of a vaccine to the patient's primary health care provider, if provided by the patient, containing:

(1) The identity of the patient;

(2) The identity of the vaccine or vaccines administered;

(3) The route of administration;

(4) The anatomic site of the administration;

(5) The dose administered; and

(6) The date of administration.

338.015. 1. The provisions of sections 338.010 to 338.015 shall not be construed to inhibit the patient's freedom of choice to obtain prescription services from any licensed pharmacist. However, nothing in sections 338.010 to 338.315 abrogates the patient's ability to waive freedom of choice under any contract with regard to payment or coverage of prescription expense.

2. All pharmacists may provide pharmaceutical consultation and advice to persons concerning the safe and therapeutic use of their prescription drugs.

3. All patients shall have the right to receive a written prescription from their prescriber to take to the facility of their choice **or to have an electronic prescription transmitted to the facility of their choice**.

338.055. 1. The board may refuse to issue any certificate of registration or authority, permit or license required pursuant to this chapter for one or any combination of causes stated in subsection 2 of this section or if the designated pharmacist-in-charge, manager-in-charge, or any officer, owner, manager, or controlling shareholder of the applicant has committed any act or practice in subsection 2 of this section. The board shall notify the applicant in writing of the reasons for the refusal and shall advise the applicant of his or her right to file a complaint with the administrative hearing commission as provided by chapter 621.

2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:

(1) Use of any controlled substance, as defined in chapter 195, or alcoholic beverage to an extent that such use impairs a person's ability to perform the work of any profession licensed or regulated by this chapter;

(2) The person has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of any profession licensed or regulated under this chapter, for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude, whether or not sentence is imposed;

(3) Use of fraud, deception, misrepresentation or bribery in securing any certificate of registration or authority, permit or license issued pursuant to this chapter or in obtaining permission to take any examination given or required pursuant to this chapter;

(4) Obtaining or attempting to obtain any fee, charge, tuition or other compensation by fraud, deception or misrepresentation;

(5) Incompetence, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by this chapter;

(6) Violation of, or assisting or enabling any person to violate, any provision of this chapter, or of any lawful rule or regulation adopted pursuant to this chapter;

(7) Impersonation of any person holding a certificate of registration or authority, permit or license or allowing any person to use his or her certificate of registration or authority, permit, license, or diploma from any school;

(8) Denial of licensure to an applicant or disciplinary action against an applicant or the holder of a license or other right to practice any profession regulated by this chapter granted by another state, territory, federal agency, or country whether or not voluntarily agreed to by the licensee or applicant, including, but not limited to, surrender of the license upon grounds for which denial or discipline is authorized in this state;

(9) A person is finally adjudged incapacitated by a court of competent jurisdiction;

(10) Assisting or enabling any person to practice or offer to practice any profession licensed or regulated by this chapter who is not registered and currently eligible to practice under this chapter;

(11) Issuance of a certificate of registration or authority, permit or license based upon a material mistake of fact;

(12) Failure to display a valid certificate or license if so required by this chapter or any rule promulgated hereunder;

(13) Violation of any professional trust or confidence;

(14) Use of any advertisement or solicitation which is false, misleading or deceptive to the general public or persons to whom the advertisement or solicitation is primarily directed;

(15) Violation of the drug laws or rules and regulations of this state, any other state or the federal government;

(16) The intentional act of substituting or otherwise changing the content, formula or brand of any drug prescribed by written**, electronic,** or oral prescription without prior written or oral approval from the prescriber for the respective change in each prescription; provided, however, that nothing contained herein shall prohibit a pharmacist from substituting or changing the brand of any drug as provided under section 338.056, and any such substituting or changing of the brand of any drug as provided for in section 338.056 shall not be deemed unprofessional or dishonorable conduct unless a violation of section 338.056 occurs;

(17) Personal use or consumption of any controlled substance unless it is prescribed, dispensed, or administered by a health care provider who is authorized by law to do so.

3. After the filing of such complaint, the proceedings shall be conducted in accordance with the provisions of chapter 621. Upon a finding by the administrative hearing commission that the grounds, provided in subsection 2 of this section, for disciplinary action are met, the board may, singly or in combination, censure or place the person named in the complaint on probation on such terms and conditions as the board deems appropriate for a period not to exceed five years, or may suspend, for a period not to exceed three years, or revoke the license, certificate, or permit. The board may impose additional discipline on a licensee, registrant, or permittee found to have violated any disciplinary terms previously imposed under this section or by agreement. The additional discipline may include, singly or in combination, censure, placing the licensee, registrant, or permittee named in the complaint on additional probation on such terms and conditions as the board deems appropriate, which additional probation shall not exceed five years, or suspension for a period not to exceed three years, or revocation of the license, certificate, or permit.

4. If the board concludes that a licensee or registrant has committed an act or is engaging in a course of conduct which would be grounds for disciplinary action which constitutes a clear and present danger to the public health and safety, the board may file a complaint before the administrative hearing commission requesting an expedited hearing and specifying the activities which give rise to the danger and the nature of the proposed restriction or suspension of the licensee's or registrant's license. Within fifteen days after service of the complaint on

the licensee or registrant, the administrative hearing commission shall conduct a preliminary hearing to determine whether the alleged activities of the licensee or registrant appear to constitute a clear and present danger to the public health and safety which justify that the licensee's or registrant's license or registration be immediately restricted or suspended. The burden of proving that the actions of a licensee or registrant constitute a clear and present danger to the public health and safety shall be upon the state board of pharmacy. The administrative hearing commission shall issue its decision immediately after the hearing and shall either grant to the board the authority to suspend or restrict the license or dismiss the action.

5. If the administrative hearing commission grants temporary authority to the board to restrict or suspend the licensee's or registrant's license, such temporary authority of the board shall become final authority if there is no request by the licensee or registrant for a full hearing within thirty days of the preliminary hearing. The administrative hearing commission shall, if requested by the licensee or registrant named in the complaint, set a date to hold a full hearing under the provisions of chapter 621 regarding the activities alleged in the initial complaint filed by the board.

6. If the administrative hearing commission dismisses the action filed by the board pursuant to subsection 4 of this section, such dismissal shall not bar the board from initiating a subsequent action on the same grounds.

338.056. 1. Except as provided in subsection 2 of this section, the pharmacist filling prescription orders for drug products prescribed by trade or brand name may select another drug product with the same active chemical ingredients of the same strength, quantity and dosage form, and of the same generic drug or interchangeable biological product type, as determined by the United States Adopted Names and accepted by the Federal Food and Drug Administration. Selection pursuant to this section is within the discretion of the pharmacist, except as provided in subsection 2 of this section. The pharmacist who selects the drug or interchangeable biological product to be dispensed pursuant to this section shall assume the same responsibility for selecting the dispensed drug or biological product as would be incurred in filling a prescription for a drug or interchangeable biological product prescribed by generic or interchangeable biologic name. The pharmacist shall not select a drug or interchangeable biological product pursuant to this section unless the product selected costs the patient less than the prescribed product.

2. A pharmacist who receives a prescription for a brand name drug or biological product may select a less expensive generically equivalent or interchangeable biological product unless:

(1) The patient requests a brand name drug or biological product; or

(2) The prescribing practitioner indicates that substitution is prohibited or displays "brand medically necessary", "dispense as written", "do not substitute", "DAW", or words of similar import on the prescription.

3. No prescription shall be valid without the signature of the prescriber**, except an electronic prescription**.

4. If an oral prescription is involved, the practitioner or the practitioner's agent, communicating the instructions to the pharmacist, shall instruct the pharmacist as to whether or not a therapeutically equivalent generic drug or interchangeable biological product may be substituted. The pharmacist shall note the instructions on the file copy of the prescription.

5. Notwithstanding the provisions of subsection 2 of this section to the contrary, a pharmacist may fill a prescription for a brand name drug by substituting a generically equivalent drug or interchangeable biological product when substitution is allowed in accordance with the laws of the state where the prescribing practitioner is located.

6. Violations of this section are infractions.

338.095. 1. The terms "prescription" and "prescription drug order" are hereby defined as a lawful order for medications or devices issued and signed by an authorized prescriber within the scope of his professional practice which is to be dispensed or administered by a pharmacist or dispensed or administered pursuant to section 334.104 to and for the ultimate user. The terms "prescription" and "drug order" do not include an order for medication requiring a prescription to be dispensed, which is provided for the immediate administration to the ultimate user or recipient.

2. The term "telephone prescription" is defined as an order for medications or devices transmitted to a pharmacist by telephone or similar electronic medium by an authorized prescriber or his authorized agent acting in the course of his professional practice which is to be dispensed or administered by a pharmacist or dispensed or administered pursuant to section 334.104 to and for the ultimate user. A telephone prescription shall be promptly reduced to written or electronic medium by the pharmacist and shall comply with all laws governing prescriptions and record keeping.

3. A licensed pharmacist may lawfully provide prescription or medical information to a licensed health care provider or his agent who is legally qualified to administer medications and treatments and who is involved in the treatment of the patient. The information may be derived by direct contact with the prescriber or through a written protocol approved by the prescriber. Such information shall authorize the provider to administer appropriate medications and treatments.

4. Nothing in this section shall be construed to limit the authority of other licensed health care providers to prescribe, administer, or dispense medications and treatments within the scope of their professional practice.

5. It shall be an unauthorized practice of pharmacy and hence unlawful for any person other than **a board licensee or registrant,** the patient**,** or the patient's authorized representative to accept a prescription presented to be dispensed unless that person is located on a premises licensed by the board as a pharmacy.

338.140. 1. The board of pharmacy shall have a common seal, and shall have power to adopt such rules and bylaws not inconsistent with law as may be necessary for the regulation of its proceedings and for the discharge of the duties imposed pursuant to sections 338.010 to 338.198, and shall have power to employ an attorney to conduct prosecutions or to assist in the conduct of prosecutions pursuant to sections 338.010 to 338.198.

2. The board shall keep a record of its proceedings.

3. The board of pharmacy shall make annually to the governor and, upon written request, to persons licensed pursuant to the provisions of this chapter a written report of its proceedings.

4. The board of pharmacy shall appoint an advisory committee composed of six members, one of whom shall be a representative of pharmacy but who shall not be a member of the pharmacy board, three of whom shall be representatives of wholesale drug distributors as defined in section 338.330, one of whom shall be a representative of drug manufacturers, and one of whom shall be a licensed veterinarian recommended to the board of pharmacy by the board of veterinary medicine. The committee shall review and make recommendations to the board on the merit of all rules and regulations dealing with pharmacy distributors, wholesale drug distributors, drug manufacturers, and veterinary legend drugs which are proposed by the board.

5. A majority of the board shall constitute a quorum for the transaction of business.

6. Notwithstanding any other provisions of law to the contrary, the board may issue letters of reprimand, censure or warning to any holder of a license or registration required pursuant to this chapter for any violations that could result in disciplinary action as defined in section 338.055. **Alternatively, at the discretion of the board, the board may enter into a voluntary compliance agreement with a licensee, permit holder, or registrant to ensure or promote compliance with this chapter and the rules of the board, in lieu of board discipline. The agreement shall be a public record. The time limitation identified in section 324.043 for commencing a disciplinary proceeding shall be tolled while an agreement authorized by this section is in effect.**

338.143. 1. For purposes of this section, the following terms shall mean:

(1) "Remote medication dispensing", dispensing or assisting in the dispensing of medication outside of a licensed pharmacy;

(2) "Technology assisted verification", the verification of medication or prescription information using a combination of scanning technology and visual confirmation by a pharmacist.

2. The board of pharmacy may approve, modify, and establish requirements for pharmacy pilot or demonstration research projects related to technology assisted verification or remote medication dispensing that are designed to enhance patient care or safety, improve patient outcomes, or expand access to pharmacy services.

3. To be approved, pilot or research projects shall be within the scope of the practice of pharmacy as defined by chapter 338, be under the supervision of a Missouri licensed pharmacist, and comply with applicable compliance and reporting as established by the board by rule, including any staff training or education requirements. Board approval shall be limited to a period of up to eighteen months, provided the board grant an additional six month extension if deemed necessary or appropriate to gather or complete research data or if deemed in the best interests of the patient. The board may rescind approval of a pilot project at any time if deemed necessary or appropriate in the interest of patient safety.

4. The provisions of this subsection shall expire on August 28, 2023. The board shall provide a final report on approved projects and related data or findings to the general assembly on or before December 31, 2022. The name, location, approval dates, general description of and responsible pharmacist for an approved pilot or research project shall be deemed an open record.

338.665. 1. For the purposes of this chapter, "nicotine replacement therapy product" means any drug or product, regardless of whether it is available over-the-counter, that delivers small doses of nicotine to a person and that is approved by the federal Food and Drug Administration for the sole purpose of aiding in tobacco cessation or smoking cessation.

2. The board of pharmacy and the board of healing arts shall jointly promulgate rules governing a pharmacist's authority to prescribe and dispense nicotine replacement therapy products. Neither board shall separately promulgate rules governing a pharmacist's authority to prescribe and dispense nicotine replacement therapy products under this subsection.

3. Nothing in this section shall be construed to require third party payment for services described in this section.

4. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2019, shall be invalid and void."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Lavender raised a point of order that there had been a violation of Rule 87.

Representative Plocher requested a parliamentary ruling.

On motion of Representative Stephens (128), **House Amendment No. 7** was adopted.

Representative Helms offered **House Amendment No. 8**.

House Amendment No. 8

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after all of said section and line the following:

"**195.422. No state official or law enforcement officer shall impede or inhibit the importation of a prescription drug for personal use so long as the patient has a valid prescription from a prescriber.**"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Helms, **House Amendment No. 8** was adopted.

Representative Gregory offered **House Amendment No. 9**.

House Amendment No. 9

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after said section and line the following:

"334.506. 1. As used in this section, "approved health care provider" means a person holding a current and active license as a physician and surgeon under this chapter, a chiropractor under chapter 331, a dentist under chapter 332, a podiatrist under chapter 330, a physician assistant under this chapter, an advanced practice registered nurse under chapter 335, or any licensed and registered physician, chiropractor, dentist, or podiatrist practicing in another jurisdiction whose license is in good standing.

2. A physical therapist **[**~~shall not~~**] may evaluate and** initiate treatment **[**~~for a new injury or illness~~**] on a patient** without a prescription **or referral** from an approved health care provider**, provided that the physical therapist has a doctorate of physical therapy or has five years of clinical practice as a physical therapist**.

3. A physical therapist may provide educational resources and training, develop fitness or wellness programs **[**~~for asymptomatic persons~~**]**, or provide screening or consultative services within the scope of physical therapy practice without **[**~~the~~**] a** prescription **[**~~and direction of~~**] or referral from** an approved health care provider.

