FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 94

103RD GENERAL ASSEMBLY

0749H.03C JOSEPH ENGLER, Chief Clerk

AN ACT

To repeal sections 135.621, 167.627, 167.630, 190.246, 191.600, 191.603, 191.605, 191.607, 191.611, 191.614, 191.615, 191.648, 191.1145, 192.769, 196.990, 208.152, 208.662, 210.030, 321.621, 332.211, 332.281, and 338.333, RSMo, and to enact in lieu thereof fifty-four new sections relating to health care, with penalty provisions.

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

Section A. Sections 135.621, 167.627, 167.630, 190.246, 191.600, 191.603, 191.605, 191.607, 191.611, 191.614, 191.615, 191.648, 191.1145, 192.769, 196.990, 208.152, 208.662, 210.030, 321.621, 332.211, 332.281, and 338.333, RSMo, are repealed and fifty-four new sections enacted in lieu thereof, to be known as sections 135.621, 167.627, 167.630, 190.246, 191.600, 191.603, 191.605, 191.607, 191.611, 191.614, 191.615, 191.648, 191.708, 191.1145, 192.021, 192.2521, 196.990, 197.708, 208.149, 208.152, 208.662, 208.1400, 208.1405, 208.1410, 208.1415, 208.1420, 208.1425, 210.030, 210.225, 321.621, 332.211, 332.281, 332.700, 332.705, 332.710, 332.715, 332.720, 332.725, 332.730, 332.735, 332.740, 332.745, 332.750, 332.755, 332.760, 338.333, 376.1240, 376.1245, 376.2100, 376.2102, 376.2104, 376.2106, 376.2108, and 407.324, to read as follows:

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

(1) "Contribution", a donation of cash, stock, bonds, other marketable securities, or real property;

(2) "Department", the department of social services;

(3) "Diaper bank", **a national diaper bank or** a nonprofit entity located in this state established and operating primarily for the purpose of collecting or purchasing disposable diapers or other hygiene products for infants, children, or incontinent adults and that regularly distributes such diapers or other hygiene products through two or more schools, health care

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.

facilities, governmental agencies, or other nonprofit entities for eventual distribution to individuals free of charge;

(4) **"National diaper bank", a nonprofit entity located in this state that meets the following criteria:**

(a) Collects, purchases, warehouses, and manages a community inventory of disposable diapers or other hygiene products for infants, children, or incontinent adults;

(b) Regularly distributes a consistent and reliable supply of such diapers or other hygiene products through two or more schools, health care facilities, governmental agencies, or other nonprofit entities for eventual distribution to individuals free of charge, with the intention of reducing diaper need; and

(c) Is a member of a national network organization serving all fifty states through which certification demonstrates nonprofit best practices, data-driven program design, and equitable distribution focused on best serving infants, children, and incontinent adults;

(5) "Tax credit", a credit against the tax otherwise due under chapter 143, excluding withholding tax imposed under sections 143.191 to 143.265, or otherwise due under chapter 148 or 153;

[~~(5)~~**] (6)** "Taxpayer", a person, firm, partner in a firm, corporation, or shareholder in an S corporation doing business in the state of Missouri and subject to the state income tax imposed under chapter 143; an insurance company paying an annual tax on its gross premium receipts in this state; any other financial institution paying taxes to the state of Missouri or any political subdivision of this state under chapter 148; an express company that pays an annual tax on its gross receipts in this state under chapter 153; an individual subject to the state income tax under chapter 143; or any charitable organization that is exempt from federal income tax and whose Missouri unrelated business taxable income, if any, would be subject to the state income tax imposed under chapter 143.

2. For all fiscal years beginning on or after July 1, 2019, a taxpayer shall be allowed to claim a tax credit against the taxpayer's state tax liability in an amount equal to fifty percent of the amount of such taxpayer's contributions to a diaper bank.

3. The amount of the tax credit claimed shall not exceed the amount of the taxpayer's state tax liability for the tax year for which the credit is claimed, and such taxpayer shall not be allowed to claim a tax credit in excess of fifty thousand dollars per tax year. However, any tax credit that cannot be claimed in the tax year the contribution was made may be carried over only to the next subsequent tax year. No tax credit issued under this section shall be assigned, transferred, or sold.

