FIRST REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED]

SENATE SUBSTITUTE FOR

HOUSE BILL NO. 402

102ND GENERAL ASSEMBLY

1407S.04T 2023

AN ACT

To repeal sections 67.145, 105.500, 190.100, 190.103, 190.134, 190.142, 190.147, 190.600, 190.603, 190.606, 190.612, 191.305, 191.500, 191.505, 191.510, 191.515, 191.520, 191.525, 191.530, 191.535, 191.540, 191.545, 191.550, 191.600, 191.828, 191.831, 192.745, 192.2405, 194.300, 195.070, 195.100, 196.1050, 197.005, 197.020, 205.375, 208.030, 208.1032, 285.040, 321.225, 321.620, 334.036, 334.104, 334.735, 334.747, 335.016, 335.019, 335.036, 335.046, 335.051, 335.056, 335.076, 335.086, 335.175, 335.203, 335.212, 335.215, 335.218, 335.221, 335.224, 335.227, 335.230, 335.233, 335.236, 335.239, 335.242, 335.245, 335.248, 335.251, 335.254, 335.257, 537.037, 632.305, 650.320, 650.340, 701.336, 701.340, 701.342, 701.344, and 701.348, RSMo, and to enact in lieu thereof seventy-four new sections relating to health care.

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

Section A. Sections 67.145, 105.500, 190.100, 190.103, 190.134, 190.142, 190.147, 190.600, 190.603, 190.606, 190.612, 191.305, 191.500, 191.505, 191.510, 191.515, 191.520, 191.525, 191.530, 191.535, 191.540, 191.545, 191.550, 191.600, 191.828, 191.831, 192.745, 192.2405, 194.300, 195.070, 195.100, 196.1050, 197.005, 197.020, 205.375, 208.030, 208.1032, 285.040, 321.225, 321.620, 334.036, 334.104, 334.735, 334.747, 335.016, 335.019, 335.036, 335.046, 335.051, 335.056, 335.076, 335.086, 335.175, 335.203, 335.212, 335.215, 335.218, 335.221, 335.224, 335.227, 335.230, 335.233, 335.236, 335.239, 335.242, 335.245, 335.248, 335.251, 335.254, 335.257, 537.037, 632.305, 650.320, 650.340, 701.336, 701.340, 701.342, 701.344, and 701.348, RSMo, are repealed and seventy-four new sections enacted in lieu thereof, to be known as sections 9.384, 67.145, 105.500, 190.100, 190.103, 190.142, 190.147, 190.600, 190.603, 190.606, 190.612, 190.613,

EXPLANATION — Matter enclosed in bold-faced brackets **[**~~thus~~**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

191.240, 191.305, 191.430, 191.435, 191.440, 191.445, 191.450, 191.600, 191.828, 191.831, 191.1820, 191.1825, 191.1830, 191.1835, 191.1840, 191.1845, 191.1850, 191.1855, 192.530, 192.745, 192.2405, 194.300, 195.070, 195.100, 196.1050, 197.005, 197.020, 197.145, 197.185, 205.375, 205.377, 208.030, 208.1032, 285.040, 321.225, 321.620, 334.036, 334.104, 334.735, 334.747, 335.016, 335.019, 335.036, 335.046, 335.051, 335.056, 335.076, 335.086, 335.175, 335.203, 335.205, 537.037, 579.088, 630.1150, 632.305, 650.320, 650.340, 701.336, 701.340, 701.342, 701.344, and 701.348, to read as follows:

9.384. The month of March of each year shall be known and designated as "Rare Kidney Disease Awareness Month". More than one in seven people is estimated to have rare kidney disease. Ninety percent of patients with rare kidney disease stages 1-3 are undiagnosed. Rare kidney disease, when diagnosed, is often found in late stages after irreversible damage to the kidneys has already occurred. People who inherit two variants of the APOL1 gene are at a significantly increased risk of developing kidney disease. These risk variants are found exclusively in people of sub-Saharan African ancestry. It is recommended to the people of the state and to state departments that the month be appropriately observed through activities that will increase awareness of rare kidney disease, available screening and genetic testing options, and efforts to improve treatment for patients.

67.145. 1. No political subdivision of this state shall prohibit any first responder from engaging in any political activity while off duty and not in uniform, being a candidate for elected or appointed public office, or holding such office unless such political activity or candidacy is otherwise prohibited by state or federal law.

2. As used in this section, "first responder" means any person trained and authorized by law or rule to render emergency medical assistance or treatment. Such persons may include, but shall not be limited to, emergency first responders, police officers, sheriffs, deputy sheriffs, firefighters, **[**~~ambulance attendants and attendant drivers,~~**]** emergency medical technicians, **[**~~mobile emergency medical technicians, emergency medical technician-paramedics,~~**]** registered nurses, or physicians.

105.500. For purposes of sections 105.500 to 105.598, unless the context otherwise requires, the following words and phrases mean:

(1) "Bargaining unit", a unit of public employees at any plant or installation or in a craft or in a function of a public body that establishes a clear and identifiable community of interest among the public employees concerned;

(2) "Board", the state board of mediation established under section 295.030;

(3) "Department", the department of labor and industrial relations established under section 286.010;

(4) "Exclusive bargaining representative", an organization that has been designated or selected, as provided in section 105.575, by a majority of the public employees in a bargaining unit as the representative of such public employees in such unit for purposes of collective bargaining;

(5) "Labor organization", any organization, agency, or public employee representation committee or plan, in which public employees participate and that exists for the purpose, in whole or in part, of dealing with a public body or public bodies concerning collective bargaining, grievances, labor disputes, wages, rates of pay, hours of employment, or conditions of work;

(6) "Public body", the state of Missouri, or any officer, agency, department, bureau, division, board or commission of the state, or any other political subdivision or special district of or within the state. Public body shall not include the department of corrections;

(7) "Public employee", any person employed by a public body;

(8) "Public safety labor organization", a labor organization wholly or primarily representing persons trained or authorized by law or rule to render emergency medical assistance or treatment, including, but not limited to, firefighters, **[**~~ambulance attendants, attendant drivers,~~**]** emergency medical technicians, **[**~~emergency medical technician paramedics,~~**]** dispatchers, registered nurses and physicians, and persons who are vested with the power of arrest for criminal code violations including, but not limited to, police officers, sheriffs, and deputy sheriffs.

190.100. As used in sections 190.001 to 190.245 and section 190.257, the following words and terms mean:

(1) "Advanced emergency medical technician" or "AEMT", a person who has successfully completed a course of instruction in certain aspects of advanced life support care as prescribed by the department and is licensed by the department in accordance with sections 190.001 to 190.245 and rules and regulations adopted by the department pursuant to sections 190.001 to 190.245;

(2) "Advanced life support (ALS)", an advanced level of care as provided to the adult and pediatric patient such as defined by national curricula, and any modifications to that curricula specified in rules adopted by the department pursuant to sections 190.001 to 190.245;

(3) "Ambulance", any privately or publicly owned vehicle or craft that is specially designed, constructed or modified, staffed or equipped for, and is intended or used, maintained or operated for the transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless, or who require the presence of medical equipment being used on such individuals, but the term does not include any motor vehicle specially designed, constructed or converted for the regular transportation of persons who are disabled,

handicapped, normally using a wheelchair, or otherwise not acutely ill, or emergency vehicles used within airports;

(4) "Ambulance service", a person or entity that provides emergency or nonemergency ambulance transportation and services, or both, in compliance with sections 190.001 to 190.245, and the rules promulgated by the department pursuant to sections 190.001 to 190.245;

(5) "Ambulance service area", a specific geographic area in which an ambulance service has been authorized to operate;

(6) "Basic life support (BLS)", a basic level of care, as provided to the adult and pediatric patient as defined by national curricula, and any modifications to that curricula specified in rules adopted by the department pursuant to sections 190.001 to 190.245;

(7) "Council", the state advisory council on emergency medical services;

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

(9) "Director", the director of the department of health and senior services or the director's duly authorized representative;

(10) "Dispatch agency", any person or organization that receives requests for emergency medical services from the public, by telephone or other means, and is responsible for dispatching emergency medical services;

(11) "Emergency", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that the absence of immediate medical care could result in:

(a) Placing the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in significant jeopardy;

(b) Serious impairment to a bodily function;

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

(d) Inadequately controlled pain;

(12) "Emergency medical dispatcher", a person who receives emergency calls from the public and has successfully completed an emergency medical dispatcher course**[**~~, meeting or exceeding the national curriculum of the United States Department of Transportation and any modifications to such curricula specified by the department through rules adopted pursuant to sections 190.001 to 190.245~~**] and any ongoing training requirements under section 650.340**;

(13) "Emergency medical responder", a person who has successfully completed an emergency first response course meeting or exceeding the national curriculum of the U.S. Department of Transportation and any modifications to such curricula specified by the department through rules adopted under sections 190.001 to 190.245 and who provides

emergency medical care through employment by or in association with an emergency medical response agency;

(14) "Emergency medical response agency", any person that regularly provides a level of care that includes first response, basic life support or advanced life support, exclusive of patient transportation;

(15) "Emergency medical services for children (EMS-C) system", the arrangement of personnel, facilities and equipment for effective and coordinated delivery of pediatric emergency medical services required in prevention and management of incidents which occur as a result of a medical emergency or of an injury event, natural disaster or similar situation;

(16) "Emergency medical services (EMS) system", the arrangement of personnel, facilities and equipment for the effective and coordinated delivery of emergency medical services required in prevention and management of incidents occurring as a result of an illness, injury, natural disaster or similar situation;

(17) "Emergency medical technician", a person licensed in emergency medical care in accordance with standards prescribed by sections 190.001 to 190.245, and by rules adopted by the department pursuant to sections 190.001 to 190.245;

(18) **[**~~"Emergency medical technician-basic" or "EMT-B", a person who has successfully completed a course of instruction in basic life support as prescribed by the department and is licensed by the department in accordance with standards prescribed by sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245;~~

~~(19)~~**]** "Emergency medical technician-community paramedic", "community paramedic", or "EMT-CP", a person who is certified as an emergency medical technician-paramedic and is certified by the department in accordance with standards prescribed in section 190.098;

[~~(20) "Emergency medical technician-paramedic" or "EMT-P", a person who has successfully completed a course of instruction in advanced life support care as prescribed by the department and is licensed by the department in accordance with sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245;~~

~~(21)~~**] (19)** "Emergency services", health care items and services furnished or required to screen and stabilize an emergency 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 or by an ambulance service or emergency medical response agency;

[~~(22)~~**] (20)** "Health care facility", a hospital, nursing home, physician's office or other fixed location at which medical and health care services are performed;

[~~(23)~~**] (21)** "Hospital", an establishment as defined in the hospital licensing law, subsection 2 of section 197.020, or a hospital operated by the state;

[~~(24)~~**] (22)** "Medical control", supervision provided by or under the direction of physicians, or their designated registered nurse, including both online medical control, instructions by radio, telephone, or other means of direct communications, and offline medical control through supervision by treatment protocols, case review, training, and standing orders for treatment;

[~~(25)~~**] (23)** "Medical direction", medical guidance and supervision provided by a physician to an emergency services provider or emergency medical services system;

[~~(26)~~**] (24)** "Medical director", a physician licensed pursuant to chapter 334 designated by the ambulance service**, dispatch agency,** or emergency medical response agency and who meets criteria specified by the department by rules pursuant to sections 190.001 to 190.245;

[~~(27)~~**] (25)** "Memorandum of understanding", an agreement between an emergency medical response agency or dispatch agency and an ambulance service or services within whose territory the agency operates, in order to coordinate emergency medical services;

(26) "Paramedic", a person who has successfully completed a course of instruction in advanced life support care as prescribed by the department and is licensed by the department in accordance with sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245;

[~~(28)~~**] (27)** "Patient", an individual who is sick, injured, wounded, diseased, or otherwise incapacitated or helpless, or dead, excluding deceased individuals being transported from or between private or public institutions, homes or cemeteries, and individuals declared dead prior to the time an ambulance is called for assistance;

[~~(29)~~**] (28)** "Person", as used in these definitions and elsewhere in sections 190.001 to 190.245, any individual, firm, partnership, copartnership, joint venture, association, cooperative organization, corporation, municipal or private, and whether organized for profit or not, state, county, political subdivision, state department, commission, board, bureau or fraternal organization, estate, public trust, business or common law trust, receiver, assignee for the benefit of creditors, trustee or trustee in bankruptcy, or any other service user or provider;

[~~(30)~~**] (29)** "Physician", a person licensed as a physician pursuant to chapter 334;

[~~(31)~~**] (30)** "Political subdivision", any municipality, city, county, city not within a county, ambulance district or fire protection district located in this state which provides or has authority to provide ambulance service;

[~~(32)~~**] (31)** "Professional organization", any organized group or association with an ongoing interest regarding emergency medical services. Such groups and associations could include those representing volunteers, labor, management, firefighters, **[**~~EMT-B's,~~**] EMTs,** nurses, **[**~~EMT-P's,~~**] paramedics,** physicians, communications specialists and instructors.

Organizations could also represent the interests of ground ambulance services, air ambulance services, fire service organizations, law enforcement, hospitals, trauma centers, communication centers, pediatric services, labor unions and poison control services;

[~~(33)~~**] (32)** "Proof of financial responsibility", proof of ability to respond to damages for liability, on account of accidents occurring subsequent to the effective date of such proof, arising out of the ownership, maintenance or use of a motor vehicle in the financial amount set in rules promulgated by the department, but in no event less than the statutory minimum required for motor vehicles. Proof of financial responsibility shall be used as proof of self-insurance;

[~~(34)~~**] (33)** "Protocol", a predetermined, written medical care guideline, which may include standing orders;

[~~(35)~~**] (34)** "Regional EMS advisory committee", a committee formed within an emergency medical services (EMS) region to advise ambulance services, the state advisory council on EMS and the department;

[~~(36)~~**] (35)** "Specialty care transportation", the transportation of a patient requiring the services of an emergency medical technician-paramedic who has received additional training beyond the training prescribed by the department. Specialty care transportation services shall be defined in writing in the appropriate local protocols for ground and air ambulance services and approved by the local physician medical director. The protocols shall be maintained by the local ambulance service and shall define the additional training required of the emergency medical technician-paramedic;

[~~(37)~~**] (36)** "Stabilize", with respect to an emergency, the provision of such medical treatment as may be necessary to attempt to assure within reasonable medical probability that no material deterioration of an individual's medical condition is likely to result from or occur during ambulance transportation unless the likely benefits of such transportation outweigh the risks;

[~~(38)~~**] (37)** "State advisory council on emergency medical services", a committee formed to advise the department on policy affecting emergency medical service throughout the state;

[~~(39)~~**] (38)** "State EMS medical directors advisory committee", a subcommittee of the state advisory council on emergency medical services formed to advise the state advisory council on emergency medical services and the department on medical issues;

[~~(40)~~**] (39)** "STEMI" or "ST-elevation myocardial infarction", a type of heart attack in which impaired blood flow to the patient's heart muscle is evidenced by ST-segment elevation in electrocardiogram analysis, and as further defined in rules promulgated by the department under sections 190.001 to 190.250;

[~~(41)~~**] (40)** "STEMI care", includes education and prevention, emergency transport, triage, and acute care and rehabilitative services for STEMI that requires immediate medical or surgical intervention or treatment;

[~~(42)~~**] (41)** "STEMI center", a hospital that is currently designated as such by the department to care for patients with ST-segment elevation myocardial infarctions;

[~~(43)~~**] (42)** "Stroke", a condition of impaired blood flow to a patient's brain as defined by the department;

[~~(44)~~**] (43)** "Stroke care", includes emergency transport, triage, and acute intervention and other acute care services for stroke that potentially require immediate medical or surgical intervention or treatment, and may include education, primary prevention, acute intervention, acute and subacute management, prevention of complications, secondary stroke prevention, and rehabilitative services;

[~~(45)~~**] (44)** "Stroke center", a hospital that is currently designated as such by the department;

[~~(46)~~**] (45)** "Time-critical diagnosis", trauma care, stroke care, and STEMI care occurring either outside of a hospital or in a center designated under section 190.241;

[~~(47)~~**] (46)** "Time-critical diagnosis advisory committee", a committee formed under section 190.257 to advise the department on policies impacting trauma, stroke, and STEMI center designations; regulations on trauma care, stroke care, and STEMI care; and the transport of trauma, stroke, and STEMI patients;

[~~(48)~~**] (47)** "Trauma", an injury to human tissues and organs resulting from the transfer of energy from the environment;

[~~(49)~~**] (48)** "Trauma care" includes injury prevention, triage, acute care and rehabilitative services for major single system or multisystem injuries that potentially require immediate medical or surgical intervention or treatment;

[~~(50)~~**] (49)** "Trauma center", a hospital that is currently designated as such by the department.

190.103. 1. One physician with expertise in emergency medical services from each of the EMS regions shall be elected by that region's EMS medical directors to serve as a regional EMS medical director. The regional EMS medical directors shall constitute the state EMS medical director's advisory committee and shall advise the department and their region's ambulance services on matters relating to medical control and medical direction in accordance with sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245. The regional EMS medical director shall serve a term of four years. The southwest, northwest, and Kansas City regional EMS medical directors shall be elected to an initial two-year term. The central, east central, and southeast regional EMS medical directors shall be elected to an initial four-year term. All subsequent terms following

the initial terms shall be four years. The state EMS medical director shall be the chair of the state EMS medical director's advisory committee, and shall be elected by the members of the regional EMS medical director's advisory committee, shall serve a term of four years, and shall seek to coordinate EMS services between the EMS regions, promote educational efforts for agency medical directors, represent Missouri EMS nationally in the role of the state EMS medical director, and seek to incorporate the EMS system into the health care system serving Missouri.

2. A medical director is required for all ambulance services and emergency medical response agencies that provide: advanced life support services; basic life support services utilizing medications or providing assistance with patients' medications; or basic life support services performing invasive procedures including invasive airway procedures. The medical director shall provide medical direction to these services and agencies in these instances.