4. **[**~~A physical therapist may examine and treat without the prescription and direction of an approved health care provider any person with a recurring self-limited injury within one year of diagnosis by an approved health care provider or a chronic illness that has been previously diagnosed by an approved health care provider. The~~**] A** physical therapist shall:

(1) **[**~~Contact the patient's current approved health care provider within seven days of initiating physical therapy services under this subsection~~**] Refer to an approved health care provider any patient whose condition at the time of evaluation or treatment is determined to be beyond the scope of practice of physical therapy**;

(2) **[**~~Not change an existing physical therapy referral available to the physical therapist without approval of the patient's current approved health care provider~~**] Refer to an approved health care provider any patient who does not demonstrate measurable or functional improvement after ten visits or twenty-one business days, whichever occurs first**; **or**

(3) **[**~~Refer to an approved health care provider any patient whose medical condition at the time of examination or treatment is determined to be beyond the scope of practice of physical therapy~~**] Consult with an approved health care provider if, after ten visits or twenty-one business days, whichever occurs first, the patient has demonstrated measurable or functional improvement from the course of physical therapy services or treatment provided and the physical therapist believes that continuation of the course of physical therapy services or treatment is reasonable and necessary based on the physical therapist's physical therapy evaluation of the patient. The physical therapist shall not provide further physical therapy services or treatment after the ten visits or twenty-one business days until the consultation has occurred. No consultation with an approved health care provider is required if the course of physical therapy services or treatment is completed within ten visits or twenty-one business days. "Consult" or "consultation", for purpose of this provision, means communication by telephone, fax, in writing, or in person, with the patient's personal licensed approved health care provider or a licensed health care provider of the patient's designation. The consultation with the approved health care provider shall include information concerning the patient's condition for which physical therapy services or treatment were provided; the basis for the course of services or treatment indicated, as determined from the physical therapy evaluation of the patient; the physical therapy services or treatment provided to the date of consultation; the patient's demonstrated measurable or functional improvement from the services or treatment provided to the date of consultation; the continuing physical therapy services or treatment proposed to be provided following the consultation; and the professional physical therapy basis for the continued physical therapy services or treatment to be provided. Continued physical therapy services or treatment under the course of services or treatment following the consultation with an approved health care provider shall proceed in accordance with any feedback, advice, opinion, or direction of the approved health care provider. The physical therapist shall notify the consulting approved health care provider of continuing physical therapy services or treatment every thirty days after the initial consultation unless the consulting approved health care provider directs otherwise[**~~;~~**

~~(4) Refer to an approved health care provider any patient whose condition for which physical therapy services are rendered under this subsection has not been documented to be progressing toward documented treatment goals after six visits or fourteen days, whichever first occurs;~~

~~(5) Notify the patient's current approved health care provider prior to the continuation of treatment if treatment rendered under this subsection is to continue beyond thirty days. The physical therapist shall provide such notification for each successive period of thirty days~~**]**.

5. The provision of physical therapy services of evaluation and screening pursuant to this section shall be limited to a physical therapist, and any authority for evaluation and screening granted within this section may not be delegated. Upon each reinitiation of physical therapy services, a physical therapist shall provide a full physical therapy evaluation prior to the reinitiation of physical therapy treatment. **[**~~Physical therapy treatment provided pursuant to the provisions of subsection 4 of this section may be delegated by physical therapists to physical therapist assistants only if the patient's current approved health care provider has been so informed as part of the physical therapist's seven-day notification upon reinitiation of physical therapy services as required in subsection 4 of this section.~~**]** Nothing in this subsection shall be construed as to limit the ability of physical therapists or physical therapist assistants to provide physical therapy services in accordance with the provisions of this chapter, and upon the referral of an approved health care provider. Nothing in this subsection shall prohibit an approved health care provider from acting within the scope of their practice as defined by the applicable chapters of RSMo.

6. No person licensed to practice, or applicant for licensure, as a physical therapist or physical therapist assistant shall make a medical diagnosis.

7. A physical therapist shall only delegate physical therapy treatment to a physical therapist assistant or to a person in an entry level of a professional education program approved by the Commission on Accreditation in Physical Therapy Education (CAPTE) who satisfies supervised clinical education requirements related to the person's physical therapist or physical therapist assistant education. The entry-level person shall be under the supervision of a physical therapist.

334.613. 1. The board may refuse to issue or renew a license to practice as a physical therapist or physical therapist assistant for one or any combination of causes stated in subsection 2 of this section. The board shall notify the applicant in writing of the reasons for the refusal and shall advise the applicant of the applicant's right to file a complaint with the administrative hearing commission as provided by chapter 621. As an alternative to a refusal to issue or renew a license to practice as a physical therapist or physical therapist assistant, the board may, at its discretion, issue a license which is subject to probation, restriction, or limitation to an applicant for licensure for any one or any combination of causes stated in subsection 2 of this section. The board's order of probation, limitation, or restriction shall contain a statement of the discipline imposed, the basis therefor, the date such action shall become effective, and a statement that the applicant has thirty days to request in writing a hearing before the administrative hearing commission. If the board issues a probationary, limited, or restricted license to an applicant for licensure, either party may file a written petition with the administrative hearing commission within thirty days of the effective date of the probationary, limited, or restricted license seeking review of the board's determination. If no written request for a hearing is received by the administrative hearing commission within the thirty-day period, the right to seek review of the board's decision shall be considered as waived.

2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of a license to practice as a physical therapist or physical therapist assistant who has failed to renew or has surrendered his or her license for any one or any combination of the following causes:

(1) Use of any controlled substance, as defined in chapter 195, or alcoholic beverage to an extent that such use impairs a person's ability to perform the work of a physical therapist or physical therapist assistant;

(2) The person has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions, or duties of a physical therapist or physical therapist assistant, for any offense an essential element of which is fraud, dishonesty, or an act of violence, or for any offense involving moral turpitude, whether or not sentence is imposed;

(3) Use of fraud, deception, misrepresentation, or bribery in securing any certificate of registration or authority, permit, or license issued under this chapter or in obtaining permission to take any examination given or required under this chapter;

(4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct, or unprofessional conduct in the performance of the functions or duties of a physical therapist or physical therapist assistant, including but not limited to the following:

(a) Obtaining or attempting to obtain any fee, charge, tuition, or other compensation by fraud, deception, or misrepresentation; willfully and continually overcharging or overtreating patients; or charging for sessions of physical therapy which did not occur unless the services were contracted for in advance, or for services which were not rendered or documented in the patient's records;

(b) Attempting, directly or indirectly, by way of intimidation, coercion, or deception, to obtain or retain a patient or discourage the use of a second opinion or consultation;

(c) Willfully and continually performing inappropriate or unnecessary treatment or services;

(d) Delegating professional responsibilities to a person who is not qualified by training, skill, competency, age, experience, or licensure to perform such responsibilities;

(e) Misrepresenting that any disease, ailment, or infirmity can be cured by a method, procedure, treatment, medicine, or device;

(f) Performing services which have been declared by board rule to be of no physical therapy value;

(g) Final disciplinary action by any professional association, professional society, licensed hospital or medical staff of the hospital, or physical therapy facility in this or any other state or territory, whether agreed to voluntarily or not, and including but not limited to any removal, suspension, limitation, or restriction of the person's professional employment, malpractice, or any other violation of any provision of this chapter;

(h) Administering treatment without sufficient examination, or for other than medically accepted therapeutic or experimental or investigative purposes duly authorized by a state or federal agency, or not in the course of professional physical therapy practice;

(i) Engaging in or soliciting sexual relationships, whether consensual or nonconsensual, while a physical therapist or physical therapist assistant/patient relationship exists; making sexual advances, requesting sexual favors, or engaging in other verbal conduct or physical contact of a sexual nature with patients or clients;

(j) Terminating the care of a patient without adequate notice or without making other arrangements for the continued care of the patient;

(k) Failing to furnish details of a patient's physical therapy records to treating physicians, other physical therapists, or hospitals upon proper request; or failing to comply with any other law relating to physical therapy records;

(l) Failure of any applicant or licensee, other than the licensee subject to the investigation, to cooperate with the board during any investigation;

(m) Failure to comply with any subpoena or subpoena duces tecum from the board or an order of the board;

(n) Failure to timely pay license renewal fees specified in this chapter;

(o) Violating a probation agreement with this board or any other licensing agency;

(p) Failing to inform the board of the physical therapist's or physical therapist assistant's current telephone number, residence, and business address;

(q) Advertising by an applicant or licensee which is false or misleading, or which violates any rule of the board, or which claims without substantiation the positive cure of any disease, or professional superiority to or greater skill than that possessed by any other physical therapist or physical therapist assistant. An applicant or licensee shall also be in violation of this provision if the applicant or licensee has a financial interest in any organization, corporation, or association which issues or conducts such advertising;

(5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence, or repeated negligence in the performance of the functions or duties of a physical therapist or physical therapist assistant. For the purposes of this subdivision, "repeated negligence" means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant's or licensee's profession;

(6) Violation of, or attempting to violate, directly or indirectly, or assisting or enabling any person to violate, any provision of this chapter, or of any lawful rule adopted under this chapter;

(7) Impersonation of any person licensed as a physical therapist or physical therapist assistant or allowing any person to use his or her license or diploma from any school;

(8) Revocation, suspension, restriction, modification, limitation, reprimand, warning, censure, probation, or other final disciplinary action against a physical therapist or physical therapist assistant for a license or other right to practice as a physical therapist or physical therapist assistant by another state, territory, federal agency or country, whether or not voluntarily agreed to by the licensee or applicant, including but not limited to the denial of licensure, surrender of the license, allowing the license to expire or lapse, or discontinuing or limiting the practice of physical therapy while subject to an investigation or while actually under investigation by any licensing authority, medical facility, branch of the Armed Forces of the United States of America, insurance company, court, agency of the state or federal government, or employer;

(9) A person is finally adjudged incapacitated or disabled by a court of competent jurisdiction;

(10) Assisting or enabling any person to practice or offer to practice who is not licensed and currently eligible to practice under this chapter; or knowingly performing any act which in any way aids, assists, procures, advises, or encourages any person to practice physical therapy who is not licensed and currently eligible to practice under this chapter;

(11) Issuance of a license to practice as a physical therapist or physical therapist assistant based upon a material mistake of fact;

(12) Failure to display a valid license pursuant to practice as a physical therapist or physical therapist assistant;

(13) Knowingly making, or causing to be made, or aiding, or abetting in the making of, a false statement in any document executed in connection with the practice of physical therapy;

(14) Soliciting patronage in person or by agents or representatives, or by any other means or manner, under the person's own name or under the name of another person or concern, actual or pretended, in such a manner as to confuse, deceive, or mislead the public as to the need or necessity for or appropriateness of physical therapy services for all patients, or the qualifications of an individual person or persons to render, or perform physical therapy services;

(15) Using, or permitting the use of, the person's name under the designation of "physical therapist", "physiotherapist", "registered physical therapist", "P.T.", "Ph.T.", "P.T.T.", "D.P.T.", "M.P.T." or "R.P.T.", "physical therapist assistant", "P.T.A.", "L.P.T.A.", "C.P.T.A.", or any similar designation with reference to the commercial exploitation of any goods, wares or merchandise;

(16) Knowingly making or causing to be made a false statement or misrepresentation of a material fact, with intent to defraud, for payment under chapter 208 or chapter 630 or for payment from Title XVIII or Title XIX of the Social Security Act;

(17) Failure or refusal to properly guard against contagious, infectious, or communicable diseases or the spread thereof; maintaining an unsanitary facility or performing professional services under unsanitary conditions; or failure to report the existence of an unsanitary condition in any physical therapy facility to the board, in writing, within thirty days after the discovery thereof;

(18) Any candidate for licensure or person licensed to practice as a physical therapist or physical therapist assistant paying or offering to pay a referral fee or**[**~~, notwithstanding section 334.010 to the contrary, practicing or offering to practice professional physical therapy independent of the prescription and direction of a person licensed and registered as a physician and surgeon under this chapter, as a physician assistant under this chapter, as a chiropractor under chapter 331, as a dentist under chapter 332, as a podiatrist under chapter 330, as an advanced practice registered nurse under chapter 335, or any licensed and registered physician, chiropractor, dentist, podiatrist, or advanced practice registered nurse practicing in another jurisdiction, whose license is in good standing~~**]** **evaluating or treating a patient in a manner inconsistent with section 224.506**;

(19) Any candidate for licensure or person licensed to practice as a physical therapist or physical therapist assistant treating or attempting to treat ailments or other health conditions of human beings other than by professional physical therapy and as authorized by sections 334.500 to 334.685;

(20) A pattern of personal use or consumption of any controlled substance unless it is prescribed, dispensed, or administered by a physician who is authorized by law to do so;

(21) Failing to maintain adequate patient records under section 334.602;

(22) Attempting to engage in conduct that subverts or undermines the integrity of the licensing examination or the licensing examination process, including but not limited to utilizing in any manner recalled or memorized licensing examination questions from or with any person or entity, failing to comply with all test center security procedures, communicating or attempting to communicate with any other examinees during the test, or copying or sharing licensing examination questions or portions of questions;

(23) Any candidate for licensure or person licensed to practice as a physical therapist or physical therapist assistant who requests, receives, participates or engages directly or indirectly in the division, transferring, assigning, rebating or refunding of fees received for professional services or profits by means of a credit or other valuable consideration such as wages, an unearned commission, discount or gratuity with any person who referred a patient, or with any relative or business associate of the referring person;

(24) Being unable to practice as a physical therapist or physical therapist assistant with reasonable skill and safety to patients by reasons of incompetency, or because of illness, drunkenness, excessive use of drugs, narcotics, chemicals, or as a result of any mental or physical condition. The following shall apply to this subdivision:

(a) In enforcing this subdivision the board shall, after a hearing by the board, upon a finding of probable cause, require a physical therapist or physical therapist assistant to submit to a reexamination for the purpose of establishing his or her competency to practice as a physical therapist or physical therapist assistant conducted in accordance with rules adopted for this purpose by the board, including rules to allow the examination of the pattern and practice of such physical therapist's or physical therapist assistant's professional conduct, or to submit to a mental or physical examination or combination thereof by a facility or professional approved by the board;

(b) For the purpose of this subdivision, every physical therapist and physical therapist assistant licensed under this chapter is deemed to have consented to submit to a mental or physical examination when directed in writing by the board;

(c) In addition to ordering a physical or mental examination to determine competency, the board may, notwithstanding any other law limiting access to medical or other health data, obtain medical data and health records relating to a physical therapist, physical therapist assistant or applicant without the physical therapist's, physical therapist assistant's or applicant's consent;

(d) Written notice of the reexamination or the physical or mental examination shall be sent to the physical therapist or physical therapist assistant, by registered mail, addressed to the physical therapist or physical therapist assistant at the physical therapist's or physical therapist assistant's last known address. Failure of a physical therapist

or physical therapist assistant to submit to the examination when directed shall constitute an admission of the allegations against the physical therapist or physical therapist assistant, in which case the board may enter a final order without the presentation of evidence, unless the failure was due to circumstances beyond the physical therapist's or physical therapist assistant's control. A physical therapist or physical therapist assistant whose right to practice has been affected under this subdivision shall, at reasonable intervals, be afforded an opportunity to demonstrate that the physical therapist or physical therapist assistant can resume the competent practice as a physical therapist or physical therapist assistant with reasonable skill and safety to patients;

(e) In any proceeding under this subdivision neither the record of proceedings nor the orders entered by the board shall be used against a physical therapist or physical therapist assistant in any other proceeding. Proceedings under this subdivision shall be conducted by the board without the filing of a complaint with the administrative hearing commission;

(f) When the board finds any person unqualified because of any of the grounds set forth in this subdivision, it may enter an order imposing one or more of the disciplinary measures set forth in subsection 3 of this section.

3. After the filing of such complaint before the administrative hearing commission, the proceedings shall be conducted in accordance with the provisions of chapter 621. Upon a finding by the administrative hearing commission that the grounds provided in subsection 2 of this section for disciplinary action are met, the board may, singly or in combination:

(1) Warn, censure or place the physical therapist or physical therapist assistant named in the complaint on probation on such terms and conditions as the board deems appropriate for a period not to exceed ten years;

(2) Suspend the physical therapist's or physical therapist assistant's license for a period not to exceed three years;

(3) Restrict or limit the physical therapist's or physical therapist assistant's license for an indefinite period of time;

(4) Revoke the physical therapist's or physical therapist assistant's license;

(5) Administer a public or private reprimand;

(6) Deny the physical therapist's or physical therapist assistant's application for a license;

(7) Permanently withhold issuance of a license;

(8) Require the physical therapist or physical therapist assistant to submit to the care, counseling or treatment of physicians designated by the board at the expense of the physical therapist or physical therapist assistant to be examined;

(9) Require the physical therapist or physical therapist assistant to attend such continuing educational courses and pass such examinations as the board may direct.

4. In any order of revocation, the board may provide that the physical therapist or physical therapist assistant shall not apply for reinstatement of the physical therapist's or physical therapist assistant's license for a period of time ranging from two to seven years following the date of the order of revocation. All stay orders shall toll this time period.

5. Before restoring to good standing a license issued under this chapter which has been in a revoked, suspended, or inactive state for any cause for more than two years, the board may require the applicant to attend such continuing medical education courses and pass such examinations as the board may direct.