4. Except for any excess credit that is carried over under subsection 3 of this section, no taxpayer shall be allowed to claim a tax credit unless the taxpayer contributes at least one

hundred dollars to one or more diaper banks during the tax year for which the credit is claimed.

5. The department shall determine, at least annually, which entities in this state qualify as diaper banks. The department may require of an entity seeking to be classified as a diaper bank any information which is reasonably necessary to make such a determination. The department shall classify an entity as a diaper bank if such entity satisfies the definition under subsection 1 of this section.

6. The department shall establish a procedure by which a taxpayer can determine if an entity has been classified as a diaper bank.

7. Diaper banks may decline a contribution from a taxpayer.

8. The cumulative amount of tax credits that may be claimed by all the taxpayers contributing to diaper banks in any one fiscal year shall not exceed five hundred thousand dollars. Tax credits shall be issued in the order contributions are received. If the amount of tax credits redeemed in a tax year is less than five hundred thousand dollars, the difference shall be added to the cumulative limit created under this subsection for the next fiscal year and carried over to subsequent fiscal years until claimed.

9. The department shall establish a procedure by which, from the beginning of the fiscal year until some point in time later in the fiscal year to be determined by the department, the cumulative amount of tax credits are equally apportioned among all entities classified as diaper banks. If a diaper bank fails to use all, or some percentage to be determined by the department, of its apportioned tax credits during this predetermined period of time, the department may reapportion such unused tax credits to diaper banks that have used all, or some percentage to be determined by the department, of their apportioned tax credits during this predetermined period of time. The department may establish multiple periods each fiscal year and reapportion accordingly. To the maximum extent possible, the department shall establish the procedure described under this subsection in such a manner as to ensure that taxpayers can claim as many of the tax credits as possible, up to the cumulative limit created under subsection 8 of this section.

10. Each diaper bank shall provide information to the department concerning the identity of each taxpayer making a contribution and the amount of the contribution. The department shall provide the information to the department of revenue. The department shall be subject to the confidentiality and penalty provisions of section 32.057 relating to the disclosure of tax information.

11. Under section 23.253 of the Missouri sunset act:

(1) The provisions of the program authorized under this section shall automatically sunset on December thirty-first six years after August 28, **[**~~2018~~**]** **2025**, unless reauthorized by an act of the general assembly;

(2) If such program is reauthorized, the program authorized under this section shall automatically sunset on December thirty-first six years after the effective date of the reauthorization of this section;

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

(4) The provisions of this subsection shall not be construed to limit or in any way impair the department's ability to issue tax credits authorized on or before the date the program authorized under this section expires or a taxpayer's ability to redeem such tax credits.

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

(1) **"Epinephrine delivery device", a single-use device approved by the United States Food and Drug Administration that is used for the delivery of a premeasured dose of epinephrine into the human body;**

(2) "Medication", any medicine prescribed or ordered by a physician for the treatment of asthma or anaphylaxis, including without limitation inhaled bronchodilators and **[**~~auto-injectible~~**]** epinephrine **delivery devices**;

[~~(2)~~**] (3)** "Self-administration", a pupil's discretionary use of medication prescribed by a physician or under a written treatment plan from a physician.

2. Each board of education and its employees and agents in this state shall grant any pupil in the school authorization for the possession and self-administration of medication to treat such pupil's chronic health condition, including but not limited to asthma or anaphylaxis if:

(1) A licensed physician prescribed or ordered such medication for use by the pupil and instructed such pupil in the correct and responsible use of such medication;

(2) The pupil has demonstrated to the pupil's licensed physician or the licensed physician's designee, and the school nurse, if available, the skill level necessary to use the medication and any device necessary to administer such medication prescribed or ordered;

(3) The pupil's physician has approved and signed a written treatment plan for managing the pupil's chronic health condition, including asthma or anaphylaxis episodes and for medication for use by the pupil. Such plan shall include a statement that the pupil is capable of self-administering the medication under the treatment plan;

(4) The pupil's parent or guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan required under subdivision (3) of this subsection and the liability statement required under subdivision (5) of this subsection; and

(5) The pupil's parent or guardian has signed a statement acknowledging that the school district and its employees or agents shall incur no liability as a result of any injury

arising from the self-administration of medication by the pupil or the administration of such medication by school staff. Such statement shall not be construed to release the school district and its employees or agents from liability for negligence.