3. The medical director, in cooperation with the ambulance service or emergency medical response agency administrator, shall have the responsibility and the authority to ensure that the personnel working under their supervision are able to provide care meeting established standards of care with consideration for state and national standards as well as local area needs and resources. The medical director, in cooperation with the ambulance service or emergency medical response agency administrator, shall establish and develop triage, treatment and transport protocols, which may include authorization for standing orders. Emergency medical technicians shall only perform those medical procedures as directed by treatment protocols approved by the local medical director or when authorized through direct communication with online medical control.

4. All ambulance services and emergency medical response agencies that are required to have a medical director shall establish an agreement between the service or agency and their medical director. The agreement will include the roles, responsibilities and authority of the medical director beyond what is granted in accordance with sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245. The agreement shall also include grievance procedures regarding the emergency medical response agency or ambulance service, personnel and the medical director.

5. Regional EMS medical directors and the state EMS medical director elected as provided under subsection 1 of this section shall be considered public officials for purposes of sovereign immunity, official immunity, and the Missouri public duty doctrine defenses.

6. The state EMS medical director's advisory committee shall be considered a peer review committee under section 537.035.

7. Regional EMS medical directors may act to provide online telecommunication medical direction to AEMTs, **[**~~EMT-Bs, EMT-Ps~~**]** **EMTs, paramedics**, and community paramedics and provide offline medical direction per standardized treatment, triage, and

transport protocols when EMS personnel, including AEMTs, **[**~~EMT-Bs, EMT-Ps~~**]** **EMTs, paramedics**, and community paramedics, are providing care to special needs patients or at the request of a local EMS agency or medical director.

8. When developing treatment protocols for special needs patients, regional EMS medical directors may promulgate such protocols on a regional basis across multiple political subdivisions' jurisdictional boundaries, and such protocols may be used by multiple agencies including, but not limited to, ambulance services, emergency response agencies, and public health departments. Treatment protocols shall include steps to ensure the receiving hospital is informed of the pending arrival of the special needs patient, the condition of the patient, and the treatment instituted.

9. Multiple EMS agencies including, but not limited to, ambulance services, emergency response agencies, and public health departments shall take necessary steps to follow the regional EMS protocols established as provided under subsection 8 of this section in cases of mass casualty or state-declared disaster incidents.

10. When regional EMS medical directors develop and implement treatment protocols for patients or provide online medical direction for patients, such activity shall not be construed as having usurped local medical direction authority in any manner.

11. The state EMS medical directors advisory committee shall review and make recommendations regarding all proposed community and regional time-critical diagnosis plans.

12. Notwithstanding any other provision of law to the contrary, when regional EMS medical directors are providing either online telecommunication medical direction to AEMTs, **[**~~EMT-Bs, EMT-Ps~~**]** **EMTs, paramedics**, and community paramedics, or offline medical direction per standardized EMS treatment, triage, and transport protocols for patients, those medical directions or treatment protocols may include the administration of the patient's own prescription medications.

190.142. 1. (1) For applications submitted before the recognition of EMS personnel licensure interstate compact under sections 190.900 to 190.939 takes effect, the department shall, within a reasonable time after receipt of an application, cause such investigation as it deems necessary to be made of the applicant for an emergency medical technician's license.

(2) For applications submitted after the recognition of EMS personnel licensure interstate compact under sections 190.900 to 190.939 takes effect, an applicant for initial licensure as an emergency medical technician in this state shall submit to a background check by the Missouri state highway patrol and the Federal Bureau of Investigation through a process approved by the department of health and senior services. Such processes may include the use of vendors or systems administered by the Missouri state highway patrol. The department may share the results of such a criminal background check with any emergency

services licensing agency in any member state, as that term is defined under section 190.900, in recognition of the EMS personnel licensure interstate compact. The department shall not issue a license until the department receives the results of an applicant's criminal background check from the Missouri state highway patrol and the Federal Bureau of Investigation, but, notwithstanding this subsection, the department may issue a temporary license as provided under section 190.143. Any fees due for a criminal background check shall be paid by the applicant.

(3) The director may authorize investigations into criminal records in other states for any applicant.

2. The department shall issue a license to all levels of emergency medical technicians, for a period of five years, if the applicant meets the requirements established pursuant to sections 190.001 to 190.245 and the rules adopted by the department pursuant to sections 190.001 to 190.245. The department may promulgate rules relating to the requirements for an emergency medical technician including but not limited to:

(1) Age requirements;

(2) Emergency medical technician and paramedic education and training requirements based on respective National Emergency Medical Services Education Standards and any modification to such curricula specified by the department through rules adopted pursuant to sections 190.001 to 190.245;

(3) Paramedic accreditation requirements. Paramedic training programs shall be accredited **[**~~by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or hold a CAAHEP letter of review~~**] as required by the National Registry of Emergency Medical Technicians**;

(4) Initial licensure testing requirements. Initial **[**~~EMT-P~~**] paramedic** licensure testing shall be through the national registry of EMTs;

(5) Continuing education and relicensure requirements; and

(6) Ability to speak, read and write the English language.

3. Application for all levels of emergency medical technician license shall be made upon such forms as prescribed by the department in rules adopted pursuant to sections 190.001 to 190.245. The application form shall contain such information as the department deems necessary to make a determination as to whether the emergency medical technician meets all the requirements of sections 190.001 to 190.245 and rules promulgated pursuant to sections 190.001 to 190.245.

4. All levels of emergency medical technicians may perform only that patient care which is:

(1) Consistent with the training, education and experience of the particular emergency medical technician; and

(2) Ordered by a physician or set forth in protocols approved by the medical director.

5. No person shall hold themselves out as an emergency medical technician or provide the services of an emergency medical technician unless such person is licensed by the department.

6. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

190.147. 1. **[**~~An emergency medical technician paramedic (EMT-P)~~**] A paramedic** may make a good faith determination that such behavioral health patients who present a likelihood of serious harm to themselves or others, as the term "likelihood of serious harm" is defined under section 632.005, or who are significantly incapacitated by alcohol or drugs shall be placed into a temporary hold for the sole purpose of transport to the nearest appropriate facility; provided that, such determination shall be made in cooperation with at least one other **[**~~EMT-P~~**] paramedic** or other health care professional involved in the transport. Once in a temporary hold, the patient shall be treated with humane care in a manner that preserves human dignity, consistent with applicable federal regulations and nationally recognized guidelines regarding the appropriate use of temporary holds and restraints in medical transport. Prior to making such a determination:

(1) The **[**~~EMT-P~~**] paramedic** shall have completed a standard crisis intervention training course as endorsed and developed by the state EMS medical director's advisory committee;

(2) The **[**~~EMT-P~~**] paramedic** shall have been authorized by his or her ground or air ambulance service's administration and medical director under subsection 3 of section 190.103; and

(3) The **[**~~EMT-P's~~**] paramedic** ground or air ambulance service has developed and adopted standardized triage, treatment, and transport protocols under subsection 3 of section 190.103, which address the challenge of treating and transporting such patients. Provided:

(a) That such protocols shall be reviewed and approved by the state EMS medical director's advisory committee; and

(b) That such protocols shall direct the **[**~~EMT-P~~**] paramedic** regarding the proper use of patient restraint and coordination with area law enforcement; and

(c) Patient restraint protocols shall be based upon current applicable national guidelines.

2. In any instance in which a good faith determination for a temporary hold of a patient has been made, such hold shall be made in a clinically appropriate and adequately justified manner, and shall be documented and attested to in writing. The writing shall be retained by the ambulance service and included as part of the patient's medical file.

3. **[**~~EMT-Ps~~**]** **Paramedics** who have made a good faith decision for a temporary hold of a patient as authorized by this section shall no longer have to rely on the common law doctrine of implied consent and therefore shall not be civilly liable for a good faith determination made in accordance with this section and shall not have waived any sovereign immunity defense, official immunity defense, or Missouri public duty doctrine defense if employed at the time of the good faith determination by a government employer.

4. Any ground or air ambulance service that adopts the authority and protocols provided for by this section shall have a memorandum of understanding with applicable local law enforcement agencies in order to achieve a collaborative and coordinated response to patients displaying symptoms of either a likelihood of serious harm to themselves or others or significant incapacitation by alcohol or drugs, which require a crisis intervention response. The memorandum of understanding shall include, but not be limited to, the following:

(1) Administrative oversight, including coordination between ambulance services and law enforcement agencies;

(2) Patient restraint techniques and coordination of agency responses to situations in which patient restraint may be required;

(3) Field interaction between paramedics and law enforcement, including patient destination and transportation; and

(4) Coordination of program quality assurance.

5. The physical restraint of a patient by an emergency medical technician under the authority of this section shall be permitted only in order to provide for the safety of bystanders, the patient, or emergency personnel due to an imminent or immediate danger, or upon approval by local medical control through direct communications. Restraint shall also be permitted through cooperation with on-scene law enforcement officers. All incidents involving patient restraint used under the authority of this section shall be reviewed by the ambulance service physician medical director.

190.600. 1. Sections 190.600 to 190.621 shall be known and may be cited as the "Outside the Hospital Do-Not-Resuscitate Act".

2. As used in sections 190.600 to 190.621, unless the context clearly requires otherwise, the following terms shall mean:

(1) "Attending physician":

(a) A physician licensed under chapter 334 selected by or assigned to a patient who has primary responsibility for treatment and care of the patient; or

(b) If more than one physician shares responsibility for the treatment and care of a patient, one such physician who has been designated the attending physician by the patient or the patient's representative shall serve as the attending physician;

(2) "Cardiopulmonary resuscitation" or "CPR", emergency medical treatment administered to a patient in the event of the patient's cardiac or respiratory arrest, and shall include cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures;

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

(4) "Emergency medical services personnel", paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians, or other emergency service personnel acting within the ordinary course and scope of their professions, but excluding physicians;

(5) "Health care facility", any institution, building, or agency or portion thereof, private or public, excluding federal facilities and hospitals, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. Health care facility includes but is not limited to ambulatory surgical facilities, health maintenance organizations, home health agencies, hospices, infirmaries, renal dialysis centers, long-term care facilities licensed under sections 198.003 to 198.186, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, and residential treatment facilities;

(6) "Hospital", a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care for not less than twenty-four consecutive hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions; or a place devoted primarily to provide for not less than twenty-four consecutive hours in any week medical or nursing care for three or more nonrelated individuals. Hospital does not include any long-term care facility licensed under sections 198.003 to 198.186;

(7) "Outside the hospital do-not-resuscitate identification" or "outside the hospital DNR identification", a standardized identification card, bracelet, or necklace of a single color, form, and design as described by rule of the department that signifies that the patient's attending physician has issued an outside the hospital do-not-resuscitate order for the patient and has documented the grounds for the order in the patient's medical file;

(8) "Outside the hospital do-not-resuscitate order" or "outside the hospital DNR order", a written physician's order signed by the patient and the attending physician, or the

patient's representative and the attending physician, in a form promulgated by rule of the department which authorizes emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from the patient in the event of cardiac or respiratory arrest;

(9) "Outside the hospital do-not-resuscitate protocol" or "outside the hospital DNR protocol", a standardized method or procedure promulgated by rule of the department for the withholding or withdrawal of cardiopulmonary resuscitation by emergency medical services personnel from a patient in the event of cardiac or respiratory arrest;

(10) "Patient", a person eighteen years of age or older who is not incapacitated, as defined in section 475.010, and who is otherwise competent to give informed consent to an outside the hospital do-not-resuscitate order at the time such order is issued, and who, with his **[**~~or her~~**]** attending physician, has executed an outside the hospital do-not-resuscitate order under sections 190.600 to 190.621. A person who has a patient's representative shall also be a patient for the purposes of sections 190.600 to 190.621, if the person or the person's patient's representative has executed an outside the hospital do-not-resuscitate order under sections 190.600 to 190.621**. A person under eighteen years of age shall also be a patient for purposes of sections 190.600 to 190.621 if the person has had a do-not-resuscitate order issued on his behalf under the provisions of section 191.250**;

(11) "Patient's representative":

(a) An attorney in fact designated in a durable power of attorney for health care for a patient determined to be incapacitated under sections 404.800 to 404.872; or

(b) A guardian or limited guardian appointed under chapter 475 to have responsibility for an incapacitated patient.

190.603. 1. A patient or patient's representative and the patient's attending physician may execute an outside the hospital do-not-resuscitate order. An outside the hospital do-not-resuscitate order shall not be effective unless it is executed by the patient or patient's representative and the patient's attending physician, and it is in the form promulgated by rule of the department.

2. **A patient under eighteen years of age is not authorized to execute an outside the hospital do-not-resuscitate order for himself but may have a do-not-resuscitate order issued on his behalf by one parent or legal guardian or by a juvenile or family court under the provisions of section 191.250. Such do-not-resuscitate order shall also function as an outside the hospital do-not-resuscitate order for the purposes of sections 190.600 to 190.621 unless such do-not-resuscitate order authorized under the provisions of section 191.250 states otherwise.**

3. If an outside the hospital do-not-resuscitate order has been executed, it shall be maintained as the first page of a patient's medical record in a health care facility unless otherwise specified in the health care facility's policies and procedures.

[~~3.~~**] 4.** An outside the hospital do-not-resuscitate order shall be transferred with the patient when the patient is transferred from one health care facility to another health care facility. If the patient is transferred outside of a hospital, the outside the hospital DNR form shall be provided to any other facility, person, or agency responsible for the medical care of the patient or to the patient or patient's representative.

190.606. The following persons and entities shall not be subject to civil, criminal, or administrative liability and are not guilty of unprofessional conduct for the following acts or omissions that follow discovery of an outside the hospital do-not-resuscitate identification upon a patient **or a do-not-resuscitate order functioning as an outside the hospital do-not-resuscitate order for a patient under eighteen years of age**, or upon being presented with an outside the hospital do-not-resuscitate order **[**~~from Missouri, another state, the District of Columbia, or a territory of the United States~~**]**; provided that the acts or omissions are done in good faith and in accordance with the provisions of sections 190.600 to 190.621 and the provisions of an outside the hospital do-not-resuscitate order executed under sections 190.600 to 190.621:

(1) Physicians, persons under the direction or authorization of a physician, emergency medical services personnel, or health care facilities that cause or participate in the withholding or withdrawal of cardiopulmonary resuscitation from such patient; and

(2) Physicians, persons under the direction or authorization of a physician, emergency medical services personnel, or health care facilities that provide cardiopulmonary resuscitation to such patient under an oral or written request communicated to them by the patient or the patient's representative.

190.612. 1. Emergency medical services personnel are authorized to comply with the outside the hospital do-not-resuscitate protocol when presented with an outside the hospital do-not-resuscitate identification or an outside the hospital do-not-resuscitate order. However, emergency medical services personnel shall not comply with an outside the hospital do-not-resuscitate order or the outside the hospital do-not-resuscitate protocol when the patient or patient's representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated.

2. **[**~~Emergency medical services personnel are authorized to comply with the outside the hospital do-not-resuscitate protocol when presented with an outside the hospital do-not-resuscitate order from another state, the District of Columbia, or a territory of the United States if such order is on a standardized written form:~~

~~(1) Signed by the patient or the patient's representative and a physician who is licensed to practice in the other state, the District of Columbia, or the territory of the United States; and~~

~~(2) Such form has been previously reviewed and approved by the department of health and senior services to authorize emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from the patient in the event of a cardiac or respiratory arrest.~~

~~Emergency medical services personnel shall not comply with an outside the hospital do-not-resuscitate order from another state, the District of Columbia, or a territory of the United States or the outside the hospital do-not-resuscitate protocol when the patient or patient's representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated.~~**]**

(1) Except as provided in subdivision (2) of this subsection, emergency medical services personnel are authorized to comply with the outside the hospital do-not-resuscitate protocol when presented with a do-not-resuscitate order functioning as an outside the hospital do-not-resuscitate order for a patient under eighteen years of age if such do-not-resuscitate order has been authorized by one parent or legal guardian or by a juvenile or family court under the provisions of section 191.250.

(2) Emergency medical services personnel shall not comply with a do-not-resuscitate order or the outside the hospital do-not-resuscitate protocol when the patient under eighteen years of age, either parent of such patient, the patient's legal guardian, or the juvenile or family court expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire for the patient to be resuscitated.

3. If a physician or a health care facility other than a hospital admits or receives a patient with an outside the hospital do-not-resuscitate identification or an outside the hospital do-not-resuscitate order, and the patient or patient's representative has not expressed or does not express to the physician or health care facility the desire to be resuscitated, and the physician or health care facility is unwilling or unable to comply with the outside the hospital do-not-resuscitate order, the physician or health care facility shall take all reasonable steps to transfer the patient to another physician or health care facility where the outside the hospital do-not-resuscitate order will be complied with.

190.613. 1. A patient or patient's representative and the patient's attending physician may execute an outside the hospital do-not-resuscitate order through the presentation of a properly executed outside the hospital do-not-resuscitate order from another state, the District of Columbia, or a territory of the United States, or a Transportable Physician Orders for Patient Preferences (TPOPP)/Physician Orders for Life-Sustaining Treatment (POLST) form containing a specific do-not-resuscitate section.

2. Any outside the hospital do-not-resuscitate form identified from another state, the District of Columbia, or a territory of the United States, or a TPOPP/POLST form shall:

(1) Have been previously reviewed and approved by the department as in compliance with the provision of sections 190.600 to 190.621;

(2) Not be accepted for a patient under eighteen years of age, except as allowed under section 191.250; and

(3) Not be effective during such time as the patient is pregnant as set forth in section 190.609.

A patient or patient's representative may express to emergency medical services personnel, at any time and by any means, the intent to revoke the outside the hospital do-not-resuscitate order.

3. The provisions of section 190.606 shall apply to the good faith acts or omissions of emergency medical services personnel under this section.

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

(1) "Health care provider", the same meaning given to the term in section 191.900;

(2) "Patient examination", a prostate, anal, or pelvic examination.