6. In any investigation, hearing or other proceeding to determine a physical therapist's, physical therapist assistant's or applicant's fitness to practice, any record relating to any patient of the physical therapist, physical therapist assistant, or applicant shall be discoverable by the board and admissible into evidence, regardless of any statutory or common law privilege which such physical therapist, physical therapist assistant, applicant, record custodian, or patient might otherwise invoke. In addition, no such physical therapist, physical therapist assistant, applicant, or record custodian may withhold records or testimony bearing upon a physical therapist's, physical therapist assistant's, or applicant's fitness to practice on the grounds of privilege between such physical therapist, physical therapist assistant, applicant, or record custodian and a patient."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Gregory, **House Amendment No. 9** was adopted.

Representative Bondon offered **House Amendment No. 10**.

House Amendment No. 10

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after all of said section and line the following:

"197.305. As used in sections 197.300 to 197.366, the following terms mean:

(1) "Affected persons", the person proposing the development of a new institutional health service, the public to be served, and health care facilities within the service area in which the proposed new health care service is to be developed;

(2) "Agency", the certificate of need program of the Missouri department of health and senior services;

(3) "Capital expenditure", an expenditure by or on behalf of a health care facility which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance;

(4) "Certificate of need", a written certificate issued by the committee setting forth the committee's affirmative finding that a proposed project sufficiently satisfies the criteria prescribed for such projects by sections 197.300 to 197.366;

(5) "Develop", to undertake those activities which on their completion will result in the offering of a new institutional health service or the incurring of a financial obligation in relation to the offering of such a service;

(6) "Expenditure minimum" shall mean:

(a) For beds in existing or proposed health care facilities licensed pursuant to chapter 198 and long-term care beds in a hospital as described in subdivision (3) of subsection 1 of section 198.012, six hundred thousand dollars in the case of capital expenditures, or four hundred thousand dollars in the case of major medical equipment, provided, however, that prior to January 1, 2003, the expenditure minimum for beds in such a facility and long-term care beds in a hospital described in section 198.012 shall be zero, subject to the provisions of subsection 7 of section 197.318;

(b) For beds or equipment in a long-term care hospital meeting the requirements described in 42 CFR, Section 412.23(e), the expenditure minimum shall be zero; and

(c) For health care facilities, new institutional health services or beds not described in paragraph (a) or (b) of this subdivision**,** one million dollars in the case of capital expenditures, excluding major medical equipment, and one million dollars in the case of medical equipment;

(7) "Health service area", a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources, consisting of a population of not less than five hundred thousand or more than three million;

(8) "Major medical equipment", medical equipment used for the provision of medical and other health services;

(9) "New institutional health service":

(a) The development of a new health care facility costing in excess of the applicable expenditure minimum;

(b) The acquisition, including acquisition by lease, of any health care facility, or major medical equipment costing in excess of the expenditure minimum;

(c) Any capital expenditure by or on behalf of a health care facility in excess of the expenditure minimum;

(d) Predevelopment activities as defined in subdivision (12) hereof costing in excess of one hundred fifty thousand dollars;

(e) Any change in licensed bed capacity of a health care facility licensed under chapter 198 which increases the total number of beds by more than ten or more than ten percent of total bed capacity, whichever is less, over a two-year period, provided that any such health care facility seeking **[**~~a nonapplicability review for~~**]** an increase in total beds or total bed capacity in an amount less than described in this paragraph shall be eligible for such review only if the facility has had no patient care class I deficiencies within the last eighteen months and has maintained at least an eighty-five percent average occupancy rate for the previous six quarters;

(f) Health services, excluding home health services, which are offered in a health care facility and which were not offered on a regular basis in such health care facility within the twelve-month period prior to the time such services would be offered;

(g) A reallocation by an existing health care facility of licensed beds among major types of service or reallocation of licensed beds from one physical facility or site to another by more than ten beds or more than ten percent of total licensed bed capacity, whichever is less, over a two-year period;

(10) "Nonsubstantive projects", projects which do not involve the addition, replacement, modernization or conversion of beds or the provision of a new health service but which include a capital expenditure which exceeds the expenditure minimum and are due to an act of God or a normal consequence of maintaining health care services, facility or equipment;

(11) "Person", any individual, trust, estate, partnership, corporation, including associations and joint stock companies, state or political subdivision or instrumentality thereof, including a municipal corporation;

(12) "Predevelopment activities", expenditures for architectural designs, plans, working drawings and specifications, and any arrangement or commitment made for financing; but excluding submission of an application for a certificate of need.

197.318. 1. As used in this section, the term "licensed and available" means beds which are actually in place and for which a license has been issued.

2. The committee shall review all letters of intent and applications for long-term care hospital beds meeting the requirements described in 42 CFR, Section 412.23(e) under its criteria and standards for long-term care beds.

3. Sections 197.300 to 197.366 shall not be construed to apply to litigation pending in state court on or before April 1, 1996, in which the Missouri health facilities review committee is a defendant in an action concerning the application of sections 197.300 to 197.366 to long-term care hospital beds meeting the requirements described in 42 CFR, Section 412.23(e).

4. Notwithstanding any other provision of this chapter to the contrary:

(1) A facility licensed pursuant to chapter 198 may increase its licensed bed capacity by:

(a) Submitting a letter of intent to expand to the department of health and senior services and the health facilities review committee;

(b) Certification from the department of health and senior services that the facility:

a. Has no patient care class I deficiencies within the last eighteen months; and

b. Has maintained **[**~~a ninety-percent~~**] an eighty-five percent** average occupancy rate for the previous six quarters;

(c) Has made an effort to purchase beds for eighteen months following the date the letter of intent to expand is submitted pursuant to paragraph (a) of this subdivision. For purposes of this paragraph, an "effort to purchase" means a copy certified by the offeror as an offer to purchase beds from another licensed facility in the same licensure category; and

(d) If an agreement is reached by the selling and purchasing entities, the health facilities review committee shall issue a certificate of need for the expansion of the purchaser facility upon surrender of the seller's license; or

(e) If no agreement is reached by the selling and purchasing entities, the health facilities review committee shall permit an expansion for:

a. A facility with more than forty beds may expand its licensed bed capacity within the same licensure category by twenty-five percent or thirty beds, whichever is greater, if that same licensure category in such facility has experienced an average occupancy of ninety-three percent or greater over the previous six quarters;

b. A facility with fewer than forty beds may expand its licensed bed capacity within the same licensure category by twenty-five percent or ten beds, whichever is greater, if that same licensure category in such facility has experienced an average occupancy of ninety-two percent or greater over the previous six quarters;

c. A facility adding beds pursuant to subparagraphs a. or b. of this paragraph shall not expand by more than fifty percent of its then licensed bed capacity in the qualifying licensure category;

(2) Any beds sold shall, for five years from the date of relicensure by the purchaser, remain unlicensed and unused for any long-term care service in the selling facility, whether they do or do not require a license;

(3) The beds purchased shall, for two years from the date of purchase, remain in the bed inventory attributed to the selling facility and be considered by the department of social services as licensed and available for purposes of this section;

(4) Any residential care facility licensed pursuant to chapter 198 may relocate any portion of such facility's current licensed beds to any other facility to be licensed within the same licensure category if both facilities are under the same licensure ownership or control, and are located within six miles of each other;

(5) A facility licensed pursuant to chapter 198 may transfer or sell individual long-term care licensed **and available** beds to facilities qualifying pursuant to paragraphs (a) and (b) of subdivision (1) of this subsection. Any facility which transfers or sells licensed **and available** beds shall not expand its licensed bed capacity in that licensure category for a period of five years from the date the licensure is relinquished **and until the average occupancy of licensed and available beds in that licensure category within a fifteen-mile radius is eighty-five percent for the prior six quarters. Any facility which transfers or sells licensed and available beds shall have an average occupancy rate of less than seventy percent in the last six quarters**.

5. Any existing licensed and operating health care facility offering long-term care services may replace one-half of its licensed beds at the same site or a site not more than thirty miles from its current location if, for at least the most recent four consecutive calendar quarters, the facility operates only fifty percent of its then licensed capacity with every resident residing in a private room. In such case:

(1) The facility shall report to the health and senior services vacant beds as unavailable for occupancy for at least the most recent four consecutive calendar quarters;

(2) The replacement beds shall be built to private room specifications and only used for single occupancy; and

(3) The existing facility and proposed facility shall have the same owner or owners, regardless of corporate or business structure, and such owner or owners shall stipulate in writing that the existing facility beds to be replaced will not later be used to provide long-term care services. If the facility is being operated under a lease, both the lessee and the owner of the existing facility shall stipulate the same in writing.

6. Nothing in this section shall prohibit a health care facility licensed pursuant to chapter 198 from being replaced in its entirety within fifteen miles of its existing site so long as the existing facility and proposed or replacement facility have the same owner or owners regardless of corporate or business structure and the health care facility being replaced remains unlicensed and unused for any long-term care services whether they do or do not require a license from the date of licensure of the replacement facility.

208.225. 1. To implement fully the provisions of section 208.152, the MO HealthNet division shall calculate the Medicaid per diem reimbursement rates of each nursing home participating in the Medicaid program as a provider of nursing home services based on its costs reported in the Title XIX cost report filed with the MO HealthNet division for its fiscal year as provided in subsection 2 of this section.

2. The recalculation of Medicaid rates to all Missouri facilities will be performed as follows: effective July 1, 2004, the department of social services shall use the Medicaid cost report containing adjusted costs for the facility fiscal year ending in 2001 and redetermine the allowable per-patient day costs for each facility. The department shall recalculate the class ceilings in the patient care, one hundred twenty percent of the median; ancillary, one hundred twenty percent of the median; and administration, one hundred ten percent of the median cost centers. Each facility shall receive as a rate increase one-third of the amount that is unpaid based on the recalculated cost determination.

3. Any intermediate care facility or skilled nursing facility, as such terms are defined in section 198.006, participating in MO HealthNet that incurs total capital expenditures, as such term is defined in section 197.305, in excess of two thousand dollars per bed shall be entitled to obtain from the MO HealthNet division a recalculation of its Medicaid per diem reimbursement rate based on its additional capital costs or all costs incurred during the facility fiscal year during which such capital expenditures were made. Such recalculated reimbursement rate shall become effective and payable when granted by the MO HealthNet division as of the date of application for a rate adjustment."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Roberts (161) offered **House Amendment No. 1 to House Amendment No. 10**.

House Amendment No. 1
to
House Amendment No. 10

AMEND House Amendment No. 10 to Senate Bill No. 358, Page 4, Line 30, by inserting after the word "**adjustment.**" the following:

"**217.930. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than cancelled or terminated, for a person who is an offender in a correctional center if:**

(a) The department of social services is notified of the person's entry into the correctional center;

(b) On the date of entry, the person was enrolled in the MO HealthNet program; and

(c) The person is eligible for MO HealthNet except for institutional status.

(2) A suspension under this subsection shall end on the date the person is no longer an offender in a correctional center.

(3) Upon release from incarceration, such person shall continue to be eligible for receipt of MO HealthNet benefits until such time as the person is otherwise determined to no longer be eligible for the program.

2. The department of corrections shall notify the department of social services:

(1) Within twenty days after receiving information that a person receiving benefits under MO HealthNet is or will be an offender in a correctional center; and

(2) Within forty-five days prior to the release of a person who is qualified for suspension under subsection 1 of this section.

221.125. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than cancelled or terminated, for a person who is an offender in a county jail, a city jail, or a private jail if:

(a) The department of social services is notified of the person's entry into the jail;

(b) On the date of entry, the person was enrolled in the MO HealthNet program; and

(c) The person is eligible for MO HealthNet except for institutional status.

(2) A suspension under this subsection shall end on the date the person is no longer an offender in a jail.

(3) Upon release from incarceration, such person shall continue to be eligible for receipt of MO HealthNet benefits until such time as the person is otherwise determined to no longer be eligible for the program.

2. City, county, and private jails shall notify the department of social services within ten days after receiving information that a person receiving medical assistance under MO HealthNet is or will be an offender in the jail."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Roberts (161), **House Amendment No. 1 to House Amendment No. 10** was adopted.

On motion of Representative Bondon, **House Amendment No. 10, as amended**, was adopted.

Representative Morris (140) offered **House Amendment No. 11**.

House Amendment No. 11

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after said section and line the following:

"**334.034. 1. An assistant physician with a license in good standing may be eligible to become a licensed physician if the assistant physician has completed:**

(1) Step 3 of the United States Medical Licensing Examination or the equivalent of such step of any board-approved medical licensing examination in less than three attempts and within a three-year period after receiving his or her initial assistant physician license;

(2) Five years of continuous, full-time, active collaborating practice. Any time the assistant physician was not working within a collaborative practice arrangement with a collaborating physician shall not count toward the five-year requirement;

(3) One hundred hours of didactics during the five-year postgraduate training. Didactic training shall be presented by the collaborating physician or any individual that the collaborating physician deems qualified to teach. Didactic hours shall be logged and retained for a period of five years; and

(4) All continuing medical education requirements as required for assistant physicians under this chapter.

2. Upon completion of subdivisions (1) to (4) of subsection 1 of this section, the assistant physician shall be eligible for licensure as a physician with the state of Missouri and eligible to sit for board certification or any other appropriate advanced fellowships or certifications.

3. Any assistant physician obtaining licensure as a physician under this section shall be fully licensed as a physician and shall be subject to all statutes and regulations pertaining to physicians.

4. Any assistant physician obtaining licensure as a physician under this section shall practice as a physician in Missouri for a minimum of two years. Failure to practice for a minimum of two years shall be cause for the revocation of the license.

334.035. Except as otherwise provided in section **334.034 or** 334.036, every applicant for a permanent license as a physician and surgeon shall provide the board with satisfactory evidence of having successfully completed such postgraduate training in hospitals or medical or osteopathic colleges as the board may prescribe by rule.

334.037. 1. A physician may enter into collaborative practice arrangements with assistant physicians. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which shall be in writing, may delegate to an assistant physician the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the assistant physician and is consistent with that assistant physician's skill, training, and competence and the skill and training of the collaborating physician.

2. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the assistant physician;

(2) A list of all other offices or locations besides those listed in subdivision (1) of this subsection where the collaborating physician authorized the assistant physician to prescribe;

(3) A requirement that there shall be posted at every office where the assistant physician is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by an assistant physician and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the assistant physician;

(5) The manner of collaboration between the collaborating physician and the assistant physician, including how the collaborating physician and the assistant physician shall:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity; except, the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar year for rural health clinics as defined by Pub. L. 95-210 (42 U.S.C. Section 1395x), as amended, as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. Such exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics if the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics if the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician shall maintain documentation related to such requirement and present it to the state board of registration for the healing arts when requested; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(6) A description of the assistant physician's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the assistant physician to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(7) A list of all other written practice agreements of the collaborating physician and the assistant physician;

(8) The duration of the written practice agreement between the collaborating physician and the assistant physician;

(9) A description of the time and manner of the collaborating physician's review of the assistant physician's delivery of health care services. The description shall include provisions that the assistant physician shall submit a minimum of ten percent of the charts documenting the assistant physician's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days; and

(10) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the assistant physician prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (9) of this subsection.

3. **The board shall complete all applications submitted by an assistant physician who has entered into a collaborative practice arrangement with a collaborating physician within thirty days of submission.**

4. 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.~~**] 5.** 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.~~**] 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 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.~~**] 7.** A collaborating physician or supervising physician shall not enter into a collaborative practice arrangement or supervision agreement with more than six full-time equivalent assistant physicians, full-time equivalent physician assistants, or full-time equivalent advance practice registered nurses, or any combination thereof. Such limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of section 334.104.