3. An authorization granted under subsection 2 of this section shall:

(1) Permit such pupil to possess and self-administer such pupil's medication while in school, at a school-sponsored activity, and in transit to or from school or school-sponsored activity; and

(2) Be effective only for the same school and school year for which it is granted. Such authorization shall be renewed by the pupil's parent or guardian each subsequent school year in accordance with this section.

4. Any current duplicate prescription medication, if provided by a pupil's parent or guardian or by the school, shall be kept at a pupil's school in a location at which the pupil or school staff has immediate access in the event of an asthma or anaphylaxis emergency.

5. The information described in subdivisions (3) and (4) of subsection 2 of this section shall be kept on file at the pupil's school in a location easily accessible in the event of an emergency.

167.630. 1. **As used in this section, the term "epinephrine delivery device" has the same meaning given to the term in section 167.627.**

2. Each school board may authorize a school nurse licensed under chapter 335 who is employed by the school district and for whom the board is responsible for to maintain an adequate supply of **[**~~prefilled auto-syringes of~~**]** epinephrine **[**~~with fifteen-hundredths milligram or three-tenths milligram~~**]** delivery **devices** at the school. The nurse shall recommend to the school board the number of **[**~~prefilled~~**]** epinephrine **[**~~auto-syringes~~**] delivery devices** that the school should maintain.

[~~2.~~**] 3.** To obtain **[**~~prefilled~~**]** epinephrine **[**~~auto-syringes~~**] delivery devices** for a school district, a prescription written by a licensed physician, a physician's assistant, or nurse practitioner is required. For such prescriptions, the school district shall be designated as the patient, the nurse's name shall be required, and the prescription shall be filled at a licensed pharmacy.

[~~3.~~**] 4.** A school nurse, contracted agent trained by a nurse, or other school employee trained by and supervised by the nurse shall have the discretion to use an epinephrine **[**~~auto syringe~~**] delivery device** on any student the school nurse, trained employee, or trained contracted agent believes is having a life-threatening anaphylactic reaction based on the training in recognizing an acute episode of an anaphylactic reaction. The provisions of section 167.624 concerning immunity from civil liability for trained employees administering lifesaving methods shall apply to trained employees administering **[**~~a prefilled auto-syringe~~**] an epinephrine delivery device** under this section. Trained contracted agents shall have

immunity from civil liability for administering **[**~~a prefilled auto syringe~~**] an epinephrine delivery device** under this section.

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

(1) "Eligible person, firm, organization or other entity", an ambulance service or emergency medical response agency, an emergency medical responder, or an emergency medical technician who is employed by, or an enrolled member, person, firm, organization or entity designated by, rule of the department of health and senior services in consultation with other appropriate agencies. All such eligible persons, firms, organizations or other entities shall be subject to the rules promulgated by the director of the department of health and senior services;

(2) "Emergency health care provider":

(a) A physician licensed pursuant to chapter 334 with knowledge and experience in the delivery of emergency care; or

(b) A hospital licensed pursuant to chapter 197 that provides emergency care**;**

(3) "Epinephrine delivery device", a single-use device approved by the United States Food and Drug Administration that is used for the delivery of a premeasured dose of epinephrine into the human body.

2. Possession and use of epinephrine **[**~~auto-injector~~**] delivery** devices shall be limited as follows:

(1) No person shall use an epinephrine **[**~~auto-injector~~**] delivery** device unless such person has successfully completed a training course in the use of epinephrine **[**~~auto-injector~~**] delivery** devices approved by the director of the department of health and senior services. Nothing in this section shall prohibit the use of an epinephrine **[**~~auto-injector~~**] delivery** device:

(a) By a health care professional licensed or certified by this state who is acting within the scope of his or her practice; or

(b) By a person acting pursuant to a lawful prescription;

(2) Every person, firm, organization and entity authorized to possess and use epinephrine **[**~~auto-injector~~**] delivery** devices pursuant to this section shall use, maintain and dispose of such devices in accordance with the rules of the department; **and**

(3) Every use of an epinephrine **[**~~auto-injector~~**] delivery** device pursuant to this section shall immediately be reported to the emergency health care provider.