2. A health care provider, or any student or trainee under the supervision of a health care provider, shall not knowingly perform a patient examination upon an anesthetized or unconscious patient in a health care facility unless:

(1) The patient or a person authorized to make health care decisions for the patient has given specific informed consent to the patient examination for nonmedical purposes;

(2) The patient examination is necessary for diagnostic or treatment purposes;

(3) The collection of evidence through a forensic examination, as defined under subsection 8 of section 595.220, for a suspected sexual assault on the anesthetized or unconscious patient is necessary because the evidence will be lost or the patient is unable to give informed consent due to a medical condition; or

(4) Circumstances are present which imply consent, as described in section 431.063.

3. A health care provider shall notify a patient of any patient examination performed under subdivisions (2) to (4) of subsection 2 of this section if the patient is unable to give verbal or written consent.

4. A health care provider who violates the provisions of this section, or who supervises a student or trainee who violates the provisions of this section, shall be subject to discipline by any licensing board that licenses the health care provider.

191.305. 1. The "Missouri Genetic Advisory Committee", consisting of fifteen members, is hereby created to advise the department in all genetic programs including metabolic disease screening programs, hemophilia, sickle cell anemia, and cystic fibrosis programs. Members of the committee shall be appointed by the **[**~~governor, by and with the advice and consent of the senate~~**]** **director of the department of health and senior services**. The first appointments to the committee shall consist of five members to serve three-year terms, five members to serve two-year terms, and five members to serve one-year terms as designated by the **[**~~governor~~**]** **director**. Each member of the committee shall serve for a term of three years thereafter.

2. The committee shall be composed of persons who reside in the state of Missouri, and a majority shall be licensed physicians. At least one member shall be a specialist in genetics; at least one member shall be a licensed obstetrician/gynecologist; at least one member shall be a licensed pediatrician in private practice; at least one member shall be a consumer, family member of a consumer or representative of a consumer group; at least one member shall be a licensed physician experienced in the study and treatment of hemophilia; at least one member shall be a specialist in sickle cell anemia; and at least one member shall be a specialist in cystic fibrosis.

3. Members of the committee shall not receive any compensation for their services, but they shall, subject to appropriations, be reimbursed for actual and necessary expenses incurred in the performance of their duties from funds appropriated for that purpose.

191.430. 1. There is hereby established within the department of health and senior services the "Health Professional Loan Repayment Program" to provide forgivable loans for the purpose of repaying existing loans related to applicable educational expenses for health care, mental health, and public health professionals. The department of health and senior services shall be the administrative agency for the implementation of the program established by this section.

2. The department of health and senior services shall prescribe the form and the time and method of filing applications and supervise the processing, including oversight and monitoring of the program, and shall promulgate rules to implement the provisions of sections 191.430 to 191.450. 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, 2023, shall be invalid and void.

3. The director of the department of health and senior services shall have the discretion to determine the health professionals and practitioners who will receive forgivable health professional loans from the department to pay their existing loans. The director shall make such determinations each fiscal year based on evidence associated with the greatest needs in the best interests of the public. The health care, mental health, and public health professionals or disciplines funded in any given year shall be contingent upon consultation with the office of workforce development in the department of higher education and workforce development and the department of mental health, or their successor agencies.

4. The department of health and senior services shall enter into a contract with each selected applicant who receives a health professional loan under this section. Each selected applicant shall apply the loan award to his or her educational debt. The contract shall detail the methods of forgiveness associated with a service obligation and the terms associated with the principal and interest accruing on the loan at the time of the award. The contract shall contain details concerning how forgiveness is earned, including when partial forgiveness is earned through a service obligation, and the terms and conditions associated with repayment of the loans for any obligation not served.

5. All health professional loans shall be made from funds appropriated by the general assembly to the health professional loan incentive fund established in section 191.445.

191.435. The department of health and senior services shall designate counties, communities, or sections of areas in the state as areas of defined need for health care, mental health, and public health services. If a county, community, or section of an area has been designated or determined as a professional shortage area, a shortage area, or a health care, mental health, or public health professional shortage area by the federal Department of Health and Human Services or its successor agency, the department of health and senior services shall designate it as an area of defined need under this section. If the director of the department of health and senior services determines that a county, community, or section of an area has an extraordinary need for health care professional services without a corresponding supply of such professionals, the department of health and senior services may designate it as an area of defined need under this section.

191.440. 1. The department of health and senior services shall enter into a contract with each individual qualifying for a forgivable loan under sections 191.430 to

191.450. The written contract between the department and the individual shall contain, but not be limited to, the following:

(1) An agreement that the state agrees to award a loan and the individual agrees to serve for a period equal to two years, or a longer period as the individual may agree to, in an area of defined need as designated by the department, with such service period to begin on the date identified on the signed contract;

(2) A provision that any financial obligations arising out of a contract entered into and any obligation of the individual that is conditioned thereon is contingent upon funds being appropriated for loans;

(3) The area of defined need where the person will practice;

(4) A statement of the damages to which the state is entitled for the individual's breach of the contract; and

(5) Such other statements of the rights and liabilities of the department and of the individual not inconsistent with sections 191.430 to 191.450.

2. The department of health and senior services may stipulate specific practice sites, contingent upon department-generated health care, mental health, and public health professional need priorities, where applicants shall agree to practice for the duration of their participation in the program.

191.445. There is hereby created in the state treasury the "Health Professional Loan Incentive Fund", which shall consist of any appropriations made by the general assembly, all funds recovered from an individual under section 191.450, and all funds generated by loan repayments received under sections 191.430 to 191.450. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and, upon appropriation, moneys in this fund shall be used solely by the department of health and senior services to provide loans under sections 191.430 to 191.450. 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. 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.

191.450. 1. An individual who enters into a written contract with the department of health and senior services, as described in section 191.440, and who fails to maintain an acceptable employment status shall be liable to the state for any amount awarded as a loan by the department directly to the individual who entered into the contract that has not yet been forgiven.

2. An individual fails to maintain an acceptable employment status under this section when the contracted individual involuntarily or voluntarily terminates qualifying employment, is dismissed from such employment before completion of the contractual service obligation within the specific time frame outlined in the contract, or fails to respond to requests made by the department.

3. If an individual breaches the written contract of the individual by failing to begin or complete such individual's service obligation, the state shall be entitled to recover from the individual an amount equal to the sum of:

(1) The total amount of the loan awarded by the department or, if the department had already awarded partial forgiveness at the time of the breach, the amount of the loan not yet forgiven;

(2) The interest on the amount that would be payable if at the time the loan was awarded it was a loan bearing interest at the maximum prevailing rate as determined by the Treasurer of the United States;

(3) An amount equal to any damages incurred by the department as a result of the breach; and

(4) Any legal fees or associated costs incurred by the department or the state of Missouri in the collection of damages.

191.600. 1. Sections 191.600 to 191.615 establish a loan repayment program for graduates of approved medical schools, schools of osteopathic medicine, schools of dentistry and accredited chiropractic colleges who practice in areas of defined need and shall be known as the "Health Professional Student Loan Repayment Program". Sections 191.600 to 191.615 shall apply to graduates of accredited chiropractic colleges when federal guidelines for chiropractic shortage areas are developed.

2. The "Health Professional Student Loan and Loan Repayment Program Fund" is hereby created in the state treasury. All funds recovered from an individual pursuant to section 191.614 and all funds generated by loan repayments and penalties received pursuant to section 191.540 shall be credited to the fund. The moneys in the fund shall be used by the department of health and senior services to provide loan repayments pursuant to section 191.611 in accordance with sections 191.600 to 191.614 **[**~~and to provide loans pursuant to sections 191.500 to 191.550~~**]**.

191.828. 1. The following departments shall conduct on-going evaluations of the effect of the initiatives enacted by the following sections:

(1) The department of commerce and insurance shall evaluate the effect of revising section 376.782 and sections 143.999, 208.178, 374.126, and 376.891 to 376.894;

(2) The department of health and senior services shall evaluate the effect of revising sections 105.711 and **[**~~sections 191.520 and~~**]** 191.600 and enacting section 191.411, and

sections 167.600 to 167.621, 191.231, 208.177, 431.064, and 660.016. In collaboration with the state board of registration for the healing arts, the state board of nursing, and the state board of pharmacy, the department of health and senior services shall also evaluate the effect of revising section 195.070, section 334.100, and section 335.016, and of sections 334.104 and 334.112, and section 338.095 and 338.198;

(3) The department of social services shall evaluate the effect of revising section 198.090, and sections 208.151, 208.152 and 208.215, and section 383.125, and of sections 167.600 to 167.621, 208.177, 208.178, 208.179, 208.181, and 211.490;

(4) The office of administration shall evaluate the effect of revising sections 105.711 and 105.721;

(5) The Missouri consolidated health care plan shall evaluate the effect of section 103.178; and

(6) The department of mental health shall evaluate the effect of section 191.831 as it relates to substance abuse treatment and of section 191.835.

2. The department of revenue and office of administration shall make biannual reports to the general assembly and the governor concerning the income received into the health initiatives fund and the level of funding required to operate the programs and initiatives funded by the health initiatives fund at an optimal level.

191.831. 1. There is hereby established in the state treasury a "Health Initiatives Fund", to which shall be deposited all revenues designated for the fund under subsection 8 of section 149.015, and subsection 3 of section 149.160, and section 167.609, and all other funds donated to the fund or otherwise deposited pursuant to law. The state treasurer shall administer the fund. Money in the fund shall be appropriated to provide funding for implementing the new programs and initiatives established by sections 105.711 and 105.721. The moneys in the fund may further be used to fund those programs established by sections 191.411**[**~~, 191.520~~**]** and 191.600, sections 208.151 and 208.152, and sections 103.178, 143.999, 167.600 to 167.621, 188.230, 191.211, 191.231, 191.825 to 191.839, 192.013, 208.177, 208.178, 208.179 and 208.181, 211.490, 285.240, 337.093, 374.126, 376.891 to 376.894, 431.064, 660.016, 660.017 and 660.018; in addition, not less than fifteen percent of the proceeds deposited to the health initiative fund pursuant to sections 149.015 and 149.160 shall be appropriated annually to provide funding for the C-STAR substance abuse rehabilitation program of the department of mental health, or its successor program, and a C-STAR pilot project developed by the director of the division of alcohol and drug abuse and the director of the department of corrections as an alternative to incarceration, as provided in subsections 2, 3, and 4 of this section. Such pilot project shall be known as the "Alt-care" program. In addition, some of the proceeds deposited to the health initiatives fund pursuant to sections 149.015 and 149.160 shall be appropriated annually to the division of alcohol and

drug abuse of the department of mental health to be used for the administration and oversight of the substance abuse traffic **[**~~offenders~~**] offender** program defined in section 302.010 **[**~~and section 577.001~~**]**. The provisions of section 33.080 to the contrary notwithstanding, money in the health initiatives fund shall not be transferred at the close of the biennium to the general revenue fund.

2. The director of the division of alcohol and drug abuse and the director of the department of corrections shall develop and administer a pilot project to provide a comprehensive substance abuse treatment and rehabilitation program as an alternative to incarceration, hereinafter referred to as "Alt-care". Alt-care shall be funded using money provided under subsection 1 of this section through the Missouri Medicaid program, the C-STAR program of the department of mental health, and the division of alcohol and drug abuse's purchase-of-service system. Alt-care shall offer a flexible combination of clinical services and living arrangements individually adapted to each client and her children. Alt-care shall consist of the following components:

(1) Assessment and treatment planning;

(2) Community support to provide continuity, monitoring of progress and access to services and resources;

(3) Counseling from individual to family therapy;

(4) Day treatment services which include accessibility seven days per week, transportation to and from the Alt-care program, weekly drug testing, leisure activities, weekly events for families and companions, job and education preparedness training, peer support and self-help and daily living skills; and

(5) Living arrangement options which are permanent, substance-free and conducive to treatment and recovery.

3. Any female who is pregnant or is the custodial parent of a child or children under the age of twelve years, and who has pleaded guilty to or found guilty of violating the provisions of chapter 195, and whose controlled substance abuse was a precipitating or contributing factor in the commission of the offense, and who is placed on probation may be required, as a condition of probation, to participate in Alt-care, if space is available in the pilot project area. Determinations of eligibility for the program, placement, and continued participation shall be made by the division of alcohol and drug abuse, in consultation with the department of corrections.

4. The availability of space in Alt-care shall be determined by the director of the division of alcohol and drug abuse in conjunction with the director of the department of corrections. If the sentencing court is advised that there is no space available, the court shall consider other authorized dispositions.

191.1820. 1. Sections 191.1820 to 191.1855 shall be known and may be cited as the "Missouri Parkinson's Disease Registry Act".

2. For purposes of sections 191.1820 to 191.1855, the following terms mean:

(1) "Advisory committee", the Parkinson's disease registry advisory committee established in section 191.1830 to assist in the development and implementation of the registry;

(2) "Medical university", the University of Missouri and any other medical research university in the state that enters into a memorandum of understanding with the University of Missouri if deemed appropriate by the University of Missouri;

(3) "Parkinson's disease", a chronic and progressive neurologic disorder that:

(a) Results from deficiency of the neurotransmitter dopamine as the consequence of specific degenerative changes in the area of the brain called the basal ganglia;

(b) Is characterized by tremor at rest, slow movements, muscle rigidity, stooped posture, and unsteady or shuffling gait; and

(c) Includes motor and nonmotor symptoms and side effects including, but not limited to, autonomic dysfunction, thinking and mood changes, and other physical changes;

(4) "Parkinsonism", any condition that causes a combination of the movement abnormalities observed in Parkinson's disease, such as tremor at rest, slow movement, muscle rigidity, impaired speech, or muscle stiffness, with symptoms often overlapping, and that may evolve from what appears to be Parkinson's disease. The term "parkinsonism" shall include, but not be limited to, multiple system atrophy, dementia with Lewy bodies, corticobasal degeneration, and progressive supranuclear palsy;

(5) "Registry", the registry established by the medical university in section 191.1825.

191.1825. 1. Beginning January 1, 2024, the medical university shall establish a registry to collect data on the incidence of Parkinson's disease in Missouri and other epidemiological data as required in sections 191.1820 to 191.1855. The database and system of collection and dissemination of information shall be under the direction of the medical university. The medical university may enter into contracts, grants, or other agreements as are necessary for the implementation of the registry.

2. The registry shall become functional and able to collect reporting data by August 28, 2024.

3. All patients diagnosed with Parkinson's disease or parkinsonism, as determined by the advice of the advisory committee, shall be notified in writing and orally about the collection of information and patient data on Parkinson's disease and

parkinsonism. If a patient does not wish to participate in the collection of data for purposes of research in the registry, the patient shall affirmatively opt out in writing after an opportunity to review relevant documents and ask questions. No patient shall be required to participate in the registry.

191.1830. 1. Within ninety days of August 28, 2023, the medical university shall establish the "Parkinson's Disease Registry Advisory Committee", which shall assist in the development and implementation of the registry, determine the data to be collected, and generally advise the medical university.

2. The committee shall be composed of at least the following members:

(1) A neurologist;

(2) A movement disorder specialist;

(3) A primary care provider;

(4) A physician informaticist;

(5) A patient living with Parkinson's disease;

(6) A public health professional;

(7) A population health researcher familiar with registries; and

(8) A Parkinson's disease researcher.

191.1835. 1. The medical university shall establish, with the advice of the advisory committee, a system for the collection and dissemination of information determining the incidence and prevalence of Parkinson's disease and parkinsonism.

2. (1) Parkinson's disease and parkinsonism shall be designated as diseases required to be reported to the registry. Beginning August 28, 2024, all cases of Parkinson's disease and parkinsonism diagnosed or treated in this state shall be reported to the registry.

(2) Notwithstanding the provisions of subdivision (1) of this subsection to the contrary, the mere incidence of a patient with Parkinson's disease or parkinsonism shall be the sole required information for the registry for any patient who chooses not to participate as described in section 191.1825. No further data shall be reported to the registry for patients who choose not to participate.

3. The medical university may create, review, and revise a list of data points required to be collected as part of the mandated reporting of Parkinson's disease and parkinsonism under this section. Any such list shall include, but not be limited to, necessary triggering diagnostic conditions consistent with the latest International Statistical Classification of Diseases and Related Health Problems and resulting case data on issues including, but not limited to, diagnosis, treatment, and survival.

4. At least ninety days before reporting to the registry is required under this section, the medical university shall publish on its website a notice about the mandatory

reporting of Parkinson's disease and parkinsonism and may also provide such notice to professional associations representing physicians, nurse practitioners, and hospitals.

5. Beginning August 28, 2024, any hospital, facility, physician, surgeon, physician assistant, or nurse practitioner diagnosing or responsible for providing primary treatment to patients with Parkinson's disease or patients with parkinsonism shall report each case of Parkinson's disease and each case of parkinsonism to the registry in a format prescribed by the medical university.

6. The medical university shall be authorized to enter into data-sharing contracts with data-reporting entities and their associated electronic medical record system vendors to securely and confidentially receive information related to Parkinson's disease testing, diagnosis, and treatment.

7. The medical university may implement and administer this section through a bulletin or similar instruction to providers without the need for regulatory action.

191.1840. The medical university may enter into agreements to furnish data collected in the registry to other states' Parkinson's disease registries, federal Parkinson's disease control agencies, local health officers, or health researchers for the study of Parkinson's disease. Before confidential information is disclosed to those agencies, officers, researchers, or out-of-state registries, the requesting entity shall agree in writing to maintain the confidentiality of the information and, if a researcher, shall:

(1) Obtain approval of the researcher's institutional review board for the protection of human subjects established in accordance with 45 CFR 46; and

(2) Provide documentation to the medical university that demonstrates to the medical university's satisfaction that the researcher has established the procedures and ability to maintain the confidentiality of the information.

191.1845. 1. Except as otherwise provided in sections 191.1820 to 191.1855, all information collected under sections 191.1820 to 191.1855 shall be confidential. For purposes of sections 191.1820 to 191.1855, this information shall be referred to as confidential information.

2. To ensure privacy, the medical university shall use a coding system for the registry that removes any identifying information about patients.

3. Notwithstanding any other provision of law to the contrary, a disclosure authorized under sections 191.1820 to 191.1855 shall include only the information necessary for the stated purpose of the requested disclosure, shall be used for the approved purpose, and shall not be further disclosed.