[~~7.~~**] 8.** 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. **Once the assistant physician has completed the one-month time period required under this subsection, the assistant physician shall be exempt from the training required under this subsection in the event there is a change in collaborating physicians.** 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. **The collaborating physician may utilize any other qualified, fully licensed physician on his or her staff to help oversee, train, and review the records of an assistant physician during the assistant physician's one-month training period.**

[~~8.~~**] 9.** 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.~~**] 10.** 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.~~**] 11.** 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.~~**] 12.** 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.~~**] 13.** (1) An assistant physician with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to prescribe controlled substances in a collaborative practice arrangement. Prescriptions for Schedule II medications prescribed by an assistant physician who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone. Such authority shall be filed with the state board of registration for the healing arts. The collaborating physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the assistant physician is permitted to prescribe. Any limitations shall be listed in the collaborative practice arrangement. Assistant physicians shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician. Assistant physicians who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

(2) The collaborating physician shall be responsible to determine and document the completion of at least one hundred twenty hours in a four-month period by the assistant physician during which the assistant physician shall practice with the collaborating physician on-site prior to prescribing controlled substances when the collaborating physician is not on-site. Such limitation shall not apply to assistant physicians of population-based public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009, or assistant physicians providing opioid addiction treatment.

(3) An assistant physician shall receive a certificate of controlled substance prescriptive authority from the state board of registration for the healing arts upon verification of licensure under section 334.036.

[~~13.~~**] 14.** Nothing in this section or section 334.036 shall be construed to limit the authority of hospitals or hospital medical staff to make employment or medical staff credentialing or privileging decisions.

334.040. 1. Except as provided in section **334.034 or** 334.260, all persons desiring to practice as physicians and surgeons in this state shall be examined as to their fitness to engage in such practice by the board. All persons applying for examination shall file a completed application with the board upon forms furnished by the board.

2. The examination shall be sufficient to test the applicant's fitness to practice as a physician and surgeon. The examination shall be conducted in such a manner as to conceal the identity of the applicant until all examinations have been scored. In all such examinations an average score of not less than seventy-five percent is required to pass; provided, however, that the board may require applicants to take the Federation Licensing Examination, also known as FLEX, or the United States Medical Licensing Examination (USMLE). If the FLEX examination is required, a weighted average score of no less than seventy-five is required to pass. Scores from one test administration of an examination shall not be combined or averaged with scores from other test administrations to achieve a passing score. Applicants graduating from a medical or osteopathic college, as described in section 334.031 prior to January 1, 1994, shall provide proof of successful completion of the FLEX, USMLE, the National Board of Osteopathic Medical Examiners Comprehensive Licensing Exam (COMLEX), a state board examination approved by the board, compliance with subsection 2 of section 334.031, or compliance with 20 CSR 2150-2.005. Applicants graduating from a medical or osteopathic college, as described in section 334.031 on or after January 1, 1994, must provide proof

of successful completion of the USMLE or the COMLEX or provide proof of compliance with subsection 2 of section 334.031. The board shall not issue a permanent license as a physician and surgeon or allow the Missouri state board examination to be administered to any applicant who has failed to achieve a passing score within three attempts on licensing examinations administered in one or more states or territories of the United States, the District of Columbia or Canada. The steps one, two and three of the United States Medical Licensing Examination or the National Board of Osteopathic Medical Examiners Comprehensive Licensing Exam shall be taken within a seven-year period with no more than three attempts on any step of the examination; however, the board may grant an extension of the seven-year period if the applicant has obtained a MD/PhD degree in a program accredited by the Liaison Committee on Medical Education (LCME) and a regional university accrediting body or a DO/PhD degree accredited by the American Osteopathic Association and a regional university accrediting body. The board may waive the provisions of this section if the applicant is licensed to practice as a physician and surgeon in another state of the United States, the District of Columbia or Canada and the applicant has achieved a passing score on a licensing examination administered in a state or territory of the United States or the District of Columbia and no license issued to the applicant has been disciplined in any state or territory of the United States or the District of Columbia.

3. If the board waives the provisions of this section, then the license issued to the applicant may be limited or restricted to the applicant's board specialty. The board shall not be permitted to favor any particular school or system of healing.

4. If an applicant has not actively engaged in the practice of clinical medicine or held a teaching or faculty position in a medical or osteopathic school approved by the American Medical Association, the Liaison Committee on Medical Education, or the American Osteopathic Association for any two years in the three-year period immediately preceding the filing of his or her application for licensure, the board may require successful completion of another examination, continuing medical education, or further training before issuing a permanent license. The board shall adopt rules to prescribe the form and manner of such reexamination, continuing medical education, and training."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 097

Anderson	Andrews	Bailey	Baker	Basye
Billington	Black 137	Black 7	Bondon	Bromley
Busick	Chipman	Coleman 32	Coleman 97	Deaton
DeGroot	Dinkins	Eggleston	Eslinger	Evans
Falkner III	Fishel	Francis	Gannon	Gregory
Griffith	Haden	Haffner	Hannegan	Hansen
Helms	Henderson	Hicks	Hill	Houx
Hovis	Hudson	Hurst	Justus	Kelley 127
Kelly 141	Kidd	Knight	Kolkmeyer	Lovasco
Love	Lynch	Mayhew	McGirl	Moon
Morris 140	Morse 151	Muntzel	Murphy	Neely
O'Donnell	Patterson	Pfautsch	Pike	Plocher
Pogue	Pollitt 52	Pollock 123	Porter	Reedy
Rehder	Toalson Reisch	Remole	Richey	Riggs
Roberts 161	Rone	Ross	Ruth	Schnelting
Schroer	Sharpe	Shaul 113	Shawan	Shields
Simmons	Solon	Sommer	Spencer	Stacy
Stephens 128	Swan	Tate	Taylor	Trent
Veit	Walsh	Wiemann	Wilson	Wood
Wright	Mr. Speaker			

NOES: 038

Appelbaum	Baringer	Beck	Bland Manlove	Brown 27
Burnett	Burns	Butz	Carpenter	Chappelle-Nadal
Clemens	Ellebracht	Ellington	Franks Jr.	Gray
Green	Ingle	Kendrick	Lavender	Mackey
McCreery	Merideth	Mitten	Morgan	Mosley
Proudie	Quade	Razer	Roberts 77	Rogers
Rowland	Runions	Sain	Sauls	Stevens 46
Unsicker	Walker	Washington		

PRESENT: 000

ABSENT WITH LEAVE: 025

Allred	Bangert	Barnes	Bosley	Brown 70
Carter	Christofanelli	Dogan	Dohrman	Fitzwater
Grier	Griesheimer	McDaniel	McGaugh	Messenger
Miller	Pierson Jr.	Pietzman	Price	Roden
Roeber	Shull 16	Smith	Vescovo	Windham

VACANCIES: 003

On motion of Representative Morris (140), **House Amendment No. 11** was adopted.

Representative Muntzel offered **House Amendment No. 12**.

House Amendment No. 12

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after all of said line the following:

"382.010. As used in sections 382.010 to 382.300, the following words and terms have the meanings indicated unless the context clearly requires otherwise:

(1) An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified;

(2) "Control", "controlling", "controlled by", or "under common control with", the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with power to vote, or holds proxies representing, ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by section 382.170 that control does not exist in fact. The director may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect;

(3) "Director", the director of the department of insurance, financial institutions and professional registration, his or her deputies, or the department of insurance, financial institutions and professional registration, as appropriate;

(4) "Enterprise risk", any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in section 375.1255 or would cause the insurer to be in hazardous financial condition as set forth in section 375.539;

(5) **"Group-wide supervisor", the regulatory official authorized to engage in conducting and coordinating group-wide supervisory activities who is determined or acknowledged by the director, under section 382.227, to have sufficient significant contacts with the internationally active insurance group;**

(6) "Insurance holding company system", two or more affiliated persons, one or more of which is an insurer;

[~~(6)~~**] (7)** "Insurer", an insurance company as defined in section 375.012, including a reciprocal or interinsurance exchange, and which is qualified and licensed by the department of insurance, financial institutions and professional registration of Missouri to transact the business of insurance in this state; but it shall not include any company organized and doing business under chapter 377, 378, or 380, agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

[~~(7)~~**] (8) "Internationally active insurance group", an insurance holding company system that includes an insurer registered under sections 382.100 to 382.180, and meets the following criteria:**

(a) Premiums written in at least three countries;

(b) The percentage of gross premiums written outside the United States is at least ten percent of the insurance holding company system's total gross written premiums; and

(c) Based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars, or the total gross written premiums of the insurance holding company system are at least ten billion dollars;

(9) "Person", an individual, corporation, limited liability company, partnership, association, joint stock company, trust, unincorporated organization, or any similar entity, or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property;

[~~(8)~~**] (10)** A "securityholder" of a specified person is one who owns any security of that person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing;

[~~(9)~~**] (11)** A "subsidiary" of a specified person is an affiliate controlled by that person directly, or indirectly through one or more intermediaries;

[~~(10)~~**] (12)** The term "voting security" includes any security convertible into or evidencing a right to acquire a voting security.

382.227. 1. The director is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the director may otherwise acknowledge another regulatory official as the group-wide supervisor if the internationally active insurance group:

(1) Does not have substantial insurance operations in the United States;

(2) Has substantial insurance operations in the United States but not in this state; or

(3) Has substantial insurance operations in the United States and in this state but the director has determined, pursuant to the factors set forth in subsections 3 and 9 of this section, that another regulatory official is the appropriate group-wide supervisor.

2. An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the director make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

3. In cooperation with other state, federal, and international regulatory agencies, the director shall identify a single group-wide supervisor for an internationally active insurance group. The director may determine that the director is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the director may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The director shall consider the following factors when making a determination or acknowledgment under this subsection:

(1) The domicile of the insurers within the internationally active insurance group that hold the largest share of the internationally active insurance group's written premiums, assets, or liabilities;

(2) The domicile of the top-tiered insurers in the insurance holding company system of the internationally active insurance group;

(3) The location of the executive offices or largest operational offices of the internationally active insurance group;

(4) Whether another regulatory official is acting as or is seeking to act as the group-wide supervisor under a regulatory system that the director determines to be:

(a) Substantially similar to the system of regulation provided under the laws of this state; or

(b) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(5) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the director with reasonably reciprocal recognition and cooperation.

4. A director identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another regulatory official to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in subdivisions (1) to (5) of subsection 3 of this section, and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

5. Notwithstanding any other provision of the law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the director shall acknowledge that regulatory official as the group-wide supervisor, subject to subsection 6 of this section. In the event of a material change in the internationally active insurance group that results in either the internationally active insurance group's insurers domiciled in this state holding the largest share of the internationally active insurance group's premiums, assets, or liabilities, or this state being the domicile of the top-tiered insurers in the insurance holding company system of the internationally active insurance group, the director shall make a determination or acknowledgment as to the appropriate group-wide supervisor for such an internationally active insurance group under subsections 3 and 4 of this section.

6. In the event of a dispute as to the proper regulatory official to act as group-wide supervisor, a determination by the director not to acknowledge the current group-wide supervisor shall be made only after notice and a public hearing, and such determination shall be accompanied by specific findings of fact and conclusions of law including, but not limited to, application of the factors listed in subdivisions (1) to (5) of subsection 3 of this section.

7. Under section 382.220, the director is authorized to collect from any insurer registered under sections 382.100 to 382.180 all information necessary to determine whether the director may act as the group-wide supervisor of an internationally active insurance group or if the director may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the director, the director shall notify the insurer registered under sections 382.100 to 382.180 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than thirty days to provide the director with additional information pertinent to the pending determination. The director shall publish on the department's website the identity of internationally active insurance groups that the director has determined are subject to group-wide supervision by the director.

8. If the director is the group-wide supervisor for an internationally active insurance group, the director is authorized to engage in any of the following group-wide supervisory activities:

(1) Assess the enterprise risks within the internationally active insurance group to ensure that:

(a) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(b) Reasonable and effective mitigation measures are in place;

(2) Request, from any member of an internationally active insurance group subject to the director's supervision, information necessary and appropriate to assess enterprise risk including, but not limited to, information about the members of the internationally active insurance group regarding:

(a) Governance, risk assessment, and management;

(b) Capital adequacy; and

(c) Material intercompany transactions;

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

(4) Communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of section 382.230, through supervisory colleges as set forth in section 382.226 or otherwise;

(5) Enter into agreements with or obtain documentation from any insurer registered under sections 382.100 to 382.180, any member of the internationally active insurance group, and any other state, federal, and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the director's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(6) Other group-wide supervision activities, consistent with the authorities and purposes enumerated in this subsection, as considered necessary by the director.

9. If the director acknowledges that another regulatory official from a jurisdiction that is not accredited by the National Association of Insurance Commissioners is the group-wide supervisor, the director is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(1) The director's cooperation is in compliance with the laws of this state; and

(2) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the director's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation are not reasonably reciprocal, the director is authorized to refuse recognition and cooperation.

10. The director is authorized to enter into agreements with, or obtain documentation from, any insurer registered under sections 382.100 to 382.180, any affiliate of the insurer, and other state, federal, and international regulatory agencies, regarding members of the internationally active insurance group, which provides the basis for or otherwise clarifies a regulatory official's role as group-wide supervisor.

11. The director may promulgate regulations necessary for the administration of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2019, shall be invalid and void.

12. An insurer registered under sections 382.100 to 382.180 and subject to this section shall be liable for and shall pay the reasonable expenses of the director's participation in the administration of this section, including the engagements of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

382.230. 1. All information, documents and copies thereof in the possession or control of the director that are obtained by or disclosed to the director or any other person in the course of an examination or investigation made under section 382.220 and all information reported **or provided to the director** under subdivisions (13) and (14) of subsection 1 of section 382.050 **[**~~and~~**] ,** sections 382.100 to 382.210**, and section 382.227** shall be given confidential treatment and privileges; shall not be subject to the provisions of chapter 610; shall not be subject to subpoena; shall not be made public by the director, the National Association of Insurance Commissioners, or any other person, except to the chief insurance regulatory official of other states; and shall not be subject to discovery or admissible as evidence in any private civil action. However, the director is authorized to use the documents, materials, or other information in furtherance of any regulatory or legal action brought as a part of the director's official duties. The director shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer to which it pertains unless the director, after giving the insurer and its affiliates who would be affected thereby, notice and opportunity to be heard, determines that the interests of policyholders, shareholders or the public will be served by the publication thereof, in which event the director may publish all or any part thereof in such manner as he or she may deem appropriate.

2. Neither the director nor any person who receives documents, materials, or other information while acting under the authority of the director or with whom such documents, materials, or other information is shared under sections 382.010 to 382.300 shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or other information subject to subsection 1 of this section.

3. In order to assist in the performance of the director's duties, the director:

(1) May share documents, materials, or other information including the confidential and privileged documents, materials, or other information subject to subsection 1 of this section with other state, federal, and international financial regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities including members of any supervisory college described in section 382.225; provided that the recipient agrees in writing to maintain the confidentiality and privileged status of such documents, materials, or other information, and has verified in writing the legal authority to maintain confidentiality;

(2) Notwithstanding the provisions of subsection 1 of this section and subdivision (1) of this subsection, may share confidential and privileged documents, materials, or other information reported under section 382.175 only with the directors of states having statutes or regulations substantially similar to subsection 1 of this section and who have agreed in writing not to disclose such information;

(3) May receive documents, materials, or other information including otherwise confidential and privileged documents, materials, or information from the National Association of Insurance Commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any documents, materials, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information; and

(4) Shall enter into a written agreement with the National Association of Insurance Commissioners governing sharing and use of information provided under sections 382.010 to 382.300 consistent with this subsection that shall:

(a) Specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries under sections 382.010 to 382.300 including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state, federal, and international regulators;

(b) Specify that ownership of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries under sections 382.010 to 382.300 remains with the director and that the National Association of Insurance Commissioners' use of such information is subject to the direction of the director;

(c) Require prompt notice to be given to an insurer whose confidential information in the possession of the National Association of Insurance Commissioners under sections 382.010 to 382.300 is subject to a request or subpoena to the National Association of Insurance Commissioners for disclosure or production; and

(d) Require the National Association of Insurance Commissioners and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries under sections 382.010 to 382.300.

4. The sharing of information by the director under sections 382.010 to 382.300 shall not constitute a delegation of regulatory or rulemaking authority, and the director is solely responsible for the administration, execution, and enforcement of the provisions of sections 382.010 to 382.300.

5. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure of such documents, materials, or other information to the director under this section or as a result of sharing as authorized in sections 382.010 to 382.300.

6. Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners under sections 382.010 to 382.300 shall be confidential by law and privileged, shall not be subject to disclosure under chapter 610, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Muntzel, **House Amendment No. 12** was adopted.

Representative Hill offered **House Amendment No. 13**.

House Amendment No. 13

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after said section and line the following:

"376.1040. **1.** No multiple employer self-insured health plan shall be offered or advertised to the public **[**~~generally~~**]**. No plan shall be sold, solicited, or marketed by persons or entities defined in section 375.012 or sections 376.1075 to 376.1095. **Multiple employer self-insured health plans with a certificate of authority approved by the director under section 376.1002 shall be exempt from the restrictions set forth in this section.**

2. A health carrier acting as an administrator for a multiple employer self insured health plan shall permit any willing licensed producer to quote, sell, solicit, or market such plan to the extent permitted by this section; provided that such producer is appointed and in good standing with the health carrier and completes all required training.

376.1042. The sale, solicitation or marketing of any plan **in violation of section 376.1040** by an agent, agency or broker shall constitute a violation of section 375.141."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative DeGroot raised a point of order that members were in violation of Rule 85.

Representative Plocher requested a parliamentary ruling.

The Parliamentary Committee took the point of order under advisement, and the Chair advised members to keep their comments confined to the question at hand.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 089

Allred	Anderson	Andrews	Baker	Basye
Billington	Black 137	Bondon	Bromley	Busick
Coleman 32	Coleman 97	Deaton	DeGroot	Dinkins
Eggleston	Eslinger	Evans	Falkner III	Fishel
Francis	Gannon	Gregory	Griffith	Haden
Haffner	Hannegan	Hansen	Helms	Henderson
Hicks	Hill	Houx	Hovis	Hudson
Hurst	Justus	Kelley 127	Kelly 141	Knight
Kolkmeyer	Lovasco	Love	Lynch	Mayhew
McGirl	Morris 140	Morse 151	Murphy	Neely
O'Donnell	Patterson	Pfautsch	Pietzman	Pike
Plocher	Pogue	Pollitt 52	Pollock 123	Porter
Reedy	Rehder	Toalson Reisch	Remole	Richey
Riggs	Roberts 161	Roden	Rone	Ross
Ruth	Sharpe	Shaul 113	Shawan	Shields
Simmons	Solon	Sommer	Spencer	Stacy
Stephens 128	Swan	Tate	Taylor	Veit
Walsh	Wiemann	Wilson	Wright	

NOES: 035

Appelbaum	Baringer	Barnes	Beck	Bland Manlove
Brown 27	Burnett	Burns	Butz	Chappelle-Nadal
Ellebracht	Ellington	Ingle	Kendrick	Lavender
Mackey	McCreery	Merideth	Mitten	Morgan

Mosley	Pierson Jr.	Proudie	Quade	Razer
Roberts 77	Rogers	Rowland	Runions	Sain
Sauls	Stevens 46	Unsicker	Walker	Washington

PRESENT: 000

ABSENT WITH LEAVE: 036

Bailey	Bangert	Black 7	Bosley	Brown 70
Carpenter	Carter	Chipman	Christofanelli	Clemens
Dogan	Dohrman	Fitzwater	Franks Jr.	Gray
Green	Grier	Griesheimer	Kidd	McDaniel
McGaugh	Messenger	Miller	Moon	Muntzel
Price	Roeber	Schnelting	Schroer	Shull 16
Smith	Trent	Vescovo	Windham	Wood
Mr. Speaker				

VACANCIES: 003

On motion of Representative Hill, **House Amendment No. 13** was adopted.

Representative Ellebracht raised a point of order that there had been a violation of Rule 87.

Representative Plocher requested a parliamentary ruling.

The Parliamentary Committee ruled the point of order not well taken.

Representative Murphy offered **House Amendment No. 14**.

House Amendment No. 14

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after said section and line the following:

"**198.008. 1. Residents of long-term care facilities in this state shall have the following rights:**

(1) To be free of abuse and exploitation;

(2) To safe, decent, and clean conditions;

(3) To be treated with courtesy, consideration, and respect;

(4) To not be subjected to discrimination based on age, race, religion, sex, nationality, or disability and to practice the resident's own religious beliefs;

(5) To place in the resident's room an electronic monitoring device that is owned and operated by the resident or provided by the resident's guardian or legal representative;

(6) To privacy, including privacy during visits and telephone calls;

(7) To complain about the institution and to organize or participate in any program that presents residents' concerns to the administrator of the long-term care facility;

(8) To have information about the resident in the possession of the long-term care facility maintained as confidential;

(9) To retain the services of a physician the resident chooses, at the resident's own expense or through a health care plan, and to have a physician explain to the resident, in language that the resident understands, the resident's complete medical condition, the recommended treatment, and the expected results of the treatment, including reasonably expected effects, side effects, and risks associated with psychoactive medications;

(10) To participate in developing a plan of care, to refuse treatment, and to refuse to participate in experimental research;

(11) To a written statement or admission agreement describing the services provided by the long-term care facility and the related charges;

(12) To manage the resident's own finances or to delegate that responsibility to another person;

(13) To access moneys and property that the resident has deposited with the long-term care facility and to an accounting of the resident's moneys and property that are deposited with the long-term care facility and all of the financial transactions made with or on behalf of the resident;

(14) To keep and use personal property, secure from theft or loss;

(15) To not be relocated within the long-term care facility;

(16) To receive visitors;

(17) To receive unopened mail and to receive assistance in reading or writing correspondence;

(18) To participate in activities inside and outside the long-term care facility;

(19) To wear the resident's own clothes;

(20) To discharge himself or herself from the long-term care facility unless the resident is an adjudicated mental incompetent;

(21) To not be discharged from the long-term care facility except as provided in the standards adopted under section 198.088;

(22) To be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms; and

(23) To receive information about prescribed psychoactive medication from the person prescribing the medication or that person's designee, to have any psychoactive medications prescribed and administered in a responsible manner, and to refuse to consent to the prescription of psychoactive medications.

2. A right of a resident may be restricted only to the extent necessary to protect:

(1) A right of another resident, particularly a right of the other resident relating to privacy and confidentiality; or

(2) The resident or another person from danger or harm.

3. The department of health and senior services may adopt rights of residents in addition to those required by this section and may consider additional rights applicable to residents in other jurisdictions.

198.610. 1. The provisions of sections 198.610 to 198.632 shall be known and may be cited as the "Authorized Electronic Monitoring in Long-Term Care Facilities Act".

2. For purposes of sections 198.610 to 198.632, the following terms shall mean:

(1) "Authorized electronic monitoring", the placement and use of an electronic monitoring device by a resident in his or her room in accordance with the provisions of sections 198.610 to 198.632;

(2) "Department", the department of health and senior services;

(3) "Electronic monitoring device", a surveillance instrument with a fixed-position video camera or an audio recording device, or a combination thereof, that is installed in a resident's room under the provisions of sections 198.610 to 198.632 and broadcasts or records activity or sounds occurring in the room;

(4) "Facility" or "Long-term care facility", any residential care facility, assisted living facility, intermediate care facility, or skilled nursing facility, as defined in section 198.006;

(5) "Guardian", the same meaning as defined under section 475.010;

(6) "Resident", a person residing in a facility.

198.612. 1. No facility shall be civilly or criminally liable for the inadvertent or intentional disclosure of a recording by a resident or a person who consents on behalf of the resident for any purpose not authorized by sections 198.610 to 198.632.

2. No facility shall be civilly or criminally liable for a violation of a resident's right to privacy arising out of any electronic monitoring conducted under sections 198.610 to 198.632.

3. The department shall promulgate rules to implement the provisions of sections 198.610 to 198.632. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2019, shall be invalid and void.

198.614. 1. For purposes of this chapter, the placement and use of an electronic monitoring device in the room of a resident is considered to be covert if:

(1) The placement and use of the device is not open and obvious; and

(2) The facility and the department are not informed about the device by the resident, by a person who placed the device in the room, or by a person who is using the device.

2. The department and the facility shall not be held to be civilly liable in connection with the covert placement or use of an electronic monitoring device in the room of a resident.

198.616. The department shall promulgate rules that prescribe the form that shall be completed and signed on a resident's admission to a facility by or on behalf of the resident. The form shall state:

(1) That a person who places an electronic monitoring device in the room of a resident or who uses or discloses a tape or other recording made by the device may be civilly liable for any unlawful violation of the privacy rights of another;

(2) That a person who covertly places an electronic monitoring device in the room of a resident or who consents to or acquiesces in the covert placement of the device in the room of a resident has waived any privacy right the person may have had in connection with images or sounds that may be acquired by the device;

(3) That a resident or the resident's guardian or legal representative is entitled to conduct authorized electronic monitoring, and that if the facility refuses to permit the electronic monitoring or fails to make reasonable physical accommodations for the authorized electronic monitoring that the person should contact the department;

(4) The basic procedures that shall be followed to request authorized electronic monitoring;

(5) The manner in which this chapter affects the legal requirement to report abuse or neglect when electronic monitoring is being conducted; and

(6) Any other information regarding covert or authorized electronic monitoring that the department considers advisable to include on the form.

198.618. 1. If a resident has capacity to request electronic monitoring and has not been judicially declared to lack the required capacity, only the resident may request authorized electronic monitoring under this chapter, notwithstanding the terms of any durable power of attorney or similar instrument.

2. If a resident has been judicially declared to lack the capacity required for taking an action such as requesting electronic monitoring, only the guardian of the resident may request electronic monitoring under this chapter.

3. If a resident does not have capacity to request electronic monitoring but has not been judicially declared to lack the required capacity, only the legal representative of the resident may request electronic monitoring under this chapter. The department by rule shall prescribe:

(1) Guidelines that will assist facilities, family members of residents, advocates for residents, and other interested persons to determine if a resident lacks the required capacity; and

(2) Who shall be considered to be a resident's legal representative for purposes of this chapter, including:

(a) Persons who shall be considered the legal representative under the terms of an instrument executed by the resident when the resident had capacity; and

(b) Persons who shall become the legal representative for the limited purpose of this chapter under a procedure prescribed by the department.

198.620. 1. A resident or the guardian or legal representative of a resident who wishes to conduct authorized electronic monitoring shall make the request to the facility on a form prescribed by the department.

2. The form prescribed by the department shall require the resident or the resident's guardian or legal representative to:

(1) Release the facility from any civil liability for a violation of the resident's privacy rights in connection with the use of the electronic monitoring device;

(2) Choose, if the electronic monitoring device is a video surveillance camera, whether the camera will always be unobstructed, or whether the camera should be obstructed in specified circumstances to protect the dignity of the resident; and

(3) Obtain the consent of other residents in the room, using a form prescribed for the purpose by department, if the resident resides in a multiperson room.

3. Consent under subdivision (3) of subsection 2 of this section shall be given only:

(1) By the other resident or residents in the room;

(2) By the guardian of a person described by subdivision (1) of subsection 3 of this section, if the person has been judicially declared to lack the required capacity; or

(3) By the legal representative who, under section 198.618, shall request electronic monitoring on behalf of a person described by subdivision (1) of subsection 3 of this section, if the person does not have capacity to sign the form but has not been judicially declared to lack the required capacity.

4. The form prescribed by the department under subdivision (3) of subsection 2 of this section shall require any other resident in the room to consent to release the facility from any civil liability for a violation of the resident's privacy rights in connection with the use of the electronic monitoring device.

5. Another resident in the room may:

(1) If the proposed electronic monitoring device is a video surveillance camera, condition consent on the camera being pointed away from the consenting resident; and

(2) Condition consent on the use of an audio electronic monitoring device being limited or prohibited.

6. If authorized electronic monitoring is being conducted in the room of a resident and another resident is moved into the room who has not yet consented to the electronic monitoring, authorized electronic monitoring shall cease until the new resident has consented in accordance with this section.

7. The department shall include other information that the department considers to be appropriate on either of the forms that the department is required to prescribe under this section.

8. The department shall adopt rules prescribing the place or places that a form signed under this section shall be maintained and the period for which it shall be maintained.

9. Authorized electronic monitoring:

(1) Shall not commence until all request and consent forms required by this section have been completed and returned to the facility; and

(2) Shall be conducted in accordance with any limitation placed on the monitoring as a condition of the consent given by or on behalf of another resident in the room.

198.622. 1. A facility shall permit a resident or the resident's guardian or legal representative to monitor the room of the resident through the use of electronic monitoring devices.

2. The facility shall require a resident who conducts authorized electronic monitoring, or the resident's guardian or legal representative, to post and maintain a conspicuous notice at the entrance to the resident's room. The notice shall state that the room is being monitored by an electronic monitoring device.

3. Authorized electronic monitoring conducted under sections 198.610 to 198.632 shall not be compulsory and shall be conducted only at the request of the resident or the resident's guardian or legal representative.

4. A facility shall not refuse to admit an individual to residency in the facility and shall not remove a resident from the facility because of a request to conduct authorized electronic monitoring. A facility shall not remove a resident from the facility because covert electronic monitoring is being conducted by or on behalf of a resident.

5. A facility shall make reasonable physical accommodation for authorized electronic monitoring, including:

(1) Providing a reasonably secure place to mount the video surveillance camera or other electronic monitoring device; and

(2) Providing access to power sources for the video surveillance camera or other electronic monitoring device.

6. The resident or the resident's guardian or legal representative shall pay for all costs associated with conducting electronic monitoring, other than the costs of electricity. The resident or the resident's guardian or legal representative shall be responsible for:

(1) All costs associated with installation of equipment; and

(2) Maintaining the equipment.

7. A facility shall require an electronic monitoring device to be installed in a manner that is safe for residents, employees, or visitors who may be moving about the room. The department shall adopt rules regarding the safe placement of an electronic monitoring device.

8. If authorized electronic monitoring is conducted, the facility shall require the resident or the resident's guardian or legal representative to conduct the electronic monitoring in plain view.

9. A facility may, but is not required to, place a resident in a different room to accommodate a request to conduct authorized electronic monitoring.

198.624. 1. For purposes of reporting abuse and neglect, a person who is conducting electronic monitoring on behalf of a resident under this chapter is considered to have viewed or listened to a tape or recording made by the electronic monitoring device on or before the fourteenth day after the date the tape or recording is made.

2. If a resident who has capacity to determine that the resident has been abused or neglected and who is conducting electronic monitoring under sections 198.610 to 198.632 gives a tape or recording made by the electronic monitoring device to a person and directs the person to view or listen to the tape or recording to determine whether abuse or neglect has occurred, the person to whom the resident gives the tape or recording is considered to have viewed or listened to the tape or recording on or before the seventh day after the date the person receives the tape or recording for the purposes of reporting abuse or neglect.

3. A person is required to report abuse based on the person's viewing of, or listening to, a tape or recording only if the incident of abuse is acquired on the tape or recording. A person is required to report neglect based on the person's viewing of, or listening to, a tape or recording only if it is clear from viewing or listening to the tape or recording that neglect has occurred.

4. If abuse or neglect of the resident is reported to the facility and the facility requests a copy of any relevant tape or recording made by an electronic monitoring device, the person who possesses the tape or recording shall provide the facility with a copy at the facility's expense.

198.626. 1. Subject to applicable rules of evidence and procedure and the requirements of this section, a tape or recording created through the use of covert or authorized electronic monitoring described by sections 198.610 to 198.632 may be admitted into evidence in a civil or criminal court action or administrative proceeding.

2. A court or administrative agency shall not admit into evidence a tape or recording created through the use of covert or authorized electronic monitoring or take or authorize action based on the tape or recording unless:

(1) If the tape or recording is a videotape or recording, the tape or recording shows the time and date that the events acquired on the tape or recording occurred;

(2) The contents of the tape or recording have not been edited or artificially enhanced; and

(3) If the contents of the tape or recording have been transferred from the original format to another technological format, the transfer was done by a qualified professional and the contents of the tape or recording were not altered.