3. (1) Use of an epinephrine **[**~~auto-injector~~**] delivery** device pursuant to this section shall be considered first aid or emergency treatment for the purpose of any law relating to liability.

(2) Purchase, acquisition, possession or use of an epinephrine **[**~~auto-injector~~**]** **delivery** device pursuant to this section shall not constitute the unlawful practice of medicine or the unlawful practice of a profession.

(3) Any person otherwise authorized to sell or provide an epinephrine **[**~~auto-injector~~**]** **delivery** device may sell or provide it to a person authorized to possess it pursuant to this section.

4. Any person, firm, organization or entity that violates the provisions of this section is guilty of a class B misdemeanor.

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~~**] an accredited graduate training program in any discipline designated in rule by the department** 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~~**], to be known as the "Missouri State Loan Repayment Program (MOSLRP)". In designating disciplines, the department shall comply with limitations set forth in the National Health Service Corps Loan Repayment Program, 42 U.S.C. Section 254l-1, and any related notices of funding opportunity**.

2. The **[**~~"Health Professional Student Loan and~~**]** **"Missouri State** 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.

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

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

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

~~(3)~~**]** "Department", the department of health and senior services**[**~~;~~

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

~~(5) "Primary care physician", physicians licensed and registered pursuant to chapter 334 engaged in general or family practice, internal medicine, pediatrics or obstetrics and~~

~~gynecology as their primary specialties, and who are providing such primary care services to the general population;~~

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

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

2. Annually, at least thirty-five percent of the appropriated funds allocated for the Missouri state loan repayment program shall be designated for awards to primary care physicians and general dentists. Any unused portion of such designated funds shall be made available within the same fiscal year to the other types of health professions designated by the department under section 191.600.

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

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

(2) Residence in the state of Missouri;

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

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

~~(5) Enrollment as a full-time chiropractic student in the final year of course study offered by an approved educational institution or licensed to practice chiropractic medicine pursuant to chapter 331~~**] Authorization to practice as any type of health professional designated in section 191.600**;

[~~(6)~~**] (4) Practice in an area of defined need; and**

(5) Submission of an application for loan repayment.

191.611. 1. A loan payment provided for an individual under a written contract under the **[**~~health professional student loan payment~~**] Missouri state loan repayment** program shall consist of payment on behalf of the individual of the principal, interest, and related expenses

on government and commercial loans received by the individual for tuition, fees, books, laboratory, and living expenses incurred by the individual.

2. For each year of obligated services that an individual contracts to serve in an area of defined need, the director may pay an amount not to exceed the maximum amounts allowed under the National Health Service Corps Loan Repayment Program, 42 U.S.C. Section **[**~~2541-1, P.L. 106-213~~**]** **254l-1**, on behalf of the individual for loans described in subsection 1 of this section.

3. The department may enter into an agreement with the holder of the loans for which repayments are made pursuant to the **[**~~health professional student loan payment~~**]** **Missouri state loan repayment** program to establish a schedule for the making of such payments if the establishment of such a schedule would result in reducing the costs to the state.

4. Any qualifying communities providing a portion of a loan repayment shall be considered first for placement.

191.614. 1. **[**~~An individual who has entered into a written contract with the department; and in the case of an individual who is enrolled in the final year of a course of study and fails to maintain an acceptable level of academic standing in the educational institution in which such individual is enrolled or voluntarily terminates such enrollment or is dismissed from such educational institution before completion of such course of study or fails to become licensed pursuant to chapter 331, 332 or 334 within one year shall be liable to the state for the amount which has been paid on his or her behalf under the contract.~~

~~2.~~**]** If an individual breaches the written contract of the individual by failing either to begin such individual's service obligation or to complete such service obligation, the state shall be entitled to recover from the individual an amount equal to the sum of:

(1) The total of the amounts prepaid by the state on behalf of the individual;

(2) The interest on the amounts which would be payable if at the time the amounts were paid they were loans 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.

[~~3.~~**]** **2.** The department may act on behalf of a qualified community to recover from an individual described in **[**~~subsections 1 and 2 of~~**]** this section the portion of a loan repayment paid by such community for such individual.