4. Provided the security of confidential information has been documented, the furnishing of confidential information to the medical university or its authorized representatives in accordance with sections 191.1820 to 191.1855 shall not expose any

person, agency, or entity furnishing the confidential information to liability and shall not be considered a waiver of any privilege or a violation of a confidential relationship.

5. The medical university shall maintain an accurate record of all persons given access to confidential information. The record shall include the name of the person authorizing access; the name, title, address, and organizational affiliation of the person given access; dates of access; and the specific purpose for which the confidential information is to be used. The record of access shall be open to public inspection during normal operating hours of the medical university.

6. (1) Notwithstanding any other provision of law to the contrary, confidential information shall not be available for subpoena and shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding. Confidential information shall not be deemed admissible as evidence in any civil, criminal, administrative, or other tribunal or court for any reason.

(2) The provisions of this subsection shall not be construed to prohibit the publication by the medical university of reports and statistical compilations that do not in any way identify individual cases or individual sources of information.

(3) Notwithstanding the restrictions in this subsection to the contrary, the individual to whom the information pertains shall have access to his or her own information.

191.1850. Sections 191.1820 to 191.1855 shall not preempt the authority of facilities or individuals providing diagnostic or treatment services to patients with Parkinson's disease or parkinsonism to maintain their own facility-based registries for Parkinson's disease or parkinsonism.

191.1855. 1. Before January 1, 2025, and before January first every year thereafter, the medical university shall provide a report to the general assembly that includes:

(1) A program summary update for that year on the incidence and prevalence of Parkinson's disease in the state by county;

(2) The number of records that have been included and reported to the registry; and

(3) Demographic information, such as a breakdown of patients by age, gender, and race.

2. The medical university shall also publish the annual report required under this section in a downloadable format on its website or on the registry's webpage.

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

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

(2) "Health care provider", the same meaning given to the term in section 376.1350;

(3) "Voluntary nonopioid directive form", a form that may be used by a patient to deny or refuse the administration or prescription of a controlled substance containing an opioid by a health care provider.

2. In consultation with the board of registration for the healing arts and the board of pharmacy, the department shall develop and publish a uniform voluntary nonopioid directive form.

3. The voluntary nonopioid directive form developed by the department shall indicate to all prescribing health care providers that the named patient shall not be offered, prescribed, supplied with, or otherwise administered a controlled substance containing an opioid.

4. The voluntary nonopioid directive form shall be posted in a downloadable format on the department's publicly accessible website.

5. (1) A patient may execute and file a voluntary nonopioid directive form with a health care provider. Each health care provider shall sign and date the form in the presence of the patient as evidence of acceptance and shall provide a signed copy of the form to the patient.

(2) The patient executing and filing a voluntary nonopioid directive form with a health care provider shall sign and date the form in the presence of the health care provider or a designee of the health care provider. In the case of a patient who is unable to execute and file a voluntary nonopioid directive form, the patient may designate a duly authorized guardian or health care proxy to execute and file the form in accordance with subdivision (1) of this subsection.

(3) A patient may revoke the voluntary nonopioid directive form for any reason and may do so by written or oral means.

6. The department shall promulgate regulations for the implementation of the voluntary nonopioid directive form that shall include, but not be limited to:

(1) A standard method for the recording and transmission of the voluntary nonopioid directive form, which shall include verification by the patient's health care provider and shall comply with the written consent requirements of the Public Health Service Act, 42 U.S.C. Section 290dd-2(b), and 42 CFR Part 2, relating to confidentiality of alcohol and drug abuse patient records, provided that the voluntary nonopioid directive form shall also provide the basic procedures necessary to revoke the voluntary nonopioid directive form;

(2) Procedures to record the voluntary nonopioid directive form in the patient's medical record or, if available, the patient's interoperable electronic medical record;

(3) Requirements and procedures for a patient to appoint a duly authorized guardian or health care proxy to override a previously filed voluntary nonopioid directive form and circumstances under which an attending health care provider may override a previously filed voluntary nonopioid directive form based on documented medical judgment, which shall be recorded in the patient's medical record;

(4) Procedures to ensure that any recording, sharing, or distributing of data relative to the voluntary nonopioid directive form complies with all federal and state confidentiality laws; and

(5) Appropriate exemptions for health care providers and emergency medical personnel to prescribe or administer a controlled substance containing an opioid when, in their professional medical judgment, a controlled substance containing an opioid is necessary, or the provider and medical personnel are acting in good faith.

The department shall develop and publish guidelines on its publicly accessible website that shall address, at a minimum, the content of the regulations promulgated under this subsection. 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, 2023, shall be invalid and void.

7. A written prescription that is presented at an outpatient pharmacy or a prescription that is electronically transmitted to an outpatient pharmacy is presumed to be valid for the purposes of this section, and a pharmacist in an outpatient setting shall not be held in violation of this section for dispensing a controlled substance in contradiction to a voluntary nonopioid directive form, except upon evidence that the pharmacist acted knowingly against the voluntary nonopioid directive form.

8. (1) A health care provider or an employee of a health care provider acting in good faith shall not be subject to criminal or civil liability and shall not be considered to have engaged in unprofessional conduct for failing to offer or administer a prescription or medication order for a controlled substance containing an opioid under the voluntary nonopioid directive form.

(2) A person acting as a representative or an agent pursuant to a health care proxy shall not be subject to criminal or civil liability for making a decision under subdivision (3) of subsection 6 of this section in good faith.

(3) Notwithstanding any other provision of law, a professional licensing board, at its discretion, may limit, condition, or suspend the license of, or assess fines against, a health care provider who recklessly or negligently fails to comply with a patient's voluntary nonopioid directive form.

192.745. 1. The "Missouri Brain Injury Advisory Council" is hereby established in the department of health and senior services. The members of the council **[**~~that are serving on February 2, 2005, shall continue to fulfill their current terms. Through attrition, the council shall decrease from the present twenty-five members to fifteen members. Thereafter, the successors to each of these members~~**]** shall serve a three-year term and until the member's successor is appointed by the **[**~~governor with the advice and consent of the senate~~**] director of the department of health and senior services**. The members appointed by the **[**~~governor~~**] director** shall include: four people with brain injuries or relatives of persons with brain injuries, and eleven other individuals from professional groups, health institutions, community groups, and private industry. In addition to the fifteen council members, individuals representing state agencies with services that impact brain injury survivors and their families shall participate on the council in an ex officio nonvoting capacity. These individuals shall be appointed by the respective agency.

2. The Missouri brain injury advisory council is assigned to the department of health and senior services. The department shall submit estimates of requirements for appropriations on behalf of the council for the necessary staff and expenses to carry out the duties and responsibilities assigned by the council.

3. Meetings of the full council shall be held at least four times a year or at the call of the council chairperson, who shall be elected by the council. Subcommittees may meet on an as-needed basis.

4. Members of the council shall not receive any compensation for their services, but they shall, subject to appropriations, be reimbursed for actual and necessary expenses incurred in the performance of their duties from funds appropriated for this purpose.

5. The council shall adopt written procedures to govern its activities.

6. The council, under the direction of the department, shall make recommendations to the department director for developing and administering a state plan to provide services for brain-injured persons.

7. No member of the council may participate in or seek to influence a decision or vote of the council if the member would be directly involved with the matter or if the member would derive income from it. A violation of the prohibition contained herein shall be grounds for a person to be removed as a member of the council by the department director.

8. The council shall be advisory and shall:

(1) Promote meetings and programs for the discussion of reducing the debilitating effects of brain injuries and disseminate information in cooperation with any other department, agency or entity on the prevention, evaluation, care, treatment and rehabilitation of persons affected by brain injuries;

(2) Study and review current prevention, evaluation, care, treatment and rehabilitation technologies and recommend appropriate preparation, training, retraining and distribution of manpower and resources in the provision of services to brain-injured persons through private and public residential facilities, day programs and other specialized services;

(3) Recommend specific methods, means and procedures to improve and upgrade the state's service delivery system for brain-injured citizens of this state;

(4) Participate in developing and disseminating criteria and standards which may be required for future funding or licensing of facilities, day programs and other specialized services for brain-injured persons in this state;

(5) Report annually to the department director on its activities, and on the results of its studies and the recommendations of the council.

9. The department may accept on behalf of the council federal funds, gifts and donations from individuals, private organizations and foundations, and any other funds that may become available.

192.2405. 1. The following persons shall be required to immediately report or cause a report to be made to the department under sections 192.2400 to 192.2470:

(1) Any person having reasonable cause to suspect that an eligible adult presents a likelihood of suffering serious physical harm, or bullying as defined in subdivision (2) of section 192.2400, and is in need of protective services; and

(2) Any adult day care worker, chiropractor, Christian Science practitioner, coroner, dentist, embalmer, employee of the departments of social services, mental health, or health and senior services, employee of a local area agency on aging or an organized area agency on aging program, emergency medical technician, firefighter, first responder, funeral director, home health agency, home health agency employee, hospital and clinic personnel engaged in the care or treatment of others, in-home services owner or provider, in-home services operator or employee, law enforcement officer, long-term care facility administrator or employee, medical examiner, medical resident or intern, mental health professional, minister, nurse, nurse practitioner, optometrist, other health practitioner, peace officer, pharmacist, physical therapist, physician, physician's assistant, podiatrist, probation or parole officer, psychologist, social worker, or other person with the responsibility for the care of an eligible adult who has reasonable cause to suspect that the eligible adult has been subjected to abuse or neglect or observes the eligible adult being subjected to conditions or circumstances which would reasonably result in abuse or neglect. Notwithstanding any other provision of this section, a

duly ordained minister, clergy, religious worker, or Christian Science practitioner while functioning in his or her ministerial capacity shall not be required to report concerning a privileged communication made to him or her in his or her professional capacity.

2. Any other person who becomes aware of circumstances that may reasonably be expected to be the result of, or result in, abuse or neglect of an eligible adult may report to the department.

3. The penalty for failing to report as required under subdivision (2) of subsection 1 of this section is provided under section 565.188.

4. As used in this section, "first responder" means any person trained and authorized by law or rule to render emergency medical assistance or treatment. Such persons may include, but shall not be limited to, emergency first responders, police officers, sheriffs, deputy sheriffs, firefighters, **or** emergency medical technicians**[**~~, or emergency medical technician-paramedics~~**]**.

194.300. 1. There is established within the department of health and senior services the "Organ Donation Advisory Committee", which shall consist of the following members appointed by the **[**~~governor with the advice and consent of the senate~~**] director of the department of health and senior services**:

(1) Four representatives of organ and tissue procurement organizations;

(2) Four members representative of organ recipients, families of organ recipients, organ donors and families of organ donors;

(3) One health care representative from a hospital located in Missouri; and

(4) One representative of the department of health and senior services.

2. Members of the advisory committee shall receive no compensation for their services, but may be reimbursed for the reasonable and necessary expenses incurred in the performance of their duties out of appropriations made for that purpose. Members shall serve for five year terms and shall serve at the pleasure of the **[**~~governor~~**] director**.

195.070. 1. A physician, podiatrist, dentist, a registered optometrist certified to administer pharmaceutical agents as provided in section 336.220, or an assistant physician in accordance with section 334.037 or a physician assistant in accordance with section 334.747 in good faith and in the course of his or her professional practice only, may prescribe, administer, and dispense controlled substances or he or she may cause the same to be administered or dispensed by an individual as authorized by statute.

2. An advanced practice registered nurse, as defined in section 335.016, but not a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016, who holds a certificate of controlled substance prescriptive authority from the board of nursing under section 335.019 and who is delegated the authority to prescribe controlled substances under a collaborative practice arrangement under section 334.104 may prescribe any

controlled substances listed in Schedules III, IV, and V of section 195.017, and may have restricted authority in Schedule II. Prescriptions for Schedule II medications prescribed by an advanced practice registered nurse who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone **and Schedule II controlled substances for hospice patients pursuant to the provisions of section 334.104**. However, no such certified advanced practice registered nurse shall prescribe controlled substance for his or her own self or family. Schedule III narcotic controlled substance and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill.

3. A veterinarian, in good faith and in the course of the veterinarian's professional practice only, and not for use by a human being, may prescribe, administer, and dispense controlled substances and the veterinarian may cause them to be administered by an assistant or orderly under his or her direction and supervision.

4. A practitioner shall not accept any portion of a controlled substance unused by a patient, for any reason, if such practitioner did not originally dispense the drug, except:

(1) When the controlled substance is delivered to the practitioner to administer to the patient for whom the medication is prescribed as authorized by federal law. Practitioners shall maintain records and secure the medication as required by this chapter and regulations promulgated pursuant to this chapter; or

(2) As provided in section 195.265.

5. An individual practitioner shall not prescribe or dispense a controlled substance for such practitioner's personal use except in a medical emergency.

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 a physician assistant,~~**]** and such directions as may be stated on the prescription. No person shall alter, deface, or remove any label so affixed.

196.1050. 1. The proceeds of any monetary settlement or portion of a global settlement between the attorney general of the state and any drug manufacturers, distributors, **pharmacies,** or combination thereof to resolve an opioid-related cause of action against such drug manufacturers, distributors, **pharmacies,** or combination thereof in a state or federal court shall only be utilized to pay for opioid addiction treatment and prevention services and health care and law enforcement costs related to opioid addiction treatment and prevention. Under no circumstances shall such settlement moneys be utilized to fund other services, programs, or expenses not reasonably related to opioid addiction treatment and prevention.

2. (1) There is hereby established in the state treasury the "Opioid Addiction Treatment and Recovery Fund", which shall consist of the proceeds of any settlement described in subsection 1 of this section, as well as any funds appropriated by the general assembly, or gifts, grants, donations, or bequests. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and money in the fund shall be used by the department of mental health, the department of health and senior services, the department of social services, the department of public safety, the department of corrections, and the judiciary for the purposes set forth in subsection 1 of this section.

(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.

(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.

197.005. 1. As used in this section, the term "Medicare conditions of participation" shall mean federal regulatory standards established under Title XVIII of the Social Security Act and defined in 42 CFR 482, as amended, for hospitals and 42 CFR 485, as amended, for hospitals designated as critical access hospitals under 42 U.S.C. Section 1395i-4 **and for facilities designated as rural emergency hospitals under 42 U.S.C. Section 1395x(kkk)(2)**.

2. To minimize the administrative cost of enforcing and complying with duplicative regulatory standards, on and after July 1, 2018, compliance with Medicare conditions of participation shall be deemed to constitute compliance with the standards for hospital licensure under sections 197.010 to 197.120 and regulations promulgated thereunder.

3. Nothing in this section shall preclude the department of health and senior services from promulgating regulations effective on or after July 1, 2018, to define separate regulatory standards that do not duplicate or contradict the Medicare conditions of participation, with specific state statutory authorization to create separate regulatory standards.

4. Regulations promulgated by the department of health and senior services to establish and enforce hospital licensure regulations under this chapter that duplicate or conflict with the Medicare conditions of participation shall lapse and expire on and after July 1, 2018.

197.020. 1. "Governmental unit" means any county, municipality or other political subdivision or any department, division, board or other agency of any of the foregoing.

2. "Hospital" means a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not less than twenty-four consecutive hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal physical conditions; or a place devoted primarily to provide for not less than twenty-four consecutive hours in any week medical or nursing care for three or more nonrelated individuals. **The term "hospital" shall include a facility designated as a rural emergency hospital by the Centers for Medicare and Medicaid Services.** The term "hospital" does not include convalescent, nursing, shelter or boarding homes as defined in chapter 198.

3. "Person" means any individual, firm, partnership, corporation, company or association and the legal successors thereof.

197.145. 1. Notwithstanding any other provision of law to the contrary, including chapter 632, when an at-risk behavioral health patient, as such term is defined in section 190.240, receives treatment at a hospital, the treating physician may temporarily hold the patient for further behavioral health assessment and, if necessary, for transfer to an appropriate treatment facility, if the physician has reason to believe that the patient is at imminent serious risk of harming themselves or others.

2. In no circumstance shall an at-risk behavioral health patient be detained in a temporary hold under this section for a period longer than necessary for an evaluation and, if necessary, transfer to an appropriate treatment facility. If, after the evaluation, the treating physician has reasonable cause to believe that the patient is not at imminent serious risk of harming themselves or others, the patient shall be immediately released from the temporary hold.

3. A physician employing a temporary hold under this section, and any other health care professional or other personnel at the hospital working to treat or transfer the patient, as well as any emergency medical services personnel or law enforcement officers who may be acting to detain or transport the patient under this section, shall not be civilly liable for the temporary hold, treatment, or transport of a patient if such actions are carried out in good faith and without gross negligence for a purpose authorized by this section.

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

(1) "Ambulatory surgical center", the same meaning given to the term in section 197.200;

(2) "Hospital", the same meaning given to the term in section 197.020;

(3) "Surgical smoke", the smoke that is generated from the use of a surgical device, including, but not limited to, surgical plume, smoke plume, bioaerosols, laser-generated airborne contaminants, and lung-damaging dust;

(4) "Surgical smoke plume evacuation system", equipment designed to capture, filter, and eliminate surgical smoke at the point of origin and before the surgical smoke makes contact with the eyes or contact with the respiratory tract of patients and staff occupying the room where a procedure that produces surgical smoke plume is being performed.

2. On or before January 1, 2026, each hospital and ambulatory surgical center accredited by the Joint Commission that performs procedures that produce surgical smoke plume shall adopt and implement policies and procedures required by the Joint Commission to ensure the evacuation of surgical smoke plume by use of a surgical smoke plume evacuation system for each procedure that generates surgical smoke plume from the use of energy-based devices, including, but not limited to, electrosurgery and lasers.

3. Any procedure that generates surgical smoke plume from the use of energy-based devices that is performed after December 31, 2025, in any hospital or ambulatory surgical center accredited by the Joint Commission shall be subject to the policies and procedures adopted under subsection 2 of this section.

205.375. 1. For the purposes of this section "nursing home" means a residential care facility, an assisted living facility, an intermediate care facility, or a skilled nursing facility as defined in section 198.006:

(1) Which is operated in connection with a hospital, or

(2) In which such nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the state.