3. A person who sends more than one tape or recording to the department shall identify for the department each tape or recording on which the person believes that an incident of abuse or evidence of neglect may be found. The department may adopt rules encouraging persons who send a tape or recording to the department to identify the place on the tape or recording that an incident of abuse or evidence of neglect may be found.

198.628. Each facility shall post a notice at the entrance to the facility stating that the rooms of some residents may be being monitored electronically by, or on behalf of, the residents and that the monitoring is not necessarily open and obvious. The department by rule shall prescribe the format and the precise content of the notice.

198.630. 1. The department may impose appropriate sanctions under this chapter on an administrator of a facility who knowingly:

(1) Refuses to permit a resident or the resident's guardian or legal representative to conduct authorized electronic monitoring;

(2) Refuses to admit an individual to residency or allows the removal of a resident from the institution because of a request to conduct authorized electronic monitoring;

(3) Allows the removal of a resident from the facility because covert electronic monitoring is being conducted by or on behalf of the resident; or

(4) Violates another provision of sections 198.610 to 198.632.

2. The department may assess an administrative penalty against a facility that:

(1) Refuses to permit a resident or the resident's guardian or legal representative to conduct authorized electronic monitoring;

(2) Refuses to admit an individual to residency or allows the removal of a resident from the institution because of a request to conduct authorized electronic monitoring;

(3) Allows the removal of a resident from the facility because covert electronic monitoring is being conducted by, or on behalf of, the resident; or

(4) Violates another provision of sections 198.610 to 198.632.

198.632. 1. A person who intentionally hampers, obstructs, tampers with, or destroys an electronic monitoring device installed in a resident's room in accordance with sections 198.610 to 198.632 or a tape or recording made by the device commits an offense. An offense under this section is a class B misdemeanor.

2. It is a defense to prosecution under subsection 1 of this section that the person who took the action with the effective consent of the resident on whose behalf the electronic monitoring device was installed, or the resident's guardian or legal representative."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 089

Anderson	Andrews	Bailey	Baker	Basye
Billington	Black 137	Black 7	Bondon	Bromley
Busick	Chipman	Coleman 32	Coleman 97	Deaton
DeGroot	Dinkins	Dogan	Dohrman	Eggleston
Eslinger	Evans	Falkner III	Francis	Gannon
Griffith	Haden	Haffner	Hannegan	Hansen
Helms	Henderson	Hicks	Hill	Hovis
Hudson	Hurst	Justus	Kelley 127	Kolkmeyer
Lovasco	Love	Lynch	Mayhew	McDaniel
McGirl	Morris 140	Morse 151	Muntzel	Murphy
Neely	O'Donnell	Patterson	Pfautsch	Pietzman
Pike	Plocher	Pogue	Pollitt 52	Pollock 123
Porter	Reedy	Rehder	Toalson Reisch	Remole
Richey	Riggs	Roberts 161	Roden	Rone
Ross	Ruth	Sharpe	Shields	Simmons
Solon	Spencer	Stacy	Stephens 128	Swan
Taylor	Trent	Veit	Walsh	Wiemann
Wilson	Wood	Wright	Mr. Speaker	

NOES: 037

Baringer	Barnes	Beck	Brown 27	Burnett
Burns	Butz	Chappelle-Nadal	Clemens	Ellebracht
Ellington	Franks Jr.	Gray	Green	Ingle
Lavender	Mackey	McCreery	Merideth	Mitten
Morgan	Mosley	Pierson Jr.	Proudie	Quade
Razer	Roberts 77	Rogers	Rowland	Runions
Sain	Sauls	Stevens 46	Unsicker	Walker
Washington	Windham			

PRESENT: 000

ABSENT WITH LEAVE: 034

Allred	Appelbaum	Bangert	Bland Manlove	Bosley
Brown 70	Carpenter	Carter	Christofanelli	Fishel
Fitzwater	Gregory	Grier	Griesheimer	Houx
Kelly 141	Kendrick	Kidd	Knight	McGaugh

Messenger	Miller	Moon	Price	Roeber
Schnelting	Schroer	Shaul 113	Shawan	Shull 16
Smith	Sommer	Tate	Vescovo	

VACANCIES: 003

On motion of Representative Murphy, **House Amendment No. 14** was adopted.

Representative Coleman (97) offered **House Amendment No. 15**.

House Amendment No. 15

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after said section and line the following:

"**217.199. 1. As used in this section, "healthcare products" include tampons and sanitary napkins.**

2. The director shall ensure that healthcare products are available for free to offenders while confined in any correctional center of the department, in a quantity that is appropriate for the healthcare needs of each offender. The director shall ensure that the healthcare products conform with applicable industry standards.

221.520. 1. As used in this section, the following terms shall mean:

(1) "Extraordinary circumstance", a substantial flight risk or some other extraordinary security circumstance that dictates restraints be used to ensure the safety and security of a pregnant prisoner in her third trimester or a postpartum prisoner within forty-eight hours postdelivery, the staff of the county or city jail or medical facility, other prisoners, or the public;

(2) "Labor", the period of time before a birth during which contractions are present;

(3) "Major bodily function", functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions;

(4) "Medical emergency", a condition that, based on reasonable medical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate removal of restraints to avert the death of the pregnant woman or for which a delay in removal of restraints will create a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman;

(5) "Physician", any person licensed by the state board of registration for the healing arts to practice medicine in this state;

(6) "Postpartum", the period of recovery immediately following childbirth, which is six weeks for a vaginal birth or eight weeks for a cesarean birth, or longer if so determined by a physician;

(7) "Reasonable medical judgment", a medical judgment made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved;

(8) "Restraints", any physical restraint or other device used to control the movement of a person's body or limbs;

(9) "Third trimester", gestational age, which is the length of pregnancy as measured from the first day of the woman's last menstrual period, of twenty-eight weeks or more;

(10) "Unborn child", the offspring of human beings from the moment of conception until birth and at every state of its biological development, including the human conceptus, zygote, morula, blastocyst, embryo, and fetus.

2. Pregnant prisoners shall be transported in vehicles equipped with seatbelts.

3. Any time restraints are used on a pregnant prisoner in her third trimester or on a postpartum prisoner within forty-eight hours postdelivery, as documented by a physician and for which the county or city officer or sheriff or jailer has written notice, the restraints shall be the least restrictive available and reasonable under the circumstances. Only in extraordinary circumstances, as determined by a county or city officer or jail official, shall ankle or waist restraints be used on any such offender.

4. If, based on his or her reasonable medical judgment, a doctor, nurse, or other licensed health care provider treating the pregnant prisoner in her third trimester or the postpartum prisoner within forty-eight hours postdelivery, as previously documented by a physician, finds that a medical emergency exists and requests that restraints not be used, the county or city officer or sheriff or jailer accompanying such prisoner

shall as soon as practical remove all restraints. The individual ordering the removal of restraints shall assume all liability for acts and damages that occur as a result of the restraints being removed and shall report in writing the specific facts justifying the medical emergency. The report shall be kept on file for at least five years.

5. In the event a county or city officer or sheriff or jailer determines that extraordinary circumstances exist and restraints are necessary, the officer, sheriff, or jailer shall fully document in writing within forty-eight hours of the incident the reasons he or she determined such extraordinary circumstances existed, the type of restraints used, and the reasons those restraints were considered the least restrictive available and reasonable under the circumstances. Such documents shall be kept on file by the county or city jail for at least five years from the date the restraints were used.

6. The county or city jail shall inform female prisoners, in writing and orally, of any policies and practices developed in accordance with this section upon admission to the jail, and post the policies and practices in locations in the jail where such notices are commonly posted and will be seen by female prisoners."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Coleman (97), **House Amendment No. 15** was adopted by the following vote, the ayes and noes having been demanded by Representative Coleman (97):

AYES: 078

Baringer	Barnes	Basye	Beck	Black 7
Bland Manlove	Bondon	Bromley	Brown 27	Burnett
Burns	Butz	Carpenter	Chappelle-Nadal	Christofanelli
Clemens	Coleman 97	Deaton	Dinkins	Dogan
Ellebracht	Ellington	Fitzwater	Franks Jr.	Gray
Green	Grier	Haden	Hannegan	Hansen
Helms	Hicks	Hudson	Ingle	Kelly 141
Kidd	Lavender	Lovasco	Mackey	Mayhew
McCreery	Merideth	Mitten	Morgan	Mosley
Muntzel	Neely	Patterson	Pfautsch	Pierson Jr.
Pike	Plocher	Proudie	Quade	Razer
Rehder	Riggs	Roberts 161	Roberts 77	Rogers
Rowland	Runions	Sain	Sauls	Schnelting
Schroer	Shawan	Smith	Stevens 46	Trent
Unsicker	Veit	Walker	Washington	Windham
Wood	Wright	Mr. Speaker		

NOES: 043

Anderson	Andrews	Bailey	Baker	Black 137
Busick	Chipman	Dohrman	Eggleston	Eslinger
Falkner III	Francis	Gannon	Haffner	Henderson
Hovis	Hurst	Kelley 127	Kolkmeyer	Love
McDaniel	McGirl	Moon	Morris 140	Murphy
O'Donnell	Pietzman	Pogue	Pollitt 52	Pollock 123
Remole	Richey	Rone	Ross	Sharpe
Simmons	Solon	Spencer	Stacy	Swan
Taylor	Wiemann	Wilson		

PRESENT: 005

Griffith	Toalson Reisch	Roden	Ruth	Walsh

ABSENT WITH LEAVE: 034

Allred	Appelbaum	Bangert	Billington	Bosley
Brown 70	Carter	Coleman 32	DeGroot	Evans
Fishel	Gregory	Griesheimer	Hill	Houx
Justus	Kendrick	Knight	Lynch	McGaugh
Messenger	Miller	Morse 151	Porter	Price
Reedy	Roeber	Shaul 113	Shields	Shull 16
Sommer	Stephens 128	Tate	Vescovo	

VACANCIES: 003

Representative Walker offered **House Amendment No. 16**.

House Amendment No. 16

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after all of said section and line the following:

"**324.037. 1. For the purposes of this section, the term "health care professional" shall mean a physician, other health care practitioner or mental health professional licensed, accredited, or certified by the state of Missouri to perform health services, including, but not limited to, a psychologist, a behavior analyst, a professional counselor, a clinical social worker, a baccalaureate social worker, an advanced macro social worker, a master social worker, or a marital and family therapist.**

2. Any health care professional in the state of Missouri may annually complete up to two hours of cultural competency training, which shall qualify as part of the continuing education requirements for his or her licensure."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Walker, **House Amendment No. 16** was adopted.

Representative Roden offered **House Amendment No. 17**.

House Amendment No. 17

AMEND Senate Bill No. 358, Page 1, Section A, Line 3, by inserting after all of said section and line the following:

"**190.256. 1. The board of registration for the healing arts shall work with certifying entities, as defined in section 334.735, to establish educational programs for an emergency medical technician-paramedic, as defined in section 190.100, to receive the education and training needed to become a physician assistant, as defined in section 334.735. The education and training programs shall be consistent with the educational requirements of the certifying entities' requirements for physician assistants. The educational and training programs shall recognize and give credit for any relevant education and training received by the emergency medical technician-paramedic.**

2. The board shall establish the education and training programs by July 1, 2020.

3. The board shall allow any state university to provide the curriculum established by the board for the education and training programs."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Roden, **House Amendment No. 17** was adopted.

Representative Carpenter offered **House Amendment No. 18**.

House Amendment No. 18

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after all of said section and line the following:

"**Section 1. 1. There is hereby created the "Missouri Task Force Task Force" for the purpose of overseeing and monitoring the work of task forces in the state. The task force shall investigate the current status of task forces in the state, including whether each task force is fulfilling its statutory obligations.**

2. The task force shall consist of the following members:

(1) One member appointed by the speaker of the house of representatives;

(2) One member appointed by the president pro tempore of the senate;

(3) One member appointed by the minority leader of the house of representatives;

(4) One member appointed by the minority leader of the senate; and

(5) Three members appointed by the governor, one of whom shall be a member of the public and two of whom shall be current members of other task forces.

3. The members shall be appointed no later than thirty days after the effective date of this section. The task force shall hold its first meeting no later than fifteen days after the members are appointed.

4. The task force shall elect a chair and vice-chair at its first meeting.

5. The staffs of senate research and house research shall provide technical assistance to the task force as necessary for the completion of its duties.

6. The task force shall submit a report of its findings and recommendations to the general assembly by December 31, 2020.

7. The task force shall terminate on December 31, 2020."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Eggleston moved the previous question.

Which motion was adopted by the following vote:

AYES: 097

Anderson	Andrews	Bailey	Baker	Basye
Billington	Black 137	Black 7	Bondon	Bromley
Busick	Chipman	Coleman 32	Coleman 97	Deaton
DeGroot	Dinkins	Dohrman	Eggleston	Eslinger
Falkner III	Fitzwater	Francis	Gannon	Grier
Griffith	Haden	Haffner	Hannegan	Hansen
Helms	Henderson	Hicks	Hill	Houx
Hovis	Hudson	Hurst	Justus	Kelley 127
Kelly 141	Kidd	Knight	Kolkmeyer	Lovasco
Love	Lynch	Mayhew	McDaniel	McGirl
Moon	Morris 140	Morse 151	Muntzel	Murphy
Neely	Patterson	Pfautsch	Pietzman	Pike
Plocher	Pogue	Pollitt 52	Pollock 123	Porter
Reedy	Rehder	Toalson Reisch	Remole	Richey
Riggs	Roberts 161	Roden	Rone	Ross
Rowland	Ruth	Schnelting	Schroer	Sharpe
Shaul 113	Shawan	Shields	Simmons	Solon
Sommer	Spencer	Stacy	Stephens 128	Swan
Taylor	Veit	Walsh	Wilson	Wood
Wright	Mr. Speaker			

NOES: 039

Appelbaum	Bangert	Baringer	Barnes	Beck
Brown 27	Burnett	Burns	Butz	Carpenter
Chappelle-Nadal	Clemens	Ellebracht	Ellington	Franks Jr.
Green	Ingle	Kendrick	Lavender	Mackey
McCreery	Merideth	Mitten	Morgan	Mosley
Pierson Jr.	Price	Proudie	Quade	Razer
Roberts 77	Rogers	Runions	Sain	Sauls
Stevens 46	Unsicker	Walker	Windham	

PRESENT: 000

ABSENT WITH LEAVE: 024

Allred	Bland Manlove	Bosley	Brown 70	Carter
Christofanelli	Dogan	Evans	Fishel	Gray
Gregory	Griesheimer	McGaugh	Messenger	Miller
O'Donnell	Roeber	Shull 16	Smith	Tate
Trent	Vescovo	Washington	Wiemann	

VACANCIES: 003

On motion of Representative Carpenter, **House Amendment No. 18** was adopted.

Representative Roberts (77) offered **House Amendment No. 19**.

House Amendment No. 19

AMEND Senate Bill No. 358, Page 1, Section A, Line 3, by inserting after said section and line the following:

"135.562. 1. If any taxpayer with a federal adjusted gross income of thirty thousand dollars or less incurs costs for the purpose of making all or any portion of such taxpayer's principal dwelling accessible to an individual with a disability who permanently resides with the taxpayer, such taxpayer shall receive a tax credit against such taxpayer's Missouri income tax liability in an amount equal to the lesser of one hundred percent of such costs or two thousand five hundred dollars per taxpayer, per tax year.

2. Any taxpayer with a federal adjusted gross income greater than thirty thousand dollars but less than sixty thousand dollars who incurs costs for the purpose of making all or any portion of such taxpayer's principal dwelling accessible to an individual with a disability who permanently resides with the taxpayer shall receive a tax credit against such taxpayer's Missouri income tax liability in an amount equal to the lesser of fifty percent of such costs or two thousand five hundred dollars per taxpayer per tax year. No taxpayer shall be eligible to receive tax credits under this section in any tax year immediately following a tax year in which such taxpayer received tax credits under the provisions of this section.

3. Tax credits issued **[**~~pursuant to~~**] under** this section may be refundable in an amount not to exceed two thousand five hundred dollars per tax year.