191.615. 1. The department shall submit a grant application to the Secretary of the United States Department of Health and Human Services as prescribed by the secretary to

obtain federal funds to finance the **[**~~health professional student~~**]** **Missouri state** loan repayment program.

2. Sections 191.600 to 191.615 shall not be construed to require the department to enter into contracts with individuals who qualify for the **[**~~health professional student~~**]** **Missouri state** loan repayment program when federal and state funds are not available for such purpose.

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

(1) "Designated sexually transmitted infection", chlamydia, gonorrhea, trichomoniasis, or any other sexually transmitted infection designated as appropriate for expedited partner therapy by the department of health and senior services or for which expedited partner therapy was recommended in the most recent Centers for Disease Control and Prevention guidelines for the prevention or treatment of sexually transmitted infections;

(2) "Expedited partner therapy" **[**~~means~~**],** the practice of treating the sex partners of persons with **[**~~chlamydia or gonorrhea~~**]** **designated sexually transmitted infections** without an intervening medical evaluation or professional prevention counseling**;**

(3) "Health care professional", a member of any profession regulated by chapter 334 or 335 authorized to prescribe medications.

2. Any licensed **[**~~physician~~**]** **health care professional** may, but shall not be required to, utilize expedited partner therapy for the management of the partners of persons with **[**~~chlamydia or gonorrhea~~**]** **designated sexually transmitted infections**. Notwithstanding the requirements of 20 CSR 2150- 5.020 (5) or any other law to the contrary, a licensed **[**~~physician~~**]** **health care professional** utilizing expedited partner therapy may prescribe and dispense medications for the treatment of **[**~~chlamydia or gonorrhea~~**]** **a designated sexually transmitted infection** for an individual who is the partner of a person with **[**~~chlamydia or gonorrhea~~**]** **a designated sexually transmitted infection** and who does not have an established **[**~~physician/patient~~**]** **health care professional/patient** relationship with such **[**~~physician~~**]** **health care professional**. **[**~~Any antibiotic medications prescribed and dispensed for the treatment of chlamydia or gonorrhea under this section shall be in pill form.~~**]**

3. Any licensed **[**~~physician~~**]** **health care professional** utilizing expedited partner therapy for the management of the partners with **[**~~chlamydia or gonorrhea~~**]** **designated sexually transmitted infections** shall provide explanation and guidance to **[**~~a~~**]** **each** patient **[**~~diagnosed with chlamydia or gonorrhea~~**]** of the preventative measures that can be taken by the patient to stop the **[**~~spread~~**]** **transmission** of such **[**~~diagnosis~~**]** **infection**.

4. Any licensed **[**~~physician~~**]** **health care professional** utilizing expedited partner therapy for the management of partners of persons with **[**~~chlamydia or gonorrhea~~**]** **designated sexually transmitted infections** under this section shall have immunity from any civil

liability that may otherwise result by reason of such actions, unless such **[**~~physician~~**]** **health care professional** acts negligently, recklessly, in bad faith, or with malicious purpose.

5. The department of health and senior services and the division of professional registration within the department of commerce and insurance shall by rule develop guidelines for the implementation of subsection 2 of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2010, shall be invalid and void.

191.708. 1. The chief medical officer or chief medical director of the department of health and senior services, the department of mental health, or the MO HealthNet division of the department of social services, or any licensed physician acting with the express written consent of the director of any such department or division, may, within his or her scope of practice, issue:

(1) Nonspecific recommendations for doula services;

(2) A medical standing order for prenatal vitamins; or

(3) A medical standing order for any other purpose, other than for controlled substances, that is promulgated by rule in compliance with chapter 536.

2. Any standing order issued under this section shall:

(1) Be made available on the relevant department's website while in effect;

(2) Terminate upon removal of the issuing medical professional's authority under this section by vacancy of his or her position or otherwise; and

(3) If not terminated sooner under subdivision (2) of this subsection, expire within one year of issuance unless renewed.

3. The chief medical officer, chief medical director, or other authorized and licensed physician described in subsection 1 of this section shall be immune from criminal prosecution, disciplinary action from his or her professional licensing board, and civil liability for issuing a medical standing order or recommendation in accordance with this section, including for any outcome related to the standing order or recommendation.