2. The county commission of any county or the township board of any township may acquire land to be used as sites for, construct and equip nursing homes and may contract for materials, supplies, and services necessary to carry out such purposes.

3. For the purpose of providing funds for the construction and equipment of nursing homes the county commissions or township boards may issue bonds as authorized by the general law governing the incurring of indebtedness by counties; provided, however, that no such tax shall be levied upon property which is within a nursing home district as provided in chapter 198 and is taxed for nursing home purposes under the provisions of that chapter, or may provide for the issuance and payment of revenue bonds in the manner provided by and in all respects subject to chapter 176 which provides for the issuance of revenue bonds of state educational institutions.

4. The county commissions or township boards may provide for the leasing and renting of the nursing homes and equipment on the terms and conditions that are necessary and proper to any person, firm, corporation or to any nonprofit organizations for the purpose of operation in the manner provided in subsection 1 of this section **or for the purpose of operating any other health care facility located within the county or township providing nursing care or other medical services to patients, including, but not limited to, residents of the county or township**.

205.377. 1. The county commission of any county having a nursing home erected under the provisions of section 205.375 may, upon a determination by the county commissioners that the sale of such nursing home is desirable, appoint an agent, by order, to sell and dispose of the nursing home and appurtenant property, both real and personal, in the manner provided for sale of other county property. The deed of the agent, under the agent's proper hand and seal, for and on behalf of the county, duly acknowledged and recorded, shall be sufficient to convey to the purchaser all the right, title, interest, and estate which the county has in property.

2. The proceeds from the sale of the property shall be applied to the payment of any interest and principal of any outstanding valid indebtedness of the county incurred for purchase of the site or construction of the nursing home, or for any repairs, alterations, improvements, or additions thereto, or for the operation of the nursing

home. If the proceeds from the sale of the nursing home property, and any interest thereon, are, or will be insufficient to pay the interest and principal of any valid outstanding bonded indebtedness as they fall due, the county commission shall continue to provide for the collection of an annual tax on all taxable personal property in the county sufficient to pay the interest and principal of the indebtedness as it falls due and to retire the bonds within the time required therein.

3. Any balance of the proceeds received by the county for the sale of the nursing home remaining after all indebtedness incurred in connection with the nursing home is paid shall be placed to the credit of the general fund of the county to be used to provide health care services in the county.

4. The sale of a nursing home under this section shall be limited to purchasers who plan to operate a similar facility or otherwise provide medical services to patients, including, but not limited to, residents of the county, for a period of not less than ten years.

208.030. 1. The family support division shall make monthly payments to each person who was a recipient of old age assistance, aid to the permanently and totally disabled, and aid to the blind and who:

(1) Received such assistance payments from the state of Missouri for the month of December, 1973, to which they were legally entitled; and

(2) Is a resident of Missouri.

2. The amount of supplemental payment made to persons who meet the eligibility requirements for and receive federal supplemental security income payments shall be in an amount, as established by rule and regulation of the family support division, sufficient to, when added to all other income, equal the amount of cash income received in December, 1973; except, in establishing the amount of the supplemental payments, there shall be disregarded cost-of-living increases provided for in Titles II and XVI of the federal Social Security Act and any benefits or income required to be disregarded by an act of Congress of the United States or any regulation duly promulgated thereunder. As long as the recipient continues to receive a supplemental security income payment, the supplemental payment shall not be reduced. The minimum supplemental payment for those persons who continue to meet the December, 1973, eligibility standards for aid to the blind shall be in an amount which, when added to the federal supplemental security income payment, equals the amount of the blind pension grant as provided for in chapter 209.

3. The amount of supplemental payment made to persons who do not meet the eligibility requirements for federal supplemental security income benefits, but who do meet the December, 1973, eligibility standards for old age assistance, permanent and total disability and aid to the blind or less restrictive requirements as established by rule or

regulation of the family support division, shall be in an amount established by rule and regulation of the family support division sufficient to, when added to all other income, equal the amount of cash income received in December, 1973; except, in establishing the amount of the supplemental payment, there shall be disregarded cost-of-living increases provided for in Titles II and XVI of the federal Social Security Act and any other benefits or income required to be disregarded by an act of Congress of the United States or any regulation duly promulgated thereunder. The minimum supplemental payments for those persons who continue to meet the December, 1973, eligibility standards for aid to the blind shall be a blind pension payment as prescribed in chapter 209.

4. The family support division shall make monthly payments to persons meeting the eligibility standards for the aid to the blind program in effect December 31, 1973, who are bona fide residents of the state of Missouri. The payment shall be in the amount prescribed in subsection 1 of section 209.040, less any federal supplemental security income payment.

5. The family support division shall make monthly payments to persons age twenty-one or over who meet the eligibility requirements in effect on December 31, 1973, or less restrictive requirements as established by rule or regulation of the family support division, who were receiving old age assistance, permanent and total disability assistance, general relief assistance, or aid to the blind assistance lawfully, who are not eligible for nursing home care under the Title XIX program, and who reside in a licensed residential care facility, a licensed assisted living facility, a licensed intermediate care facility or a licensed skilled nursing facility in Missouri and whose total cash income is not sufficient to pay the amount charged by the facility; and to all applicants age twenty-one or over who are not eligible for nursing home care under the Title XIX program who are residing in a licensed residential care facility, a licensed assisted living facility, a licensed intermediate care facility or a licensed skilled nursing facility in Missouri, who make application after December 31, 1973, provided they meet the eligibility standards for old age assistance, permanent and total disability assistance, general relief assistance, or aid to the blind assistance in effect on December 31, 1973, or less restrictive requirements as established by rule or regulation of the family support division, who are bona fide residents of the state of Missouri, and whose total cash income is not sufficient to pay the amount charged by the facility. Until July 1, 1983, the amount of the total state payment for home care in licensed residential care facilities shall not exceed one hundred twenty dollars monthly, for care in licensed intermediate care facilities or licensed skilled nursing facilities shall not exceed three hundred dollars monthly, and for care in licensed assisted living facilities shall not exceed two hundred twenty-five dollars monthly. Beginning July 1, 1983, for fiscal year 1983-1984 and each year thereafter, the amount of the total state payment for home care in licensed residential care facilities shall **[**~~not exceed one hundred fifty-six dollars monthly~~**]** **be subject to appropriations**, for care in licensed

intermediate care facilities or licensed skilled nursing facilities shall not exceed three hundred ninety dollars monthly, and for care in licensed assisted living facilities shall not exceed two hundred ninety-two dollars and fifty cents monthly. No intermediate care or skilled nursing payment shall be made to a person residing in a licensed intermediate care facility or in a licensed skilled nursing facility unless such person has been determined, by his or her own physician or doctor, to medically need such services subject to review and approval by the department. Residential care payments may be made to persons residing in licensed intermediate care facilities or licensed skilled nursing facilities. Any person eligible to receive a monthly payment pursuant to this subsection shall receive an additional monthly payment equal to the Medicaid vendor nursing facility personal needs allowance. The exact amount of the additional payment shall be determined by rule of the department. This additional payment shall not be used to pay for any supplies or services, or for any other items that would have been paid for by the family support division if that person would have been receiving medical assistance benefits under Title XIX of the federal Social Security Act for nursing home services pursuant to the provisions of section 208.159. Notwithstanding the previous part of this subsection, the person eligible shall not receive this additional payment if such eligible person is receiving funds for personal expenses from some other state or federal program.

208.1032. 1. The department of social services shall be authorized to design and implement in consultation and coordination with eligible providers as described in subsection 2 of this section an intergovernmental transfer program relating to ground emergency medical transport services, including those services provided at the emergency medical responder, emergency medical technician (EMT), advanced EMT, **[**~~EMT-intermediate,~~**]** or paramedic levels in the prestabilization and preparation for transport, in order to increase capitation payments for the purpose of increasing reimbursement to eligible providers.

2. A provider shall be eligible for increased reimbursement under this section only if the provider meets the following conditions in an applicable state fiscal year:

(1) Provides ground emergency medical transportation services to MO HealthNet participants;

(2) Is enrolled as a MO HealthNet provider for the period being claimed; and

(3) Is owned, operated, or contracted by the state or a political subdivision.

3. (1) To the extent intergovernmental transfers are voluntarily made by and accepted from an eligible provider described in subsection 2 of this section or a governmental entity affiliated with an eligible provider, the department of social services shall make increased capitation payments to applicable MO HealthNet eligible providers for covered ground emergency medical transportation services.

(2) The increased capitation payments made under this section shall be in amounts at least actuarially equivalent to the supplemental fee-for-service payments and up to equivalent of commercial reimbursement rates available for eligible providers to the extent permissible under federal law.

(3) Except as provided in subsection 6 of this section, all funds associated with intergovernmental transfers made and accepted under this section shall be used to fund additional payments to eligible providers.

(4) MO HealthNet managed care plans and coordinated care organizations shall pay one hundred percent of any amount of increased capitation payments made under this section to eligible providers for providing and making available ground emergency medical transportation and prestabilization services pursuant to a contract or other arrangement with a MO HealthNet managed care plan or coordinated care organization.

4. The intergovernmental transfer program developed under this section shall be implemented on the date federal approval is obtained, and only to the extent intergovernmental transfers from the eligible provider, or the governmental entity with which it is affiliated, are provided for this purpose. The department of social services shall implement the intergovernmental transfer program and increased capitation payments under this section on a retroactive basis as permitted by federal law.

5. Participation in the intergovernmental transfers under this section is voluntary on the part of the transferring entities for purposes of all applicable federal laws.

6. As a condition of participation under this section, each eligible provider as described in subsection 2 of this section or the governmental entity affiliated with an eligible provider shall agree to reimburse the department of social services for any costs associated with implementing this section. Intergovernmental transfers described in this section are subject to an administration fee of up to twenty percent of the nonfederal share paid to the department of social services and shall be allowed to count as a cost of providing the services not to exceed one hundred twenty percent of the total amount.

7. As a condition of participation under this section, MO HealthNet managed care plans, coordinated care organizations, eligible providers as described in subsection 2 of this section, and governmental entities affiliated with eligible providers shall agree to comply with any requests for information or similar data requirements imposed by the department of social services for purposes of obtaining supporting documentation necessary to claim federal funds or to obtain federal approvals.

8. This section shall be implemented only if and to the extent federal financial participation is available and is not otherwise jeopardized, and any necessary federal approvals have been obtained.

9. To the extent that the director of the department of social services determines that the payments made under this section do not comply with federal Medicaid requirements, the director retains the discretion to return or not accept an intergovernmental transfer, and may adjust payments under this section as necessary to comply with federal Medicaid requirements.

285.040. 1. As used in this section, "public safety employee" shall mean a person trained or authorized by law or rule to render emergency medical assistance or treatment, including, but not limited to, firefighters, **[**~~ambulance attendants and attendant drivers,~~**]** emergency medical technicians, **[**~~emergency medical technician paramedics,~~**]** dispatchers, registered nurses, physicians, and sheriffs and deputy sheriffs.

2. No public safety employee of a city not within a county who is hired prior to September 1, 2023, shall be subject to a residency requirement of retaining a primary residence in a city not within a county but may be required to maintain a primary residence located within a one-hour response time.

3. Public safety employees of a city not within a county who are hired after August 31, 2023, may be subject to a residency rule no more restrictive than a requirement of retaining a primary residence in a city not within a county for a total of seven years and of then allowing the public safety employee to maintain a primary residence outside the city not within a county so long as the primary residence is located within a one-hour response time.

321.225. 1. A fire protection district may, in addition to its other powers and duties, provide emergency ambulance service within its district if a majority of the voters voting thereon approve a proposition to furnish such service and to levy a tax not to exceed thirty cents on the one hundred dollars assessed valuation to be used exclusively to supply funds for the operation of an emergency ambulance service. The district shall exercise the same powers and duties in operating an emergency ambulance service as it does in operating its fire protection service.

2. The proposition to furnish emergency ambulance service may be submitted by the board of directors at any municipal general, primary or general election or at any election of the members of the board.

3. The question shall be submitted in substantially the following form:

Shall the board of directors of _____ Fire Protection District be authorized to provide emergency ambulance service within the district and be authorized to levy a tax not to exceed thirty cents on the one hundred dollars assessed valuation to provide funds for such service?

4. If a majority of the voters casting votes thereon be in favor of emergency ambulance service and the levy, the district shall forthwith commence such service.

5. As used in this section "emergency" means a situation resulting from a sudden or unforeseen situation or occurrence that requires immediate action to save life or prevent suffering or disability.

6. In addition to all other taxes authorized on or before September 1, 1990, the board of directors of any fire protection district may, if a majority of the voters of the district voting thereon approve, levy an additional tax of not more than forty cents per one hundred dollars of assessed valuation to be used for the support of the ambulance service or partial or complete support of **[**~~an emergency medical technician defibrillator program or partial or complete support of an emergency medical technician~~**] a** paramedic first responder program. The proposition to levy the tax authorized by this subsection may be submitted by the board of directors at the next annual election of the members of the board or at any regular municipal or school election conducted by the county clerk or board of election commissioners in such district or at a special election called for the purpose, or upon petition of five hundred registered voters of the district. A separate ballot containing the question shall read as follows:

> Shall the board of directors of the _____ Fire Protection District be authorized to levy an additional tax of not more than forty cents per one hundred dollars assessed valuation to provide funds for the support of an ambulance service or partial or complete support of an emergency medical technician defibrillator program or partial or complete support of an emergency medical technician paramedic first responder program?
>
> □ FOR THE PROPOSITION
>
> □ AGAINST THE PROPOSITION
>
> (Place an X in the square opposite the one for which you wish to vote.)

If a majority of the qualified voters casting votes thereon be in favor of the question, the board of directors shall accordingly levy a tax in accordance with the provisions of this subsection, but if a majority of voters casting votes thereon do not vote in favor of the levy authorized by this subsection, any levy previously authorized shall remain in effect.

321.620. 1. Fire protection districts in first class counties may, in addition to their other powers and duties, provide ambulance service within their district if a majority of the voters voting thereon approve a proposition to furnish such service and to levy a tax not to exceed thirty cents on the one hundred dollars assessed valuation to be used exclusively to supply funds for the operation of an emergency ambulance service. The district shall exercise the same powers and duties in operating an ambulance service as it does in operating its fire protection service. As used in this section "emergency" means a situation resulting from a

sudden or unforeseen situation or occurrence that requires immediate action to save life or prevent suffering or disability.

2. The proposition to furnish ambulance service may be submitted by the board of directors at any municipal general, primary or general election or at any election of the members of the board or upon petition by five hundred voters of such district.

3. The question shall be submitted in substantially the following form:

Shall the board of directors of _____ Fire Protection District be authorized to provide ambulance service within the district and be authorized to levy a tax not to exceed thirty cents on the one hundred dollars assessed valuation to provide funds for such service?

4. If a majority of the voters casting votes thereon be in favor of ambulance service and the levy, the district shall forthwith commence such service.

5. In addition to all other taxes authorized on or before September 1, 1990, the board of directors of any fire protection district may, if a majority of the voters of the district voting thereon approve, levy an additional tax of not more than forty cents per one hundred dollars of assessed valuation to be used for the support of the ambulance service, or partial or complete support of **[**~~an emergency medical technician defibrillator program or partial or complete support of an emergency medical technician~~**] a** paramedic first responder program. The proposition to levy the tax authorized by this subsection may be submitted by the board of directors at the next annual election of the members of the board or at any regular municipal or school election conducted by the county clerk or board of election commissioners in such district or at a special election called for the purpose, or upon petition of five hundred registered voters of the district. A separate ballot containing the question shall read as follows:

> Shall the board of directors of the _____ Fire Protection District be authorized to levy an additional tax of not more than forty cents per one hundred dollars assessed valuation to provide funds for the support of an ambulance service or partial or complete support of an emergency medical technician defibrillator program or partial or complete support of an emergency medical technician paramedic first responder program?
>
> □ FOR THE PROPOSITION
>
> □ AGAINST THE PROPOSITION
>
> (Place an X in the square opposite the one for which you wish to vote).

If a majority of the qualified voters casting votes thereon be in favor of the question, the board of directors shall accordingly levy a tax in accordance with the provisions of this subsection,

but if a majority of voters casting votes thereon do not vote in favor of the levy authorized by this subsection, any levy previously authorized shall remain in effect.

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

(1) "Assistant physician", any **graduate of a** medical school **[**~~graduate~~**] accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or an organization accredited by the Educational Commission for Foreign Medical Graduates** who:

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

(b) Has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such step of any other board-approved medical licensing examination within the three-year period immediately preceding application for licensure as an assistant physician, or within three years after graduation from a medical college or osteopathic medical college, whichever is later;

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

(d) Has proficiency in the English language.

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

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

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

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

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

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

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

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

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

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

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

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

6. The provisions of section 334.037 shall apply to all assistant physician collaborative practice arrangements. Any renewal of licensure under this section shall

include verification of actual practice under a collaborative practice arrangement in accordance with this subsection during the immediately preceding licensure period.

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

334.104. 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. **(1)** 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.

(2) Notwithstanding any other provision of this section to the contrary, a collaborative practice arrangement may delegate to an advanced practice registered nurse the authority to administer, dispense, or prescribe Schedule II controlled substances for hospice patients; provided, that the advanced practice registered nurse is employed by a hospice provider certified pursuant to chapter 197 and the advanced practice registered nurse is providing care to hospice patients pursuant to a collaborative practice arrangement that designates the certified hospice as a location where the advanced practice registered nurse is authorized to practice and prescribe.

(3) 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.