4. Eligible costs for which the credit may be claimed include:

(1) Constructing entrance or exit ramps;

(2) Widening exterior or interior doorways;

(3) Widening hallways;

(4) Installing handrails or grab bars;

(5) Moving electrical outlets and switches;

(6) Installing stairway lifts;

(7) Installing or modifying fire alarms, smoke detectors, and other alerting systems;

(8) Modifying hardware of doors; or

(9) Modifying bathrooms.

5. The tax credits allowed, including the maximum amount that may be claimed, **[**~~pursuant to~~**] under** this section shall be reduced by an amount sufficient to offset any amount of such costs a taxpayer has already deducted from such taxpayer's federal adjusted gross income or to the extent such taxpayer has applied any other state or federal income tax credit to such costs.

6. A taxpayer shall claim a credit allowed by this section in the same **[**~~taxable~~**] tax** year as the credit is issued, and at the time such taxpayer files his or her Missouri income tax return; provided that such return is timely filed.

7. The department may, in consultation with the department of social services, promulgate such rules or regulations as are necessary to administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

8. The provisions of this section shall apply to all tax years beginning on or after January 1, 2008.

9. The provisions of this section shall expire December 31, **[**~~2019~~**] 2025**, unless reauthorized by the general assembly. This section shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under this section is sunset. The provisions of this subsection shall not be construed to limit or in any way impair the department's ability to redeem tax credits authorized on or before the date the program authorized under this section expires or a taxpayer's ability to redeem such tax credits.

10. In no event shall the aggregate amount of all tax credits allowed **[**~~pursuant to~~**] under** this section exceed one hundred thousand dollars in any given fiscal year. The tax credits issued pursuant to this section shall be on a first-come, first-served filing basis."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

Representative Roden offered **House Amendment No. 1 to House Amendment No. 19**.

House Amendment No. 1
to
House Amendment No. 19

AMEND House Amendment No. 19 to Senate Bill No. 358, Page 1, Line 4, by deleting said line and inserting in lieu thereof the following:

"135.090. 1. As used in this section, the following terms mean:

(1) "Homestead", the dwelling in Missouri owned by the surviving spouse and not exceeding five acres of land surrounding it as is reasonably necessary for use of the dwelling as a home. As used in this section, "homestead" shall not include any dwelling which is occupied by more than two families;

(2) "Public safety officer", any firefighter, police officer, capitol police officer, parole officer, probation officer, correctional employee, water patrol officer, park ranger, conservation officer, commercial motor enforcement officer, emergency medical technician, first responder, or highway patrolman employed by the state of Missouri or a political subdivision thereof who is killed in the line of duty, unless the death was the result of the officer's own misconduct or abuse of alcohol or drugs;

(3) "Surviving spouse", a spouse, who has not remarried, of a public safety officer.

2. For all tax years beginning on or after January 1, 2008, a surviving spouse shall be allowed a credit against the tax otherwise due under chapter 143, excluding withholding tax imposed by sections 143.191 to 143.265, in an amount equal to the total amount of the property taxes on the surviving spouse's homestead paid during the tax year for which the credit is claimed. A surviving spouse may claim the credit authorized under this section for each tax year beginning the year of death of the public safety officer spouse until the tax year in which the surviving spouse remarries. No credit shall be allowed for the tax year in which the surviving spouse remarries. If the amount allowable as a credit exceeds the income tax reduced by other credits, then the excess shall be considered an overpayment of the income tax.

3. The department of revenue shall promulgate rules to implement the provisions of this section.

4. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

5. Pursuant to section 23.253 of the Missouri sunset act:

(1) The program authorized under this section shall expire on December 31, **[**~~2019~~**] 2027**, unless reauthorized by the general assembly; and

(2) This section shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under this section is sunset; and

(3) The provisions of this subsection shall not be construed to limit or in any way impair the department's ability to redeem tax credits authorized on or before the date the program authorized under this section expires or a taxpayer's ability to redeem such tax credits.

135.562. 1. If any taxpayer with a federal adjusted gross income of thirty thousand dollars"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Roden, **House Amendment No. 1 to House Amendment No. 19** was adopted.

On motion of Representative Roberts (77), **House Amendment No. 19, as amended**, was adopted.

Representative Rowland offered **House Amendment No. 20**.

House Amendment No. 20

AMEND Senate Bill No. 358, Page 1, Section A, Line 3, by inserting after all of said section and line the following:

"178.931. 1. Beginning July 1, 2018, and thereafter, the department of elementary and secondary education shall pay monthly, out of the funds appropriated to it for that purpose, to each sheltered workshop a sum equal to the amount calculated under subsection 2 of this section but at least the amount necessary to ensure that at least twenty-one dollars is paid for each six-hour or longer day worked by a handicapped employee **for each standard workweek of up to and including thirty-eight hours worked. For each handicapped worker employed by a sheltered workshop for less than a thirty-eight-hour week or a six-hour day, the workshop shall receive a percentage of the corresponding amount normally paid based on the percentage of time worked by the handicapped employee**.

2. In order to calculate the monthly amount due to each sheltered workshop, the department shall:

(1) Determine the quotient obtained by dividing the appropriation for the fiscal year by twelve; and

(2) Divide the amount calculated under subdivision (1) of this subsection among the sheltered workshops in proportion to each sheltered workshop's number of hours submitted to the department for the preceding calendar month.

3. The department shall accept, as prima facie proof of payment due to a sheltered workshop, information as designated by the department, either in paper or electronic format. A statement signed by the president, secretary, and manager of the sheltered workshop, setting forth the dates worked and the number of hours worked each day by each handicapped person employed by that sheltered workshop during the preceding calendar month, together with any other information required by the rules or regulations of the department, shall be maintained at the workshop location."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Rowland, **House Amendment No. 20** was adopted.

Representative Neely offered **House Amendment No. 21**.

House Amendment No. 21

AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after all of said section and line the following:

"376.1578. 1. Within two working days after receipt of a faxed or mailed completed application, the health carrier shall send a notice of receipt to the practitioner. A health carrier shall provide access to a provider web portal that allows the practitioner to receive notice of the status of an electronically submitted application.

2. A health carrier shall assess a health care practitioner's credentialing information and make a decision as to whether to approve or deny the practitioner's credentialing application within sixty business days of the date of receipt of the completed application. The sixty-day deadline established in this section shall not apply if the application or subsequent verification of information indicates that the practitioner has:

(1) A history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;

(2) Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;

(3) Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or

(4) A judgment or judicial award against the practitioner arising from a medical malpractice liability lawsuit.

3. **Once a practitioner has been credentialed or re-credentialed with a health carrier, the health carrier shall provide retroactive payments for any covered services performed by the practitioner during the application period, which begins when the health carrier has received a completed application for credentialing.**

4. The department of insurance, financial institutions and professional registration shall establish a mechanism for reporting alleged violations of this section to the department."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.

On motion of Representative Neely, **House Amendment No. 21** was adopted.

On motion of Representative Swan, **SB 358, as amended**, was read the third time and passed by the following vote:

AYES: 088

Anderson	Andrews	Bangert	Baringer	Barnes
Basye	Black 137	Bondon	Brown 27	Burns
Butz	Coleman 32	Coleman 97	DeGroot	Dinkins
Dogan	Eggleston	Ellebracht	Falkner III	Francis
Gannon	Green	Grier	Griesheimer	Haden
Hannegan	Hansen	Helms	Hicks	Houx
Ingle	Justus	Kendrick	Kidd	Knight
Lovasco	Love	Lynch	Miller	Morris 140
Morse 151	Mosley	Muntzel	Murphy	Neely
O'Donnell	Patterson	Pfautsch	Pike	Plocher
Pollitt 52	Porter	Proudie	Quade	Razer
Reedy	Richey	Riggs	Roberts 161	Roberts 77
Roden	Rogers	Rone	Rowland	Ruth
Sain	Schroer	Sharpe	Shaul 113	Shawan
Shields	Smith	Solon	Sommer	Stephens 128
Stevens 46	Swan	Tate	Trent	Unsicker
Veit	Vescovo	Walker	Wiemann	Windham
Wood	Wright	Mr. Speaker		

NOES: 050

Appelbaum	Bailey	Baker	Beck	Billington
Black 7	Bland Manlove	Bromley	Burnett	Busick
Chappelle-Nadal	Chipman	Christofanelli	Clemens	Deaton
Dohrman	Ellington	Evans	Fitzwater	Franks Jr.
Haffner	Hill	Hovis	Hudson	Hurst
Kelley 127	Kelly 141	Kolkmeyer	Lavender	Mackey
Mayhew	McCreery	McGirl	Merideth	Moon
Morgan	Pierson Jr.	Pietzman	Pogue	Pollock 123
Rehder	Remole	Runions	Schnelting	Simmons
Spencer	Stacy	Taylor	Washington	Wilson

PRESENT: 004

Griffith	Toalson Reisch	Sauls	Walsh

ABSENT WITH LEAVE: 018

Allred	Bosley	Brown 70	Carpenter	Carter
Eslinger	Fishel	Gray	Gregory	Henderson
McDaniel	McGaugh	Messenger	Mitten	Price
Roeber	Ross	Shull 16		

VACANCIES: 003

Representative Plocher declared the bill passed.

HCS SB 87, as amended, relating to taxation, was taken up by Representative Swan.

On motion of Representative Swan, **HCS SB 87, as amended**, was adopted.

On motion of Representative Swan, **HCS SB 87, as amended**, was read the third time and passed by the following vote:

AYES: 112

Anderson	Andrews	Bailey	Baker	Bangert
Baringer	Basye	Billington	Black 137	Black 7
Bondon	Bromley	Brown 27	Burns	Busick
Carpenter	Chipman	Christofanelli	Coleman 32	Coleman 97
Deaton	DeGroot	Dinkins	Dogan	Dohrman
Eggleston	Ellebracht	Evans	Falkner III	Fishel
Fitzwater	Francis	Gannon	Green	Grier
Griesheimer	Griffith	Haden	Haffner	Hannegan
Hansen	Helms	Hicks	Hill	Houx
Hovis	Hudson	Ingle	Justus	Kelley 127
Kelly 141	Kendrick	Kidd	Knight	Kolkmeyer
Lovasco	Love	Lynch	Mayhew	McDaniel
McGirl	Miller	Morris 140	Morse 151	Mosley
Muntzel	Murphy	Neely	O'Donnell	Patterson
Pfautsch	Pike	Plocher	Pollitt 52	Pollock 123
Porter	Reedy	Rehder	Toalson Reisch	Remole
Richey	Riggs	Roberts 161	Roberts 77	Roden

Rogers	Rowland	Ruth	Sain	Sauls
Schnelting	Schroer	Sharpe	Shaul 113	Shawan
Shields	Simmons	Smith	Solon	Sommer
Stephens 128	Swan	Tate	Trent	Veit
Vescovo	Walsh	Wiemann	Wilson	Wood
Wright	Mr. Speaker			

NOES: 030

Appelbaum	Barnes	Beck	Burnett	Butz
Chappelle-Nadal	Ellington	Franks Jr.	Gray	Hurst
Lavender	Mackey	McCreery	Merideth	Mitten
Moon	Pierson Jr.	Pietzman	Pogue	Proudie
Quade	Razer	Runions	Spencer	Stacy
Stevens 46	Taylor	Unsicker	Walker	Washington

PRESENT: 002

Clemens	Windham

ABSENT WITH LEAVE: 016

Allred	Bland Manlove	Bosley	Brown 70	Carter
Eslinger	Gregory	Henderson	McGaugh	Messenger
Morgan	Price	Roeber	Rone	Ross
Shull 16				

VACANCIES: 003

Representative Plocher declared the bill passed.

The emergency clause was adopted by the following vote:

AYES: 137

Anderson	Andrews	Appelbaum	Bailey	Baker
Bangert	Baringer	Barnes	Basye	Beck
Billington	Black 137	Black 7	Bondon	Bosley
Bromley	Brown 27	Burns	Busick	Butz
Carpenter	Chappelle-Nadal	Chipman	Christofanelli	Clemens
Coleman 32	Coleman 97	Deaton	DeGroot	Dinkins
Dogan	Dohrman	Eggleston	Ellebracht	Eslinger
Evans	Falkner III	Fishel	Francis	Franks Jr.
Gannon	Gray	Green	Grier	Griesheimer
Griffith	Haden	Haffner	Hannegan	Hansen
Helms	Hicks	Hill	Houx	Hovis
Hudson	Ingle	Justus	Kelley 127	Kelly 141
Kendrick	Knight	Kolkmeyer	Lavender	Lovasco
Love	Lynch	Mackey	Mayhew	McCreery
McDaniel	McGirl	Merideth	Miller	Mitten
Morgan	Morris 140	Morse 151	Mosley	Muntzel
Murphy	Neely	O'Donnell	Patterson	Pfautsch
Pierson Jr.	Pietzman	Pike	Plocher	Pollitt 52
Pollock 123	Porter	Proudie	Quade	Razer
Reedy	Rehder	Toalson Reisch	Remole	Richey
Riggs	Roberts 161	Roberts 77	Roden	Rogers
Rone	Rowland	Ruth	Sain	Sauls

Schnelting	Schroer	Sharpe	Shaul 113	Shawan
Shields	Simmons	Smith	Solon	Sommer
Stacy	Stephens 128	Stevens 46	Swan	Tate
Trent	Unsicker	Veit	Vescovo	Walker
Walsh	Washington	Wiemann	Windham	Wood
Wright	Mr. Speaker			

NOES: 010

Burnett	Ellington	Fitzwater	Hurst	Moon
Pogue	Runions	Spencer	Taylor	Wilson

PRESENT: 000

ABSENT WITH LEAVE: 013

Allred	Bland Manlove	Brown 70	Carter	Gregory
Henderson	Kidd	McGaugh	Messenger	Price
Roeber	Ross	Shull 16		

VACANCIES: 003

THIRD READING OF SENATE CONCURRENT RESOLUTIONS

SCR 5, relating to the establishment of the Joint Committee on Solid Waste Management District Operations, was taken up by Representative Anderson.

Representative Roden assumed the Chair.

On motion of Representative Anderson, **SCR 5** was truly agreed to and finally passed by the following vote:

AYES: 141

Anderson	Andrews	Appelbaum	Bailey	Baker
Bangert	Baringer	Barnes	Basye	Beck
Billington	Black 137	Black 7	Bondon	Bosley
Bromley	Brown 27	Burnett	Burns	Busick
Butz	Carpenter	Chappelle-Nadal	Chipman	Christofanelli
Clemens	Coleman 32	Coleman 97	Deaton	DeGroot
Dinkins	Dogan	Dohrman	Eggleston	Ellebracht
Eslinger	Evans	Falkner III	Fishel	Fitzwater
Francis	Franks Jr.	Gannon	Gray	Green
Gregory	Grier	Griesheimer	Griffith	Haden
Haffner	Hannegan	Hansen	Helms	Henderson
Hicks	Houx	Hovis	Hudson	Hurst
Ingle	Justus	Kelley 127	Kelly 141	Kendrick
Kidd	Knight	Kolkmeyer	Lavender	Lovasco
Love	Lynch	Mackey	Mayhew	McCreery
McDaniel	McGirl	Merideth	Miller	Mitten
Moon	Morgan	Morris 140	Morse 151	Mosley
Muntzel	Murphy	Neely	O'Donnell	Patterson
Pfautsch	Pierson Jr.	Pietzman	Pike	Pollitt 52
Pollock 123	Porter	Proudie	Quade	Razer

Reedy	Rehder	Toalson Reisch	Remole	Richey
Riggs	Roberts 161	Roberts 77	Roden	Rogers
Rone	Ross	Rowland	Runions	Ruth
Sain	Sauls	Schnelting	Sharpe	Shawan
Shields	Simmons	Smith	Solon	Sommer
Spencer	Stacy	Stephens 128	Stevens 46	Swan
Tate	Taylor	Trent	Unsicker	Vescovo
Walker	Walsh	Washington	Wiemann	Wright
Mr. Speaker				

NOES: 001

Pogue

PRESENT: 001

Ellington

ABSENT WITH LEAVE: 017

Allred	Bland Manlove	Brown 70	Carter	Hill
McGaugh	Messenger	Plocher	Price	Roeber
Schroer	Shaul 113	Shull 16	Veit	Wilson
Windham	Wood			

VACANCIES: 003

Representative Roden declared the bill passed.