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

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

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

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

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

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

(6) "Telehealth" or "telemedicine", the delivery of health care services by means of information and communication technologies**, including audiovisual and audio-only technologies,** which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology. **Health care providers shall not be limited in their choice of electronic platforms used to deliver telehealth or telemedicine, provided that all services delivered are in accordance with the Health Insurance Portability and Accountability Act of 1996.**

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

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

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

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

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

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

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

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

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

192.021. 1. The department of health and senior services shall be authorized to contract directly with a designated Missouri affiliate of the National Network of Public Health Institutes, or a similar or successor entity, in order to assist in carrying out its duties to promote the health and wellbeing of the residents of this state. Such contracts may include, but not be limited to, efforts to assist in the delivery of health services to residents throughout the state and the administration of grant funds and related programs.

2. Within sixty days after the end of each fiscal year, the department and the designated affiliate shall provide the general assembly with an annual report and accounting of any appropriations and grant funds received and expended by the designated affiliate pursuant to this section during the immediate prior fiscal year and may provide recommendations and suggestions for improvement in services provided.

192.2521. A specialty hospital is exempt from the provisions of sections 192.2520 and 197.135 if such hospital has a policy for transfer of a victim of a sexual assault to an appropriate hospital with an emergency department. As used in this section, "specialty hospital" means a hospital that has been designated by the department of health and senior services as something other than a general acute care hospital.

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

(1) "Administer", the direct application of an epinephrine **[**~~auto-injector~~**]** **delivery device** to the body of an individual;

(2) "Authorized entity", any entity or organization at or in connection with which allergens capable of causing anaphylaxis may be present including, but not limited to, qualified first responders, as such term is defined in section 321.621, **facilities licensed under chapter 198,** restaurants, recreation camps, youth sports leagues, **child care facilities,**

amusement parks, and sports arenas. "Authorized entity" shall not include any public school or public charter school;

(3) "Epinephrine **[**~~auto-injector~~**] delivery device**", a single-use device used for the **[**~~automatic injection~~**] delivery** of a premeasured dose of epinephrine into the human body;

(4) "Physician", a physician licensed in this state under chapter 334;

(5) "Provide", the supply of one or more epinephrine **[**~~auto-injectors~~**] delivery devices** to an individual;

(6) "Self-administration", a person's discretionary use of an epinephrine **[**~~auto-injector~~**] delivery device**.

2. A physician may prescribe epinephrine **[**~~auto-injectors~~**] delivery devices** in the name of an authorized entity for use in accordance with this section, and pharmacists, physicians, and other persons authorized to dispense prescription medications may dispense epinephrine **[**~~auto-injectors~~**] delivery devices** under a prescription issued in the name of an authorized entity.

3. An authorized entity may acquire and stock a supply of epinephrine **[**~~auto-injectors~~**] delivery devices** under a prescription issued in accordance with this section. Such epinephrine **[**~~auto-injectors~~**] delivery devices** shall be stored in a location readily accessible in an emergency and in accordance with the epinephrine **[**~~auto-injector's~~**] delivery device's** instructions for use and any additional requirements established by the department of health and senior services by rule. An authorized entity shall designate employees or agents who have completed the training required under this section to be responsible for the storage, maintenance, and general oversight of epinephrine **[**~~auto-injectors~~**] delivery devices** acquired by the authorized entity.

4. An authorized entity that acquires a supply of epinephrine **[**~~auto-injectors~~**] delivery devices** under a prescription issued in accordance with this section shall ensure that:

(1) Expected epinephrine **[**~~auto-injector~~**] delivery device** users receive training in recognizing symptoms of severe allergic reactions including anaphylaxis and the use of epinephrine **[**~~auto-injectors~~**] delivery devices** from a nationally recognized organization experienced in training laypersons in emergency health treatment or another entity or person approved by the department of health and senior services;

(2) All epinephrine **[**~~auto-injectors~~**] delivery devices** are maintained and stored according to the epinephrine **[**~~auto-injector's~~**] delivery device's** instructions for use;

(3) Any person who provides or administers an epinephrine **[**~~auto-injector~~**] delivery device** to an individual who the person believes in good faith is experiencing anaphylaxis activates the emergency medical services system as soon as possible; and

(4) A proper review of all situations in which an epinephrine **[**~~auto-injector~~**] delivery device** is used to render emergency care is conducted.