(4) 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 **as specified in this paragraph. The following provisions shall apply with respect to this requirement:**

a. Until August 28, 2025, an advanced practice registered nurse providing services in a correctional center, as defined in section 217.010, and his or her collaborating physician shall satisfy the geographic proximity requirement if they practice within two hundred miles by road of one another. An incarcerated patient who requests or requires a physician consultation shall be treated by a physician as soon as appropriate;

b. 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 **(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. 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**[**.**];**

c. The collaborative practice arrangement may allow for geographic proximity to be waived when the arrangement outlines the use of telehealth, as defined in section 191.1145;

d. In addition to the waivers and exemptions provided in this subsection, an application for a waiver for any other reason of any applicable geographic proximity shall be available if a physician is collaborating with an advanced practice registered nurse in excess of any geographic proximity limit. The board of nursing and the state board of registration for the healing arts shall review each application for a waiver of geographic proximity and approve the application if the boards determine that adequate supervision exists between the collaborating physician and the advanced practice registered nurse. The boards shall have forty-five calendar days to review the completed application for the waiver of geographic proximity. If no action is taken by the boards within forty-five days after the submission of the application for a waiver, then the application shall be deemed approved. If the application is denied by the boards, the provisions of section 536.063 for contested cases shall apply and govern proceedings for appellate purposes; and

e. 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**; and**

(11) If a collaborative practice arrangement is used in clinical situations where a collaborating advanced practice registered nurse provides health care services that include the diagnosis and initiation of treatment for acutely or chronically ill or injured persons, then the collaborating physician or any other physician designated in the collaborative practice arrangement shall be present for sufficient periods of time, at least once every two weeks, except in extraordinary circumstances that shall be documented, to participate in a chart review and to provide necessary medical direction, medical services, consultations, and supervision of the health care staff.

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 geographic proximity shall allow a collaborating physician and a collaborating advanced practice registered nurse to practice within two hundred miles by road of one another until August 28, 2025, if the nurse is providing services in a correctional center, as defined in section 217.010.** 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 **or her** 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~~**]** **arrangement**, including collaborative practice **[**~~agreements~~**]** **arrangements** delegating the authority to prescribe controlled substances, or physician assistant **[**~~agreement~~**]** **collaborative practice arrangement** and also report to the board the name of each licensed professional with whom the physician has entered into such **[**~~agreement~~**]** **arrangement**. The board **[**~~may~~**]** **shall** make this information available to the public. The board shall track the reported information and may routinely conduct random reviews of such **[**~~agreements~~**]** **arrangements** to ensure that **[**~~agreements~~**]** **arrangements** 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 shall not enter into a collaborative practice arrangement 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**, or to collaborative practice arrangements between a primary care physician and a primary care advanced practice registered nurse or a behavioral health physician and a behavioral health advanced practice registered nurse, where the collaborating physician is new to a patient population to which the advanced practice registered nurse is familiar**.

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

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

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

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

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

(4) "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 commerce and insurance or a designated agency thereof;

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

(7) "Physician assistant", a person who has graduated from a physician assistant program accredited by the 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;

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

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 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 collaborative practice arrangement with a licensed physician as the physician assistant has been trained and is proficient to perform.

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 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 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 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 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 collaboration or in any location where the 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 collaborative practice arrangement between the physician and physician assistant.

6. 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, 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. 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.

8. **(1)** 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.

(2) Notwithstanding any other provision of this section to the contrary, a collaborative practice arrangement may delegate to a physician assistant the authority to administer, dispense, or prescribe Schedule II controlled substances for hospice patients; provided, that the physician assistant is employed by a hospice provider certified pursuant to chapter 197 and the physician assistant is providing care to hospice patients pursuant to a collaborative practice arrangement that designates the certified hospice as a location where the physician assistant is authorized to practice and prescribe.

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~~**]** **1395x**, 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 arrangement shall require a physician to act as a 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 collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any physician assistant. 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.

15. Physician assistants shall file with the board a copy of their collaborating physician form.

16. No physician shall be designated to serve as 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 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.

334.747. 1. **(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 collaborative practice arrangement. Such authority shall be listed on the collaborating physician form on file with the state board of healing arts. The 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 collaborating physician form. Prescriptions for Schedule II medications prescribed by a physician assistant with authority to prescribe delegated in a 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 **narcotic** 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. 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) Notwithstanding any other provision of this section to the contrary, a collaborative practice arrangement may delegate to a physician assistant the authority to administer, dispense, or prescribe Schedule II controlled substances for hospice patients; provided, that the physician assistant is employed by a hospice provider certified pursuant to chapter 197 and the physician assistant is providing care to hospice patients pursuant to a collaborative practice arrangement that designates the certified hospice as a location where the physician assistant is authorized to practice and prescribe.

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 physician assistant during which the physician assistant 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 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 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 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.

335.016. As used in this chapter, unless the context clearly requires otherwise, the following words and terms mean:

(1) "Accredited", the official authorization or status granted by an agency for a program through a voluntary process;

(2) "Advanced practice registered nurse" **or "APRN"**, a **[**~~nurse who has education beyond the basic nursing education and is certified by a nationally recognized professional organization as a certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or a certified clinical nurse specialist. The board shall promulgate rules specifying which nationally recognized professional organization certifications are to be recognized for the purposes of this section. Advanced practice nurses and only such individuals may use the title "Advanced Practice Registered Nurse" and the abbreviation "APRN"~~**] person who is licensed under the provisions of this chapter to engage in the practice of advanced practice nursing as a certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist**;

(3) "Approval", official recognition of nursing education programs which meet standards established by the board of nursing;

(4) "Board" or "state board", the state board of nursing;

(5) "Certified clinical nurse specialist", a registered nurse who is currently certified as a clinical nurse specialist by a nationally recognized certifying board approved by the board of nursing;

(6) "Certified nurse midwife", a registered nurse who is currently certified as a nurse midwife by the American **[**~~College of Nurse Midwives~~**] Midwifery Certification Board**, or other nationally recognized certifying body approved by the board of nursing;

(7) "Certified nurse practitioner", a registered nurse who is currently certified as a nurse practitioner by a nationally recognized certifying body approved by the board of nursing;

(8) "Certified registered nurse anesthetist", a registered nurse who is currently certified as a nurse anesthetist by the Council on Certification of Nurse Anesthetists, the **[**~~Council on Recertification of Nurse Anesthetists~~**] National Board of Certification and Recertification for Nurse Anesthetists**, or other nationally recognized certifying body approved by the board of nursing;

(9) "Executive director", a qualified individual employed by the board as executive secretary or otherwise to administer the provisions of this chapter under the board's direction. Such person employed as executive director shall not be a member of the board;

(10) "Inactive **[**~~nurse~~**] license status**", as defined by rule pursuant to section 335.061;

(11) "Lapsed license status", as defined by rule under section 335.061;

(12) "Licensed practical nurse" or "practical nurse", a person licensed pursuant to the provisions of this chapter to engage in the practice of practical nursing;

(13) "Licensure", the issuing of a license **[**~~to practice professional or practical nursing~~**]** to candidates who have met the **[**~~specified~~**]** requirements **specified under this chapter, authorizing the person to engage in the practice of advanced practice, professional, or practical nursing,** and the recording of the names of those persons as holders of a license to practice **advanced practice,** professional**,** or practical nursing;

(14) **"Practice of advanced practice nursing", the performance for compensation of activities and services consistent with the required education, training, certification, demonstrated competencies, and experiences of an advanced practice registered nurse;**

(15) "**Practice of** practical nursing", the performance for compensation of selected acts for the promotion of health and in the care of persons who are ill, injured, or experiencing alterations in normal health processes. Such performance requires substantial specialized skill, judgment and knowledge. All such nursing care shall be given under the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse. For the purposes of this chapter, the term "direction" shall mean guidance or supervision provided by a person licensed by a state regulatory board to prescribe medications and treatments or a registered professional nurse, including, but not limited to, oral, written, or otherwise communicated orders or directives for patient care. When practical nursing care is delivered pursuant to the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse, such care may be delivered by a licensed practical nurse without direct physical oversight;

[~~(15)~~**] (16)** "**Practice of** professional nursing", the performance for compensation of any act **or action** which requires substantial specialized education, judgment and skill based on knowledge and application of principles derived from the biological, physical, social**,** **behavioral,** and nursing sciences, including, but not limited to:

(a) Responsibility for the **promotion and** teaching of health care and the prevention of illness to the patient and his or her family;

(b) Assessment, **data collection,** nursing diagnosis, nursing care, **evaluation,** and counsel of persons who are ill, injured**,** or experiencing alterations in normal health processes;

(c) The administration of medications and treatments as prescribed by a person licensed by a state regulatory board to prescribe medications and treatments;

(d) The coordination and assistance in the **determination and** delivery of a plan of health care with all members of a health team;

(e) The teaching and supervision of other persons in the performance of any of the foregoing;

[~~(16) A~~**] (17)** "Registered professional nurse" or "registered nurse", a person licensed pursuant to the provisions of this chapter to engage in the practice of professional nursing;

[~~(17)~~**] (18)** "Retired license status", any person licensed in this state under this chapter who retires from such practice. Such person shall file with the board an affidavit, on a form to be furnished by the board, which states the date on which the licensee retired from such practice, an intent to retire from the practice for at least two years, and such other facts as tend to verify the retirement as the board may deem necessary; but if the licensee thereafter reengages in the practice, the licensee shall renew his or her license with the board as provided by this chapter and by rule and regulation.

335.019. **1. An advanced practice registered nurse's prescriptive authority shall include authority to:**

(1) Prescribe, dispense, and administer medications and nonscheduled legend drugs, as defined in section 338.330, within such APRN's practice and specialty; and

(2) Notwithstanding any other provision of this chapter to the contrary, receive, prescribe, administer, and provide nonscheduled legend drug samples from pharmaceutical manufacturers to patients at no charge to the patient or any other party.

2. The board of nursing may grant a certificate of controlled substance prescriptive authority to an advanced practice registered nurse who:

(1) Submits proof of successful completion of an advanced pharmacology course that shall include preceptorial experience in the prescription of drugs, medicines**,** and therapeutic devices; and

(2) Provides documentation of a minimum of three hundred clock hours preceptorial experience in the prescription of drugs, medicines, and therapeutic devices with a qualified preceptor; and

(3) Provides evidence of a minimum of one thousand hours of practice in an advanced practice nursing category prior to application for a certificate of prescriptive authority. The one thousand hours shall not include clinical hours obtained in the advanced practice nursing education program. The one thousand hours of practice in an advanced practice nursing category may include transmitting a prescription order orally or telephonically or to an inpatient medical record from protocols developed in collaboration with and signed by a licensed physician; and

(4) Has a controlled substance prescribing authority delegated in the collaborative practice arrangement under section 334.104 with a physician who has an unrestricted federal Drug Enforcement Administration registration number and who is actively engaged in a

practice comparable in scope, specialty, or expertise to that of the advanced practice registered nurse.

335.036. 1. The board shall:

(1) Elect for a one-year term a president and a secretary, who shall also be treasurer, and the board may appoint, employ and fix the compensation of a legal counsel and such board personnel as defined in subdivision (4) of subsection 11 of section 324.001 as are necessary to administer the provisions of sections 335.011 to **[**~~335.096~~**] 335.099**;

(2) Adopt and revise such rules and regulations as may be necessary to enable it to carry into effect the provisions of sections 335.011 to **[**~~335.096~~**] 335.099**;

(3) Prescribe minimum standards for educational programs preparing persons for licensure **as a registered professional nurse or licensed practical nurse** pursuant to the provisions of sections 335.011 to **[**~~335.096~~**] 335.099**;

(4) Provide for surveys of such programs every five years and in addition at such times as it may deem necessary;

(5) Designate as "approved" such programs as meet the requirements of sections 335.011 to **[**~~335.096~~**] 335.099** and the rules and regulations enacted pursuant to such sections; and the board shall annually publish a list of such programs;

(6) Deny or withdraw approval from educational programs for failure to meet prescribed minimum standards;

(7) Examine, license, and cause to be renewed the licenses of duly qualified applicants;

(8) Cause the prosecution of all persons violating provisions of sections 335.011 to **[**~~335.096~~**] 335.099**, and may incur such necessary expenses therefor;

(9) Keep a record of all the proceedings; and make an annual report to the governor and to the director of the department of commerce and insurance.

2. The board shall set the amount of the fees which this chapter authorizes and requires by rules and regulations. The fees shall be set at a level to produce revenue which shall not substantially exceed the cost and expense of administering this chapter.

3. All fees received by the board pursuant to the provisions of sections 335.011 to **[**~~335.096~~**] 335.099** shall be deposited in the state treasury and be placed to the credit of the state board of nursing fund. All administrative costs and expenses of the board shall be paid from appropriations made for those purposes. The board is authorized to provide funding for the nursing education incentive program established in sections 335.200 to 335.203.

4. 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 appropriation from the board's funds for the preceding fiscal year or, if the board requires by rule, permit renewal

less frequently than yearly, then three times the appropriation from the board's funds 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 board's funds for the preceding fiscal year.

5. 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 chapter 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. All rulemaking authority delegated prior to August 28, 1999, is of no force and effect and repealed. Nothing in this section shall be interpreted to repeal or affect the validity of any rule filed or adopted prior to August 28, 1999, if it fully complied with all applicable provisions of law. 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, 1999, shall be invalid and void.

335.046. 1. An applicant for a license to practice as a registered professional nurse shall submit to the board a written application on forms furnished to the applicant. The original application shall contain the applicant's statements showing the applicant's education and other such pertinent information as the board may require. The applicant shall be of good moral character and have completed at least the high school course of study, or the equivalent thereof as determined by the state board of education, and have successfully completed the basic professional curriculum in an accredited or approved school of nursing and earned a professional nursing degree or diploma. Each application shall contain a statement that it is made under oath or affirmation and that its representations are true and correct to the best knowledge and belief of the person signing same, subject to the penalties of making a false affidavit or declaration. Applicants from non-English-speaking lands shall be required to submit evidence of proficiency in the English language. The applicant must be approved by the board and shall pass an examination as required by the board. The board may require by rule as a requirement for licensure that each applicant shall pass an oral or practical examination. Upon successfully passing the examination, the board may issue to the applicant a license to practice nursing as a registered professional nurse. The applicant for a license to practice registered professional nursing shall pay a license fee in such amount as set by the board. The fee shall be uniform for all applicants. Applicants from foreign countries shall be licensed as prescribed by rule.

2. An applicant for license to practice as a licensed practical nurse shall submit to the board a written application on forms furnished to the applicant. The original application shall contain the applicant's statements showing the applicant's education and other such pertinent

information as the board may require. Such applicant shall be of good moral character, and have completed at least two years of high school, or its equivalent as established by the state board of education, and have successfully completed a basic prescribed curriculum in a state-accredited or approved school of nursing, earned a nursing degree, certificate or diploma and completed a course approved by the board on the role of the practical nurse. Each application shall contain a statement that it is made under oath or affirmation and that its representations are true and correct to the best knowledge and belief of the person signing same, subject to the penalties of making a false affidavit or declaration. Applicants from non-English-speaking countries shall be required to submit evidence of their proficiency in the English language. The applicant must be approved by the board and shall pass an examination as required by the board. The board may require by rule as a requirement for licensure that each applicant shall pass an oral or practical examination. Upon successfully passing the examination, the board may issue to the applicant a license to practice as a licensed practical nurse. The applicant for a license to practice licensed practical nursing shall pay a fee in such amount as may be set by the board. The fee shall be uniform for all applicants. Applicants from foreign countries shall be licensed as prescribed by rule.

3. **(1) An applicant for a license to practice as an advanced practice registered nurse shall submit to the board a written application on forms furnished to the applicant. The original application shall contain:**

(a) Statements showing the applicant's education and other such pertinent information as the board may require; and

(b) A statement that it is made under oath or affirmation and that its representations are true and correct to the best knowledge and belief of the person signing same, subject to the penalties of making a false affidavit or declaration.

(2) The applicant for a license to practice as an advanced practice registered nurse shall pay a fee in such amount as may be set by the board. The fee shall be uniform for all applicants.

(3) An applicant shall:

(a) Hold a current registered professional nurse license or privilege to practice, shall not be currently subject to discipline or any restrictions, and shall not hold an encumbered license or privilege to practice as a registered professional nurse or advanced practice registered nurse in any state or territory;

(b) Have completed an accredited graduate-level advanced practice registered nurse program and achieved at least one certification as a clinical nurse specialist, nurse midwife, nurse practitioner, or registered nurse anesthetist, with at least one population focus prescribed by rule of the board;

(c) Be currently certified by a national certifying body recognized by the Missouri state board of nursing in the advanced practice registered nurse role; and

(d) Have a population focus on his or her certification, corresponding with his or her educational advanced practice registered nurse program.

(4) Any person holding a document of recognition to practice nursing as an advanced practice registered nurse in this state that is current on August 28, 2023, shall be deemed to be licensed as an advanced practice registered nurse under the provisions of this section and shall be eligible for renewal of such license under the conditions and standards prescribed in this chapter and as prescribed by rule.

4. Upon refusal of the board to allow any applicant to **[**~~sit for~~**] take** either the registered professional nurses' examination or the licensed practical nurses' examination, **[**~~as the case may be,~~**] or upon refusal to issue an advanced practice registered nurse license,** the board shall comply with the provisions of section 621.120 and advise the applicant of his or her right to have a hearing before the administrative hearing commission. The administrative hearing commission shall hear complaints taken pursuant to section 621.120.

[~~4.~~**] 5.** The board shall not deny a license because of sex, religion, race, ethnic origin, age or political affiliation.

335.051. 1. The board shall issue a license to practice nursing as **[**~~either~~**] an advanced practice registered nurse,** a registered professional nurse**,** or a licensed practical nurse without examination to an applicant who has duly become licensed as **[**~~a~~**] an advanced practice registered nurse,** registered nurse**,** or licensed practical nurse pursuant to the laws of another state, territory, or foreign country if the applicant meets the qualifications required of **advanced practice registered nurses,** registered nurses**,** or licensed practical nurses in this state at the time the applicant was originally licensed in the other state, territory, or foreign country.

2. Applicants from foreign countries shall be licensed as prescribed by rule.

3. Upon application, the board shall issue a temporary permit to an applicant pursuant to subsection 1 of this section for a license as **[**~~either~~**] an advanced practice registered nurse,** a registered professional nurse**,** or a licensed practical nurse who has made a prima facie showing that the applicant meets all of the requirements for such a license. The temporary permit shall be effective only until the board shall have had the opportunity to investigate his **or her** qualifications for licensure pursuant to subsection 1 of this section and to notify the applicant that his or her application for a license has been either granted or rejected. In no event shall such temporary permit be in effect for more than twelve months after the date of its issuance nor shall a permit be reissued to the same applicant. No fee shall be charged for such temporary permit. The holder of a temporary permit which has not expired, or been suspended or revoked, shall be deemed to be the holder of a license issued

pursuant to section 335.046 until such temporary permit expires, is terminated or is suspended or revoked.