SCR 6, relating to Falun Gong, was taken up by Representative Morris (140).

On motion of Representative Morris (140), **SCR 6** was truly agreed to and finally passed by the following vote:

AYES: 147

Anderson	Andrews	Appelbaum	Bailey	Baker
Bangert	Baringer	Barnes	Basye	Beck
Billington	Black 137	Black 7	Bland Manlove	Bondon
Bosley	Bromley	Brown 27	Burnett	Burns
Busick	Butz	Carpenter	Chappelle-Nadal	Chipman
Christofanelli	Clemens	Coleman 32	Coleman 97	Deaton
DeGroot	Dinkins	Dogan	Dohrman	Eggleston
Ellebracht	Ellington	Eslinger	Evans	Falkner III
Fishel	Fitzwater	Francis	Franks Jr.	Gannon
Gray	Green	Gregory	Grier	Griesheimer
Griffith	Haden	Haffner	Hannegan	Hansen
Helms	Henderson	Hicks	Houx	Hovis
Hudson	Hurst	Ingle	Justus	Kelley 127
Kelly 141	Kendrick	Kidd	Knight	Kolkmeyer
Lavender	Lovasco	Love	Lynch	Mackey
Mayhew	McCreery	McGirl	Merideth	Miller
Mitten	Moon	Morgan	Morris 140	Morse 151
Mosley	Muntzel	Murphy	Neely	O'Donnell
Patterson	Pfautsch	Pierson Jr.	Pietzman	Pike
Pogue	Pollitt 52	Pollock 123	Porter	Proudie

Quade	Razer	Reedy	Rehder	Toalson Reisch
Remole	Richey	Riggs	Roberts 161	Roberts 77
Roden	Rogers	Rone	Ross	Rowland
Runions	Ruth	Sain	Sauls	Schnelting
Schroer	Sharpe	Shawan	Shields	Simmons
Smith	Solon	Sommer	Spencer	Stacy
Stephens 128	Stevens 46	Swan	Tate	Taylor
Trent	Unsicker	Veit	Vescovo	Walker
Walsh	Washington	Wiemann	Wilson	Wood
Wright	Mr. Speaker			

NOES: 001

McDaniel

PRESENT: 000

ABSENT WITH LEAVE: 012

Allred	Brown 70	Carter	Hill	McGaugh
Messenger	Plocher	Price	Roeber	Shaul 113
Shull 16	Windham			

VACANCIES: 003

Representative Roden declared the bill passed.

THIRD READING OF SENATE BILLS - INFORMAL

SCS SB 180, **SCS SB 89, as amended**, **SB 264**, **HCS SS SCS SB 291**, **SB 84**, **HCS SB 206**, **SB 246**, **SB 405**, **SS#3 SCS SB 29**, **HCS SS SCS SB 108**, **SS SB 213**, **HCS SB 275**, **HCS SCS SB 6**, **SS SCS SB 34**, **HCS SCS SB 60**, **HCS SB 71**, **SS SB 414**, **SB 373**, **HCS SB 72**, **HCS SB 297**, **SB 397**, **HCS SCS SB 203**, **HCS SB 11**, **SB 138**, **HCS SCS SB 363**, **HCS SS SCS SBs 70 & 128**, and **HCS SB 468** were placed back on the Senate Bills for Third Reading Calendar.

REFERRAL OF SENATE BILLS

The following Senate Bill was referred to the Committee indicated:

HCS SB 152 - Fiscal Review

COMMITTEE REPORTS

Special Committee on Homeland Security, Chairman Hicks reporting:

Mr. Speaker: Your Special Committee on Homeland Security, to which was referred **HB 1155**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(b) be referred to the Committee on Rules - Administrative Oversight by the following vote:

Ayes (5): Barnes, Haffner, Hicks, Kidd and Schnelting

Noes (0)

Absent (2): Ellington and Pogue

Special Committee on Urban Issues, Chairman Franks Jr. reporting:

Mr. Speaker: Your Special Committee on Urban Issues, to which was referred **HCR 33**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (6): Franks Jr., Helms, Price, Rone, Tate and Windham

Noes (0)

Absent (4): Kelly (141), Miller, Plocher and Proudie

Committee on Utilities, Chairman Fitzwater reporting:

Mr. Speaker: Your Committee on Utilities, to which was referred **HB 909**, begs leave to report it has examined the same and recommends that it **Do Pass with House Committee Substitute**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (11): Black (137), Bromley, Fitzwater, Francis, Hicks, Ingle, Kidd, McCreery, Pierson Jr., Sain and Simmons

Noes (0)

Absent (5): DeGroot, Haffner, McDaniel, Miller and Roberts (77)

Committee on Rules - Legislative Oversight, Chairman Miller reporting:

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HCS SS SB 3**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (7): Bondon, Chipman, Christofanelli, Fitzwater, Houx, Miller and Unsicker

Noes (0)

Absent (3): Runions, Sommer and Washington

SUBCOMMITTEE APPOINTMENTS

May 15, 2019

Ms. Dana Rademan Miller
Chief Clerk
Missouri House of Representatives
State Capitol, Room 310
Jefferson City, MO 65101

Dear Ms. Miller:

I hereby appoint the following to the Subcommittee on Health Care Reform:

Representative Steve Helms, Chair
Representative Dale Wright
Representative Ann Kelley
Representative Doug Clemens
Representative Cora Faith Walker

This Committee will report to the Committee on Health and Mental Health Policy.

If you have any questions, please feel free to contact my office.

Sincerely,

/s/ Elijah Haahr
Speaker of the House

COMMUNICATIONS

May 15, 2019

Emily White
Assistant Chief Clerk
Missouri House of Representatives
201 W. Capitol Ave.
Jefferson City, MO 65101

Dear Emily,

House Resolution No. 3287, sponsored by Representative Barbara Washington, has been referred to the Committee on Consent and House Procedures. This resolution concerns the use of the House Chamber by the Emerging Leaders Youth Conference on June 24, 2019. Due to the fact that we are so near the end of session, I believe it is unnecessary for the Consent and House Procedures committee to meet solely to hear and take a vote on this resolution.

To that end, I have spoken with Representative Washington and received her assurance that she will personally attend this program in the House Chamber on June 24. This is an annual educational program that was started by former House Minority Floor Leader Gail McCann Beatty, and as such is a program that deserves the use of the Chamber and that will use the Chamber responsibly.

I ask that you permit the Emerging Leaders Youth Conference the use of the House Chamber on June 24, 2019, without approval for **HR 3287** by the Committee on Consent and House Procedure.

Thank you,

/s/ Donna Pfautsch
State Representative – District 33
Chair, Committee on Consent and House Procedure

CONFERENCE COMMITTEE REPORT
ON
SENATE BILL NO. 17

The Conference Committee appointed on Senate Bill No. 17, with House Amendment Nos. 1, 2, 3, 4, and 5, begs leave to report that we, after free and fair discussion of the differences, have agreed to recommend and do recommend to the respective bodies as follows:

1. That the House recede from its position on Senate Bill No. 17, as amended.

2. That the Senate recede from its position on Senate Bill No. 17.

3. That the attached Conference Committee Substitute for Senate Bill No. 17 be Third Read and Finally Passed.

FOR THE SENATE:

/s/ Gary Romine
/s/ Bob Onder
/s/ Doug Libla
/s/ Gina Walsh
/s/ Karla May

FOR THE HOUSE:

/s/ Rusty Black (7)
/s/ Patricia Pike
/s/ Barry Hovis
/s/ Richard Brown (27)
/s/ Doug Clemens

CONFERENCE COMMITTEE REPORT
ON
SENATE COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 83

The Conference Committee appointed on Senate Committee Substitute for Senate Bill No. 83, with House Amendment No. 1, House Amendment Nos. 1 and 2 to House Amendment No. 2, and House Amendment No. 2, as amended, begs leave to report that we, after free and fair discussion of the differences, have agreed to recommend and do recommend to the respective bodies as follows:

1. That the House recede from its position on Senate Committee Substitute for Senate Bill No. 83, as amended.

2. That the Senate recede from its position on Senate Committee Substitute for Senate Bill No. 83.

3. That the attached Conference Committee Substitute for Senate Committee Substitute for Senate Bill No. 83 be Third Read and Finally Passed.

FOR THE SENATE:

/s/ Mike Cunningham
/s/ David Sater
/s/ Jeanie Riddle
/s/ Scott Sifton
/s/ Jill Schupp

FOR THE HOUSE:

/s/ Robert Ross
/s/ Holly Rehder
/s/ David Evans
/s/ Ian Mackey
/s/ Gina Mitten

REFERRAL OF CONFERENCE COMMITTEE REPORTS

The following Conference Committee Reports were referred to the Committee indicated:

CCR SB 17, as amended - Fiscal Review
CCR SCS SB 83, as amended - Fiscal Review

The following member's presence was noted: Brown (70).

ADJOURNMENT

On motion of Representative Eggleston, the House adjourned until 10:00 a.m., Thursday, May 16, 2019.

COMMITTEE HEARINGS

BUDGET
Thursday, May 16, 2019, upon adjournment, House Hearing Room 3.
Executive session may be held on any matter referred to the committee.
To further consider tax credit authorizations.

FISCAL REVIEW
Thursday, May 16, 2019, 9:00 AM, House Hearing Room 6.
Executive session may be held on any matter referred to the committee.

FISCAL REVIEW
Friday, May 17, 2019, 9:00 AM, House Hearing Room 6.
Executive session may be held on any matter referred to the committee.

RULES - ADMINISTRATIVE OVERSIGHT
Thursday, May 16, 2019, 12:00 PM or upon morning recess (whichever is later),
House Hearing Room 4.
Executive session may be held on any matter referred to the committee.
Members should be prepared to exec on any bill referred to the committee.
Members should be prepared to recess and reconvene upon recess and adjournment for consideration of additional referrals.
Note: Time change.
CORRECTED

RULES - LEGISLATIVE OVERSIGHT
Thursday, May 16, 2019, 8:00 AM, House Hearing Room 4.
Executive session may be held on any matter referred to the committee.
Members should be prepared to exec on any bill referred to the committee.
Members should be prepared to recess and reconvene upon recess and adjournment for consideration of additional referrals.

HOUSE CALENDAR

SEVENTY-FIRST DAY, THURSDAY, MAY 16, 2019

HOUSE JOINT RESOLUTIONS FOR PERFECTION

HCS HJR 37 - Bosley
HJR 30 - Anderson

HOUSE BILLS FOR PERFECTION

HCS HB 37 - Walsh
HB 115 - Remole
HB 541 - Murphy
HCS HB 1023 - Mackey

HOUSE BILLS FOR PERFECTION - INFORMAL

HB 877 - Kelly (141)
HB 1053 - Smith

HOUSE CONCURRENT RESOLUTIONS FOR THIRD READING

HCR 17 - Messenger
HCR 24 - Muntzel
HCR 4 - Love

HOUSE JOINT RESOLUTIONS FOR THIRD READING

HCS HJR 19 - Christofanelli

HOUSE BILLS FOR THIRD READING

HCS HB 656 - Carpenter

HOUSE BILLS FOR THIRD READING - INFORMAL

HB 923 - Swan
HCS HBs 167 & 166 - Rehder
HCS HB 427 - Helms
HB 940 - Roberts (161)

SENATE JOINT RESOLUTIONS FOR THIRD READING

SS SCS SJRs 14 & 9 - Shaul (113)

SENATE BILLS FOR THIRD READING

HCS SB 164 - Ross
HCS SS SCS SB 9 - Gregory
SCS SB 180 - Lynch
SCS SB 89, as amended - Griesheimer
SB 264 - Coleman (97)
HCS SS SCS SB 291, E.C. - Swan
SB 84 - Anderson
HCS SB 206 - Richey
SB 246 - Black (137)
SB 405 - Morse (151)
SS#3 SCS SB 29 - Smith
HCS SS SCS SB 108 - Coleman (97)
SS SB 213 - Trent
HCS SB 275 - Coleman (97)
HCS SCS SB 6 - Hill
SS SCS SB 34 - Houx
HCS SCS SB 60 - Neely
HCS SB 71 - Wiemann
SS SB 414, E.C. - Hill
SB 373 - Dogan
HCS SB 72 - Andrews
HCS SB 297 - Kelley (127)
SB 397 - Roberts (161)
HCS SCS SB 203 - Plocher
HCS SB 11 - Bondon
SB 138 - Fitzwater
HCS SCS SB 363, E.C. - Anderson
HCS SS SCS SBs 70 & 128 - Patterson
HCS SB 468 - Coleman (97)
HCS SB 282 - Morris (140)
SCS SBs 12 & 123 - Wilson
SB 88 - Rehder
SB 185 - Wiemann
HCS SS#4 SB 224 - Schroer
SB 228 - Andrews
HCS SB 333 - Kidd
SB 514, as amended, (Fiscal Review 5/15/19) - Wood
HCS SS SB 3 - Hannegan
HCS SB 103 - Pfautsch
HCS SB 152, (Fiscal Review 5/15/19) - Patterson

SENATE CONCURRENT RESOLUTIONS FOR THIRD READING

SCR 11 - Trent
HCS SCR 12 - Justus
SCR 17 - Muntzel
SCR 4 - Patterson
SCR 10 - Ross
SCR 2 - Andrews
SCR 3 - Wilson
SCR 13 - Baker
SS#2 SCR 14 - Ruth

HOUSE BILLS WITH SENATE AMENDMENTS

SS SCS HB 565, as amended - Morse (151)
SCS HCS HB 447, as amended - Houx
SS SCS HCS HB 399, as amended (Fiscal Review 5/15/19), E.C. - Basye
SS#2 HB 219, as amended (Fiscal Review 5/15/19), E.C. - Wood

BILLS CARRYING REQUEST MESSAGES

HCS SCS SB 174, as amended (request House recede/grant conference), E.C. - Shaul (113)
SS HCS#2 HB 499, (request Senate recede/grant conference) - Griesheimer

BILLS IN CONFERENCE

HCS SB 53, as amended - Reedy
CCR SB 368, with HA 1, HA 2, HA 3, HA 4, HA 5, HA 6, HA 7 and HA 8 - Shawan
CCR HCS SB 182, as amended - Coleman (32)
CCR SB 17, with HA 1, HA 2, HA 3, HA 4 and HA 5 (Fiscal Review 5/15/19), E.C. - Black (7)
CCR SS SCS SB 230, with HA 1, HA 2, HA 1 to HA 3, HA 3, as amended, HA 4, HA 5 and HA 6 - Knight
CCR SCS SB 83, with HA 1, HA 1 to HA 2, HA 2 to HA 2, and HA 2, as amended (Senate exceeded differences), (Fiscal Review 5/15/19) - Ross
HCS SCS SB 147, as amended - Taylor
HCS SB 202, as amended - Dinkins
HCS SB 36, as amended - Ross
HCS SB 54, as amended - Muntzel

ACTIONS PURSUANT TO ARTICLE IV, SECTION 27

HCS HB 2001 - Smith
CCS SCS HCS HB 2002 - Smith
CCS SCS HCS HB 2003 - Smith
CCS SCS HCS HB 2004 - Smith
CCS SCS HCS HB 2005 - Smith

CCS SCS HCS HB 2006 - Smith
CCS SCS HCS HB 2007 - Smith
CCS SCS HCS HB 2008 - Smith
CCS SCS HCS HB 2009 - Smith
CCS SS SCS HCS HB 2010 - Smith
CCS SCS HCS HB 2011 - Smith
CCS SCS HCS HB 2012 - Smith
SCS HCS HB 2013 - Smith
HCS HB 2017 - Smith
HCS HB 2018 - Smith
HCS HB 2019 - Smith

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