5. Any authorized entity that acquires a supply of epinephrine **[**~~auto-injectors~~**]** **delivery devices** under a prescription issued in accordance with this section shall notify the emergency communications district or the ambulance dispatch center of the primary provider of emergency medical services where the epinephrine **[**~~auto-injectors~~**]** **delivery devices** are to be located within the entity's facility.

6. No person shall provide or administer an epinephrine **[**~~auto-injector~~**]** **delivery device** to any individual who is under eighteen years of age without the verbal consent of a parent or guardian who is present at the time when provision or administration of the epinephrine **[**~~auto-injector~~**]** **delivery device** is needed. Provided, however, that a person may provide or administer an epinephrine **[**~~auto-injector~~**]** **delivery device** to such an individual without the consent of a parent or guardian if the parent or guardian is not physically present and the person reasonably believes the individual shall be in imminent danger without the provision or administration of the epinephrine **[**~~auto-injector~~**]** **delivery device**.

7. The following persons and entities shall not be liable for any injuries or related damages that result from the administration or self-administration of an epinephrine **[**~~auto-injector~~**]** **delivery device** in accordance with this section that may constitute ordinary negligence:

(1) An authorized entity that possesses and makes available epinephrine **[**~~auto-injectors~~**]** **delivery devices** and its employees, agents, and other trained persons;

(2) Any person who uses an epinephrine **[**~~auto-injector~~**]** **delivery device** made available under this section;

(3) A physician that prescribes epinephrine **[**~~auto-injectors~~**]** **delivery devices** to an authorized entity; or

(4) Any person or entity that conducts the training described in this section.

Such immunity does not apply to acts or omissions constituting a reckless disregard for the safety of others or willful or wanton conduct. The administration of an epinephrine **[**~~auto-injector~~**]** **delivery device** in accordance with this section shall not be considered the practice of medicine. The immunity from liability provided under this subsection is in addition to and not in lieu of that provided under section 537.037. An authorized entity located in this state shall not be liable for any injuries or related damages that result from the provision or administration of an epinephrine **[**~~auto-injector~~**]** **delivery device** by its employees or agents outside of this state if the entity or its employee or agent is not liable for such injuries or related damages under the laws of the state in which such provision or administration occurred. No trained person who is in compliance with this section and who in good faith and exercising reasonable care fails to administer an epinephrine **[**~~auto-injector~~**]** **delivery device** shall be liable for such failure.

8. All basic life support ambulances and stretcher vans operated in the state shall be equipped with epinephrine **[**~~auto-injectors~~**] delivery devices** and be staffed by at least one individual trained in the use of epinephrine **[**~~auto-injectors~~**] delivery devices**.

9. The provisions of this section shall apply in all counties within the state and any city not within a county.

10. Nothing in this section shall be construed as superseding the provisions of section 167.630.

197.708. Each hospital shall display in a prominent place within the waiting rooms of the emergency department and the labor and delivery department a printed sign with the following text in all capital letters: "WARNING: ASSAULTING A HEALTH CARE PROFESSIONAL WHO IS ENGAGED IN THE PERFORMANCE OF HIS OR HER OFFICIAL DUTIES, INCLUDING STRIKING A HEALTH CARE PROFESSIONAL WITH ANY BODILY FLUID, IS A SERIOUS CRIME AND WILL BE PROSECUTED TO THE FULLEST EXTENT OF THE LAW.".

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

(1) "Clinical pathology services", professional medical services provided by a pathologist for the examination, diagnosis, and interpretation of laboratory tests performed on patient specimens to aid in the diagnosis and treatment of disease. Clinical pathology services include, but are not limited to, hematology, microbiology, immunology, clinical chemistry, molecular pathology, and other laboratory-based diagnostic procedures;

(2) "Hospital-based pathologist", a licensed physician specializing in pathology who provides clinical pathology services within a hospital setting;

(3) "Professional component of clinical pathology services", the portion of clinical pathology services that involves the pathologist's professional expertise in interpreting and supervising laboratory tests, excluding the technical component of performing the laboratory tests.