335.056. **1.** The license of every person licensed under the provisions of **[**~~sections 335.011 to 335.096~~**] this chapter** shall be renewed as provided. An application for renewal of license shall be mailed to every person to whom a license was issued or renewed during the current licensing period. The applicant shall complete the application and return it to the board by the renewal date with a renewal fee in an amount to be set by the board. The fee shall be uniform for all applicants. The certificates of renewal shall render the holder thereof a legal practitioner of nursing for the period stated in the certificate of renewal. Any person who practices nursing as **an advanced practice registered nurse,** a registered professional nurse**,** or **[**~~as~~**]** a licensed practical nurse during the time his **or her** license has lapsed shall be considered an illegal practitioner and shall be subject to the penalties provided for violation of the provisions of sections 335.011 to **[**~~335.096~~**] 335.099**.

2. The renewal of advanced practice registered nurse licenses and registered professional nurse licenses shall occur at the same time, as prescribed by rule. Failure to renew and maintain the registered professional nurse license or privilege to practice or failure to provide the required fee and evidence of active certification or maintenance of certification as prescribed by rules and regulations shall result in expiration of the advanced practice registered nurse license.

3. A licensed nurse who holds an APRN license shall be disciplined on their APRN license for any violations of this chapter.

335.076. 1. Any person who holds a license to practice professional nursing in this state may use the title "Registered Professional Nurse" and the abbreviation **[**~~"R.N."~~**] "RN"**. No other person shall use the title "Registered Professional Nurse" or the abbreviation **[**~~"R.N."~~**] "RN"**. No other person shall assume any title or use any abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is a registered professional nurse.

2. Any person who holds a license to practice practical nursing in this state may use the title "Licensed Practical Nurse" and the abbreviation **[**~~"L.P.N."~~**] "LPN"**. No other person shall use the title "Licensed Practical Nurse" or the abbreviation **[**~~"L.P.N."~~**] "LPN"**. No other person shall assume any title or use any abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is a licensed practical nurse.

3. Any person who holds a license **[**~~or recognition~~**]** to practice advanced practice nursing in this state may use the title "Advanced Practice Registered Nurse", **the designations of "certified registered nurse anesthetist", "certified nurse midwife", "certified clinical nurse specialist", and "certified nurse practitioner",** and the **[**~~abbreviation~~**] abbreviations** "APRN", **[**~~and any other title designations appearing on his~~

~~or her license~~**] "CRNA", "CNM", "CNS", and "NP", respectively**. No other person shall use the title "Advanced Practice Registered Nurse" or the abbreviation "APRN". No other person shall assume any title or use any abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is an advanced practice registered nurse.

4. No person shall practice or offer to practice professional nursing, practical nursing, or advanced practice nursing in this state or use any title, sign, abbreviation, card, or device to indicate that such person is a practicing professional nurse, practical nurse, or advanced practice nurse unless he or she has been duly licensed under the provisions of this chapter.

5. In the interest of public safety and consumer awareness, it is unlawful for any person to use the title "nurse" in reference to himself or herself in any capacity, except individuals who are or have been licensed as a registered nurse, licensed practical nurse, or advanced practice registered nurse under this chapter.

6. Notwithstanding any law to the contrary, nothing in this chapter shall prohibit a Christian Science nurse from using the title "Christian Science nurse", so long as such person provides only religious nonmedical services when offering or providing such services to those who choose to rely upon healing by spiritual means alone and does not hold his or her own religious organization and does not hold himself or herself out as a registered nurse, advanced practice registered nurse, nurse practitioner, licensed practical nurse, nurse midwife, clinical nurse specialist, or nurse anesthetist, unless otherwise authorized by law to do so.

335.086. No person, firm, corporation or association shall:

(1) Sell or attempt to sell or fraudulently obtain or furnish or attempt to furnish any nursing diploma, license, renewal or record or aid or abet therein;

(2) Practice **[**~~professional or practical~~**]** nursing as defined by sections 335.011 to **[**~~335.096~~**] 335.099** under cover of any diploma, license, or record illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation;

(3) Practice **[**~~professional nursing or practical~~**]** nursing as defined by sections 335.011 to **[**~~335.096~~**] 335.099** unless duly licensed to do so under the provisions of sections 335.011 to **[**~~335.096~~**] 335.099**;

(4) Use in connection with his **or her** name any designation tending to imply that he **or she** is a licensed **advanced practice registered nurse, a licensed** registered professional nurse**,** or a licensed practical nurse unless duly licensed so to practice under the provisions of sections 335.011 to **[**~~335.096~~**] 335.099**;

(5) Practice **[**~~professional nursing or practical~~**]** nursing during the time his **or her** license issued under the provisions of sections 335.011 to **[**~~335.096~~**] 335.099** shall be suspended or revoked; or

(6) Conduct a nursing education program for the preparation of professional or practical nurses unless the program has been accredited by the board.

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.~~**]**

335.203. 1. There is hereby established the "Nursing Education Incentive Program" within the state board of nursing.

2. Subject to appropriation and board disbursement, grants shall be awarded through the nursing education incentive program to eligible institutions of higher education based on criteria jointly determined by the board and the department of higher education and workforce development. **[**~~Grant award amounts shall not exceed one hundred fifty thousand dollars.~~**]** No campus shall receive more than one grant per year.

3. To be considered for a grant, an eligible institution of higher education shall offer a program of nursing that meets the predetermined category and area of need as established by the board and the department under subsection 4 of this section.

4. The board and the department shall determine categories and areas of need for designating grants to eligible institutions of higher education. In establishing categories and areas of need, the board and department may consider criteria including, but not limited to:

(1) Data generated from licensure renewal data and the department of health and senior services; and

(2) National nursing statistical data and trends that have identified nursing shortages.

5. The board shall be the administrative agency responsible for implementation of the program established under sections 335.200 to 335.203, and shall promulgate reasonable rules for the exercise of its functions and the effectuation of the purposes of sections 335.200 to 335.203. The board shall, by rule, prescribe the form, time, and method of filing applications and shall supervise the processing of such applications.

6. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2011, shall be invalid and void.

335.205. The board, in addition to any other duties it may have regarding licensure of nurses, shall collect, at the time of any initial license application or license renewal application, a nursing education incentive program surcharge from each person licensed or relicensed under chapter 335, in the amount of one dollar per year for practical nurses and five dollars per year for registered professional nurses. These funds shall be deposited in the state board of nursing fund described in section 335.036.

537.037. 1. Any physician or surgeon, registered professional nurse or licensed practical nurse licensed to practice in this state under the provisions of chapter 334 or 335, or licensed to practice under the equivalent laws of any other state and any person licensed as **[**~~a mobile~~**] an** emergency medical technician under the provisions of chapter 190, may:

(1) In good faith render emergency care or assistance, without compensation, at the scene of an emergency or accident, and shall not be liable for any civil damages for acts or omissions other than damages occasioned by gross negligence or by willful or wanton acts or omissions by such person in rendering such emergency care;

(2) In good faith render emergency care or assistance, without compensation, to any minor involved in an accident, or in competitive sports, or other emergency at the scene of an accident, without first obtaining the consent of the parent or guardian of the minor, and shall not be liable for any civil damages other than damages occasioned by gross negligence or by willful or wanton acts or omissions by such person in rendering the emergency care.

2. Any other person who has been trained to provide first aid in a standard recognized training program may, without compensation, render emergency care or assistance to the level

for which he or she has been trained, at the scene of an emergency or accident, and shall not be liable for civil damages for acts or omissions other than damages occasioned by gross negligence or by willful or wanton acts or omissions by such person in rendering such emergency care.

3. Any mental health professional, as defined in section 632.005, or qualified counselor, as defined in section 631.005, or any practicing medical, osteopathic, or chiropractic physician, or certified nurse practitioner, or physicians' assistant may in good faith render suicide prevention interventions at the scene of a threatened suicide and shall not be liable for any civil damages for acts or omissions other than damages occasioned by gross negligence or by willful or wanton acts or omissions by such person in rendering such suicide prevention interventions.

4. Any other person may, without compensation, render suicide prevention interventions at the scene of a threatened suicide and shall not be liable for civil damages for acts or omissions other than damages occasioned by gross negligence or by willful or wanton acts or omissions by such person in rendering such suicide prevention interventions.

579.088. Notwithstanding any other provision of this chapter or chapter 195 to the contrary, it shall not be unlawful to manufacture, possess, sell, deliver, or use any device, equipment, or other material for the purpose of analyzing controlled substances to detect the presence of fentanyl or any synthetic controlled substance fentanyl analogue.

630.1150. 1. The department of mental health and the department of social services shall oversee and implement a collaborative project to:

(1) Assess the incidence and implications of continued hospitalization of foster children and clients of the department of mental health that occurs without medical justification because appropriate postdischarge placement options are unavailable;

(2) Assess the incidence and implications of continued hospitalization of foster children with mental illnesses, mental disorders, intellectual disabilities, and developmental disabilities that occurs without medical justification because they are awaiting screening for appropriateness of residential services; and

(3) Develop recommendations to ensure that patients described in this subsection receive treatment in the most cost-effective and efficacious settings, consistent with federal and state standards for treatment in the least restrictive environment.

2. The departments shall solicit and consider data and recommendations from foster children, clients of the department of mental health, and other stakeholders who may provide or coordinate treatment, or have responsibility, for such children or patients, including:

(1) Hospital social workers and discharge planners;

(2) Health insurers;

(3) Psychiatrists and psychologists;

(4) Hospitals, as defined in section 197.020;

(5) Skilled nursing facilities and intermediate care facilities licensed under chapter 198;

(6) Vendors, as defined in section 630.005;

(7) Vulnerable persons or persons under the care and custody of the children's division of the department of social services;

(8) Consumers;

(9) Public elementary and secondary schools;

(10) Family support teams and case workers; and

(11) The courts.

3. The departments shall issue interim reports by December 31, 2023, and July 1, 2024, and a final report by December 1, 2024. Copies of each report shall be submitted concurrently to the general assembly.

4. The provisions of this section shall expire on January 1, 2025.

632.305. 1. An application for detention for evaluation and treatment may be executed by any adult person, who need not be an attorney or represented by an attorney, including the mental health coordinator, on a form provided by the court for such purpose, and shall allege under oath, without a notarization requirement, that the applicant has reason to believe that the respondent is suffering from a mental disorder and presents a likelihood of serious harm to himself or herself or to others. The application shall specify the factual information on which such belief is based and should contain the names and addresses of all persons known to the applicant who have knowledge of such facts through personal observation.

2. The filing of a written application in court by any adult person, who need not be an attorney or represented by an attorney, including the mental health coordinator, shall authorize the applicant to bring the matter before the court on an ex parte basis to determine whether the respondent should be taken into custody and transported to a mental health facility. The application may be filed in the court having probate jurisdiction in any county where the respondent may be found. If the court finds that there is probable cause, either upon testimony under oath or upon a review of affidavits, **declarations, or other supporting documentation,** to believe that the respondent may be suffering from a mental disorder and presents a likelihood of serious harm to himself or herself or others, it shall direct a peace officer to take the respondent into custody and transport him or her to a mental health facility for detention for evaluation and treatment for a period not to exceed ninety-six hours unless further detention and treatment is authorized pursuant to this chapter. Nothing herein shall be

construed to prohibit the court, in the exercise of its discretion, from giving the respondent an opportunity to be heard.

3. A mental health coordinator may request a peace officer to take or a peace officer may take a person into custody for detention for evaluation and treatment for a period not to exceed ninety-six hours only when such mental health coordinator or peace officer has reasonable cause to believe that such person is suffering from a mental disorder and that the likelihood of serious harm by such person to himself or herself or others is imminent unless such person is immediately taken into custody. Upon arrival at the mental health facility, the peace officer or mental health coordinator who conveyed such person or caused him or her to be conveyed shall either present the application for detention for evaluation and treatment upon which the court has issued a finding of probable cause and the respondent was taken into custody or complete an application for initial detention for evaluation and treatment for a period not to exceed ninety-six hours which shall be based upon his or her own personal observations or investigations and shall contain the information required in subsection 1 of this section.

4. If a person presents himself or herself or is presented by others to a mental health facility and a licensed physician, a registered professional nurse or a mental health professional designated by the head of the facility and approved by the department for such purpose has reasonable cause to believe that the person is mentally disordered and presents an imminent likelihood of serious harm to himself or herself or others unless he or she is accepted for detention, the licensed physician, the mental health professional or the registered professional nurse designated by the facility and approved by the department may complete an application for detention for evaluation and treatment for a period not to exceed ninety-six hours. The application shall be based on his or her own personal observations or investigation and shall contain the information required in subsection 1 of this section.

5. **[**~~Any oath required by the provisions of this section~~**] No notarization shall be required for an application or any affidavits, declarations, or other documents supporting an application. The application and any affidavits, declarations, or other documents supporting the application** shall be subject to the provisions of section 492.060 **allowing for declaration under penalty of perjury**.

650.320. For the purposes of sections 650.320 to 650.340, the following terms mean:

(1) **"Ambulance service", the same meaning given to the term in section 190.100;**

(2) "Board", the Missouri 911 service board established in section 650.325;

(3) "Dispatch agency", the same meaning given to the term in section 190.100;

(4) "Medical director", the same meaning given to the term in section 190.100;

(5) "Memorandum of understanding", the same meaning given to the term in section 190.100;

[~~(2)~~**] (6)** "Public safety answering point", the location at which 911 calls are answered;

[~~(3)~~**] (7)** "Telecommunicator", any person employed as an emergency telephone worker, call taker or public safety dispatcher whose duties include receiving, processing or transmitting public safety information received through a 911 public safety answering point.

650.340. 1. The provisions of this section may be cited and shall be known as the "911 Training and Standards Act".

2. Initial training requirements for telecommunicators who answer 911 calls that come to public safety answering points shall be as follows:

(1) Police telecommunicator, 16 hours;

(2) Fire telecommunicator, 16 hours;

(3) Emergency medical services telecommunicator, 16 hours;

(4) Joint communication center telecommunicator, 40 hours.

3. All persons employed as a telecommunicator in this state shall be required to complete ongoing training so long as such person engages in the occupation as a telecommunicator. Such persons shall complete at least twenty-four hours of ongoing training every three years by such persons or organizations as provided in subsection 6 of this section.

4. Any person employed as a telecommunicator on August 28, 1999, shall not be required to complete the training requirement as provided in subsection 2 of this section. Any person hired as a telecommunicator after August 28, 1999, shall complete the training requirements as provided in subsection 2 of this section within twelve months of the date such person is employed as a telecommunicator.

5. The training requirements as provided in subsection 2 of this section shall be waived for any person who furnishes proof to the committee that such person has completed training in another state which is at least as stringent as the training requirements of subsection 2 of this section.

6. The board shall determine by administrative rule the persons or organizations authorized to conduct the training as required by subsection 2 of this section.

7. **[**~~This section shall not apply to an emergency medical dispatcher or agency as defined in section 190.100, or a person trained by an entity accredited or certified under section 190.131, or a person who provides prearrival medical instructions who works for an agency which meets the requirements set forth in section 190.134.~~**] The board shall be responsible for the approval of training courses for emergency medical dispatchers. The board shall develop necessary rules and regulations in collaboration with the state EMS medical director's advisory committee, as described in section 190.103, which may**

provide recommendations relating to the medical aspects of prearrival medical instructions.

8. A dispatch agency is required to have a memorandum of understanding with all ambulance services that it dispatches. If a dispatch agency provides prearrival medical instructions, it is required to have a medical director whose duties include the maintenance of standards and approval of protocols or guidelines.

701.336. 1. The department of health and senior services shall cooperate with the federal government in implementing subsections (d) and (e) of 15 U.S.C. Section 2685 to establish public education activities and an information clearinghouse regarding childhood lead poisoning. The department may develop additional educational materials on lead hazards to children, lead poisoning prevention, lead poisoning screening, lead abatement and disposal, and on health hazards during abatement.

2. The department of health and senior services and the department of social services, in collaboration with related not-for-profit organizations, health maintenance organizations, and the Missouri consolidated health care plan, shall devise an educational strategy to increase the number of children who are tested for lead poisoning under the Medicaid program. **[**~~The goal of the educational strategy is to have seventy-five percent of the children who receive Medicaid tested for lead poisoning. The educational strategy shall be implemented over a three-year period and shall be in accordance with all federal laws and regulations.~~**]**

3. The children's division, in collaboration with the department of health and senior services, shall regularly inform eligible clients of the availability and desirability of lead screening and treatment services, including those available through the early and periodic screening, diagnosis, and treatment (EPSDT) component of the Medicaid program.

701.340. 1. **[**~~Beginning January 1, 2002,~~**]** The department of health and senior services shall, subject to appropriations, implement a childhood lead testing program **[**~~which requires every child less than six years of age to be tested for lead poisoning~~**]** in accordance with the provisions of sections 701.340 to 701.349. **Every medical provider who serves children shall annually provide education to all parents and guardians of children under four years of age regarding lead hazards to children and shall annually provide the option to test every child under four years of age for lead poisoning with the consent of the parent or guardian.** In coordination with the department of health and senior services, every health care facility serving children **[**~~less than six~~**] under four** years of age, including but not limited to hospitals and clinics licensed pursuant to chapter 197, shall take appropriate steps to ensure that **[**~~their patients receive~~**] the medical providers in the facility offer** such lead poisoning testing **in accordance with the provisions of this section**.

2. The test for lead poisoning shall consist of a blood sample that shall be sent for analysis to a laboratory licensed pursuant to the federal Clinical Lab Improvement Act (CLIA). The department of health and senior services shall, by rule, determine the blood test protocol to be used.

3. Nothing in sections 701.340 to 701.349 shall be construed to require a child to undergo lead testing whose parent or guardian objects to the testing **[**~~in a written statement that states the parent's or guardian's reason for refusing such testing~~**]**.

701.342. 1. The department of health and senior services shall, using factors established by the department, including but not limited to the geographic index from data from testing reports, identify geographic areas in the state that are at high risk for lead poisoning. **[**~~All children less than six years of age who reside or spend more than ten hours a week in an area identified as high risk by the department shall be tested annually for lead poisoning.~~**]**

2. Every child **[**~~less than~~**] under** six years of age **[**~~not residing or spending more than ten hours a week in geographic areas identified as high risk by the department~~**]** shall be assessed annually using a questionnaire to determine whether such child is at high risk for lead poisoning. The department, in collaboration with the department of social services, shall develop the questionnaire, which shall follow the recommendations of the federal Centers for Disease Control and Prevention. The department may modify the questionnaire to broaden the scope of the high-risk category. Local boards or commissions of health may add questions to the questionnaire.

3. Every child deemed to be at high risk for lead poisoning according to the questionnaire developed pursuant to subsection 2 of this section shall**, with the consent of a parent or guardian,** be tested using a blood sample.

4. **[**~~Any child deemed to be at high risk for lead poisoning pursuant to this section who resides in housing currently undergoing renovations may be tested at least once every six months during the renovation and once after the completion of the renovation.~~

~~5.~~**]** Any laboratory providing test results for lead poisoning pursuant to sections 701.340 to 701.349 shall notify the department of the test results of any child tested for lead poisoning as required in section 701.326. Any child who tests positive for lead poisoning shall receive follow-up testing in accordance with rules established by the department. The department shall, by rule, establish the methods and intervals of follow-up testing and treatment for such children.

[~~6.~~**] 5.** When the department is notified of a case of lead poisoning, the department shall require the testing of all other children **[**~~less than~~**] under** six years of age, and any other children or persons at risk, as determined by the director, who are residing or have recently resided in the household of the lead-poisoned child.

701.344. 1. In geographic areas determined to be of high risk for lead poisoning as set forth in section 701.342, every child care facility, as defined in section 210.201, and every child care facility affiliated with a school system, a business organization or a nonprofit organization shall, within thirty days of enrolling a child **twelve months of age or older and under five years of age**, require the child's parent or guardian to provide evidence of lead poisoning testing in the form of a statement from the health care professional that administered the test or provide a written statement that states the **[**~~parent's or guardian's reason for refusing~~**]** **parent or guardian refused** such testing. If there is no evidence of testing, the person in charge of the facility shall provide the parent or guardian with information about lead poisoning and locations in the area where the child can be tested. When a parent or guardian cannot obtain such testing, the person in charge of the facility may arrange for the child to be tested by a local health officer with the consent of the child's parent or guardian. At the beginning of each year of enrollment in such facility, the parent or guardian shall provide proof of testing in accordance with the provisions of sections 701.340 to 701.349 and any rules promulgated thereunder.

2. No child shall be denied access to education or child care because of failure to comply with the provisions of sections 701.340 to 701.349.

701.348. Nothing in sections 701.340 to 701.349 shall prohibit a political subdivision of this state **[**~~or~~**],** a local board of health**, or a state agency** from enacting and enforcing ordinances, rules or laws for the prevention, detection and control of lead poisoning which provide the same or more stringent provisions as sections 701.340 to 701.349, or the rules promulgated thereunder.

[~~190.134. A dispatch agency is required to have a memorandum of understanding with all ambulance services that it dispatches. If a dispatch agency provides prearrival medical instructions, it is required to have a medical director, whose duties include the maintenance of standards and protocol approval.~~**]**

[~~191.500. As used in sections 191.500 to 191.550, unless the context clearly indicates otherwise, the following terms mean:~~

~~(1) "Area of defined need", a community or section of an urban area of this state which is certified by the department of health and senior services as being in need of the services of a physician to improve the patient-doctor ratio in the area, to contribute professional physician services to an area of economic impact, or to contribute professional physician services to an area suffering from the effects of a natural disaster;~~

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

~~(3) "Eligible student", a full-time student accepted and enrolled in a formal course of instruction leading to a degree of doctor of medicine or doctor of osteopathy, including psychiatry, at a participating school, or a~~

~~doctor of dental surgery, doctor of dental medicine, or a bachelor of science degree in dental hygiene;~~

~~(4) "Financial assistance", an amount of money paid by the state of Missouri to a qualified applicant pursuant to sections 191.500 to 191.550;~~

~~(5) "Participating school", an institution of higher learning within this state which grants the degrees of doctor of medicine or doctor of osteopathy, and which is accredited in the appropriate degree program by the American Medical Association or the American Osteopathic Association, or a degree program by the American Dental Association or the American Psychiatric Association, and applicable residency programs for each degree type and discipline;~~

~~(6) "Primary care", general or family practice, internal medicine, pediatric , psychiatric, obstetric and gynecological care as provided to the general public by physicians licensed and registered pursuant to chapter 334, dental practice, or a dental hygienist licensed and registered pursuant to chapter 332;~~

~~(7) "Resident", any natural person who has lived in this state for one or more years for any purpose other than the attending of an educational institution located within this state;~~

~~(8) "Rural area", a town or community within this state which is not within a standard metropolitan statistical area, and has a population of six thousand or fewer inhabitants as determined by the last preceding federal decennial census or any unincorporated area not within a standard metropolitan statistical area.~~**]**

[~~191.505. The department of health and senior services shall be the administrative agency for the implementation of the program established by sections 191.500 to 191.550. The department shall promulgate reasonable rules and regulations for the exercise of its functions in the effectuation of the purposes of sections 191.500 to 191.550. It shall prescribe the form and the time and method of filing applications and supervise the processing thereof.~~**]**

[~~191.510. The department shall enter into a contract with each applicant receiving a state loan under sections 191.500 to 191.550 for repayment of the principal and interest and for forgiveness of a portion thereof for participation in the service areas as provided in sections 191.500 to 191.550.~~**]**

[~~191.515. An eligible student may apply to the department for a loan under sections 191.500 to 191.550 only if, at the time of his application and throughout the period during which he receives the loan, he has been formally accepted as a student in a participating school in a course of study leading to the degree of doctor of medicine or doctor of osteopathy, including psychiatry, or a doctor of dental surgery, a doctor of dental medicine, or a bachelor of science degree in dental hygiene, and is a resident of this state.~~**]**

[~~191.520. No loan to any eligible student shall exceed twenty-five thousand dollars for each academic year, which shall run from August first of~~

~~any year through July thirty-first of the following year. All loans shall be made from funds appropriated to the medical school loan and loan repayment program fund created by section 191.600, by the general assembly.~~]

[~~191.525. No more than twenty-five loans shall be made to eligible students during the first academic year this program is in effect. Twenty-five new loans may be made for the next three academic years until a total of one hundred loans are available. At least one half of the loans shall be made to students from rural areas as defined in section 191.500. An eligible student may receive loans for each academic year he is pursuing a course of study directly leading to a degree of doctor of medicine or doctor of osteopathy, doctor of dental surgery, or doctor of dental medicine, or a bachelor of science degree in dental hygiene.~~]

[~~191.530. Interest at the rate of nine and one-half percent per year shall be charged on all loans made under sections 191.500 to 191.550 but one-fourth of the interest and principal of the total loan at the time of the awarding of the degree shall be forgiven for each year of participation by an applicant in the practice of his profession in a rural area or an area of defined need. The department shall grant a deferral of interest and principal payments to a loan recipient who is pursuing an internship or a residency in primary care. The deferral shall not exceed three years. The status of each loan recipient receiving a deferral shall be reviewed annually by the department to ensure compliance with the intent of this provision. The loan recipient will repay the loan beginning with the calendar year following completion of his internship or his primary care residency in accordance with the loan contract.~~]

[~~191.535. If a student ceases his study prior to receiving a degree, interest at the rate specified in section 191.530 shall be charged on the amount received from the state under the provisions of sections 191.500 to 191.550.~~]

[~~191.540. 1. The department shall establish schedules and procedures for repayment of the principal and interest of any loan made under the provisions of sections 191.500 to 191.550 and not forgiven as provided in section 191.530.~~

~~2. A penalty shall be levied against a person in breach of contract. Such penalty shall be twice the sum of the principal and the accrued interest.~~]

[~~191.545. When necessary to protect the interest of the state in any loan transaction under sections 191.500 to 191.550, the board may institute any action to recover any amount due.~~]

[~~191.550. The contracts made with the participating students shall be approved by the attorney general.~~]

[~~335.212. As used in sections 335.212 to 335.242, the following terms mean:~~

~~(1) "Board", the Missouri state board of nursing;~~

~~(2) "Department", the Missouri department of health and senior services;~~

~~(3) "Director", director of the Missouri department of health and senior services;~~

~~(4) "Eligible student", a resident who has been accepted as a full-time student in a formal course of instruction leading to an associate degree, a diploma, a bachelor of science, a master of science in nursing (M.S.N.), a doctorate in nursing (Ph.D. or D.N.P.), or a student with a master of science in nursing seeking a doctorate in education (Ed.D.), or leading to the completion of educational requirements for a licensed practical nurse. The doctoral applicant may be a part-time student;~~

~~(5) "Participating school", an institution within this state which is approved by the board for participation in the professional and practical nursing student loan program established by sections 335.212 to 335.242, having a nursing department and offering a course of instruction based on nursing theory and clinical nursing experience;~~

~~(6) "Qualified applicant", an eligible student approved by the board for participation in the professional and practical nursing student loan program established by sections 335.212 to 335.242;~~

~~(7) "Qualified employment", employment on a full-time basis in Missouri in a position requiring licensure as a licensed practical nurse or registered professional nurse in any hospital as defined in section 197.020 or in any agency, institution, or organization located in an area of need as determined by the department of health and senior services. Any forgiveness of such principal and interest for any qualified applicant engaged in qualified employment on a less than full-time basis may be prorated to reflect the amounts provided in this section;~~

~~(8) "Resident", any person who has lived in this state for one or more years for any purpose other than the attending of an educational institution located within this state.~~**]**

[~~335.215. 1. The department of health and senior services shall be the administrative agency for the implementation of the professional and practical nursing student loan program established under sections 335.212 to 335.242, and the nursing student loan repayment program established under sections 335.245 to 335.259.~~

~~2. An advisory panel of nurses shall be appointed by the director. It shall be composed of not more than eleven members representing practical, associate degree, diploma, baccalaureate and graduate nursing education, community health, primary care, hospital, long-term care, a consumer, and the Missouri state board of nursing. The panel shall make recommendations to the director on the content of any rules, regulations or guidelines prior to their promulgation. The panel may make recommendations to the director regarding fund allocations for loans and loan repayment based on current nursing shortage needs.~~

~~3. The department of health and senior services shall promulgate reasonable rules and regulations for the exercise of its function pursuant to sections 335.212 to 335.259. It shall prescribe the form, the time and method~~

~~of filing applications and supervise the proceedings thereof. No rule or portion of a rule promulgated under the authority of sections 335.212 to 335.257 shall become effective unless it has been promulgated pursuant to the provisions of section 536.024.~~

~~4. Ninety-five percent of funds loaned pursuant to sections 335.212 to 335.242 shall be loaned to qualified applicants who are enrolled in professional nursing programs in participating schools and five percent of the funds loaned pursuant to sections 335.212 to 335.242 shall be loaned to qualified applicants who are enrolled in practical nursing programs. Priority shall be given to eligible students who have established financial need. All loan repayment funds pursuant to sections 335.245 to 335.259 shall be used to reimburse successful associate, diploma, baccalaureate or graduate professional nurse applicants' educational loans who agree to serve in areas of defined need as determined by the department.~~**]**

[~~335.218. There is hereby established the "Professional and Practical Nursing Student Loan and Nurse Loan Repayment Fund". All fees pursuant to section 335.221, general revenue appropriations to the student loan or loan repayment program, voluntary contributions to support or match the student loan and loan repayment program activities, funds collected from repayment and penalties, and funds received from the federal government shall be deposited in the state treasury and be placed to the credit of the professional and practical nursing student loan and nurse loan repayment fund. The fund shall be managed by the department of health and senior services and all administrative costs and expenses incurred as a result of the effectuation of sections 335.212 to 335.259 shall be paid from this fund.~~**]**

[~~335.221. The board, in addition to any other duties it may have regarding licensure of nurses, shall collect, at the time of licensure or licensure renewal, an education surcharge from each person licensed or relicensed pursuant to sections 335.011 to 335.096, in the amount of one dollar per year for practical nurses and five dollars per year for professional nurses. These funds shall be deposited in the professional and practical nursing student loan and nurse loan repayment fund. All expenditures authorized by sections 335.212 to 335.259 shall be paid from funds appropriated by the general assembly from the professional and practical nursing student loan and nurse loan repayment fund. 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.~~**]**

[~~335.224. The department of health and senior services shall enter into a contract with each qualified applicant receiving financial assistance under the provisions of sections 335.212 to 335.242 for repayment of the principal and interest.~~**]**

[~~335.227. An eligible student may apply to the department for financial assistance under the provisions of sections 335.212 to 335.242 if, at the time of his application for a loan, the eligible student has formally applied~~

~~for acceptance at a participating school. Receipt of financial assistance is contingent upon acceptance and continued enrollment at a participating school.~~**]**

[~~335.230. Financial assistance to any qualified applicant shall not exceed ten thousand dollars for each academic year for a professional nursing program and shall not exceed five thousand dollars for each academic year for a practical nursing program. All financial assistance shall be made from funds credited to the professional and practical nursing student loan and nurse loan repayment fund. A qualified applicant may receive financial assistance for each academic year he remains a student in good standing at a participating school.~~**]**

[~~335.233. The department shall establish schedules for repayment of the principal and interest on any financial assistance made under the provisions of sections 335.212 to 335.242. Interest at the rate of nine and one-half percent per annum shall be charged on all financial assistance made under the provisions of sections 335.212 to 335.242, but the interest and principal of the total financial assistance granted to a qualified applicant at the time of the successful completion of a nursing degree, diploma program or a practical nursing program shall be forgiven through qualified employment.~~**]**

[~~335.236. The financial assistance recipient shall repay the financial assistance principal and interest beginning not more than six months after completion of the degree for which the financial assistance was made in accordance with the repayment contract. If an eligible student ceases his study prior to successful completion of a degree or graduation at a participating school, interest at the rate specified in section 335.233 shall be charged on the amount of financial assistance received from the state under the provisions of sections 335.212 to 335.242, and repayment, in accordance with the repayment contract, shall begin within ninety days of the date the financial aid recipient ceased to be an eligible student. All funds repaid by recipients of financial assistance to the department shall be deposited in the professional and practical nursing student loan and nurse loan repayment fund for use pursuant to sections 335.212 to 335.259.~~**]**

[~~335.239. The department shall grant a deferral of interest and principal payments to a financial assistance recipient who is pursuing an advanced degree, special nursing program, or upon special conditions established by the department. The deferral shall not exceed four years. The status of each deferral shall be reviewed annually by the department of health and senior services to ensure compliance with the intent of this section.~~**]**

[~~335.242. When necessary to protect the interest of the state in any financial assistance transaction under sections 335.212 to 335.259, the department of health and senior services may institute any action to recover any amount due.~~**]**

[~~335.245. As used in sections 335.245 to 335.259, the following terms mean:~~

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

~~(2) "Eligible applicant", a Missouri licensed nurse who has attained either an associate degree, a diploma, a bachelor of science, or graduate degree in nursing from an accredited institution approved by the board of nursing or a student nurse in the final year of a full-time baccalaureate school of nursing leading to a baccalaureate degree or graduate nursing program leading to a master's degree in nursing and has agreed to serve in an area of defined need as established by the department;~~

~~(3) "Participating school", an institution within this state which grants an associate degree in nursing, grants a bachelor or master of science degree in nursing or provides a diploma nursing program which is accredited by the state board of nursing, or a regionally accredited institution in this state which provides a bachelor of science completion program for registered professional nurses;~~

~~(4) "Qualified employment", employment on a full-time basis in Missouri in a position requiring licensure as a licensed practical nurse or registered professional nurse in any hospital as defined in section 197.020 or public or nonprofit agency, institution, or organization located in an area of need as determined by the department of health and senior services. Any forgiveness of such principal and interest for any qualified applicant engaged in qualified employment on a less than full-time basis may be prorated to reflect the amounts provided in this section.~~]

[~~335.248. Sections 335.245 to 335.259 shall be known as the "Nursing Student Loan Repayment Program". The department of health and senior services shall be the administrative agency for the implementation of the authority established by sections 335.245 to 335.259. The department shall promulgate reasonable rules and regulations necessary to implement sections 335.245 to 335.259. Promulgated rules shall include, but not be limited to, applicant eligibility, selection criteria, prioritization of service obligation sites and the content of loan repayment contracts, including repayment schedules for those in default and penalties. The department shall promulgate rules regarding recruitment opportunities for minority students into nursing schools. Priority for student loan repayment shall be given to eligible applicants who have demonstrated financial need. All funds collected by the department from participants not meeting their contractual obligations to the state shall be deposited in the professional and practical nursing student loan and nurse loan repayment fund for use pursuant to sections 335.212 to 335.259.~~]

[~~335.251. Upon proper verification to the department by the eligible applicant of securing qualified employment in this state, the department shall enter into a loan repayment contract with the eligible applicant to repay the interest and principal on the educational loans of the applicant to the limit of the contract, which contract shall provide for instances of less than full-time qualified employment consistent with the provisions of section 335.233, out of~~

~~any appropriation made to the professional and practical nursing student loan and nurse loan repayment fund. If the applicant breaches the contract by failing to begin or complete the qualified employment, the department is entitled to recover the total of the loan repayment paid by the department plus interest on the repaid amount at the rate of nine and one half percent per annum.~~**]**

[~~335.254. Sections 335.212 to 335.259 shall not be construed to require the department to enter into contracts with individuals who qualify for nursing education loans or nursing loan repayment programs when federal, state and local funds are not available for such purposes.~~**]**

[~~335.257. Successful applicants for whom loan payments are made under the provisions of sections 335.245 to 335.259 shall verify to the department twice each year in the manner prescribed by the department that qualified employment in this state is being maintained.~~**]**

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