2. The fee for the professional component of clinical pathology services shall be paid by MO HealthNet for professional services provided by a hospital-based pathologist for inpatient clinical pathology services rendered to patients covered by the MO HealthNet program.

3. The reimbursement amount for the professional component of clinical pathology services shall be set at thirty percent of the approved outpatient simplified fee schedule based on Medicare's clinical laboratory fee schedule for the corresponding clinical pathology services payable by MO HealthNet.

4. (1) If the fee for the professional component of clinical pathology services is paid for professional services provided by a pathologist employed by the hospital where

the clinical pathology services are rendered to covered MO HealthNet patients, the professional fee shall be paid directly to the hospital.

(2) If the fee for the professional component of clinical pathology services is paid for professional services provided by a pathologist who is not employed by the hospital where clinical pathology services are rendered to covered MO HealthNet patients, the professional fee shall be paid directly to the third party providing the services.

5. The department of social services shall promulgate all necessary rules and regulations for the administration of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2025, shall be invalid and void.

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as described in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section **[**~~301,~~**]** **1396** et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his **or her** plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he **or she** is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere, provided, that no funds shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate, as defined in section 188.015, of such abortion facility;

(7) Subject to appropriation, up to twenty visits per year for services limited to examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned articulations and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand MO HealthNet services;

(8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(9) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(10) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of **[**~~P.L.~~**]** **Pub. L.** 101-239 **(42 U.S.C. Sections 1396a and 1396d), as amended,** and federal regulations promulgated thereunder;

(11) Home health care services;

(12) Family planning as defined by federal rules and regulations; provided, that no funds shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate, as defined in section 188.015, of such abortion facility; and further provided, however, that such family planning services shall not include abortions or any abortifacient drug or device that is used for the purpose of inducing an abortion unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(13) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);

(14) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(15) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198**,** shall be authorized on a tier level based on

the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(16) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section **[**~~301~~**] 1396 et seq.**, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(17) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;

(18) The services of an advanced practice registered nurse with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

(19) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the

same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(20) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(21) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(22) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(24) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(25) **Doula services in accordance with sections 208.1400 to 208.1425;**

(26) Childbirth education classes for pregnant women and a support person;

(27) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as described in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a

nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to **an** optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. 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 subdivision 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, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (15) and (16) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required

payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that

would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).

10. The MO HealthNet division may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining eligibility under this section.

12. If the Missouri Medicaid audit and compliance unit changes any interpretation or application of the requirements for reimbursement for MO HealthNet services from the interpretation or application that has been applied previously by the state in any audit of a MO HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO HealthNet providers five business days before such change shall take effect. Failure of the Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to continue to receive and retain reimbursement until such notification is provided and shall waive any liability of such provider for recoupment or other loss of any payments previously made prior to the five business days after such notice has been sent. Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall agree to receive communications electronically. The notification required under this section shall be delivered in writing by the United States Postal Service or electronic mail to each provider.

13. Nothing in this section shall be construed to abrogate or limit the department's statutory requirement to promulgate rules under chapter 536.

14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems shall be reimbursed utilizing the behavior assessment and intervention reimbursement codes 96150 to 96154 or their successor codes under the Current Procedural Terminology (CPT) coding system. Providers eligible for such reimbursement shall include psychologists.

15. There shall be no payments made under this section for gender transition surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section 191.1720, for the purpose of a gender transition.

16. The department of social services shall study the impact that the childbirth education classes provided under subdivision (26) of subsection 1 of this section have on infant and maternal mortality among pregnant women. The department of social services shall submit a report to the general assembly with the results of the study before January 1, 2028.

208.662. 1. There is hereby established within the department of social services the "Show-Me Healthy Babies Program" as a separate children's health insurance program (CHIP) for any low-income unborn child. The program shall be established under the authority of Title XXI of the federal Social Security Act, the State Children's Health Insurance Program, as amended, and 42 CFR 457.1.

2. For an unborn child to be enrolled in the show-me healthy babies program, his or her mother shall not be eligible for coverage under Title XIX of the federal Social Security Act, the Medicaid program, as it is administered by the state, and shall not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. In addition, the unborn child shall be in a family with income eligibility of no more than three hundred percent of the federal poverty level, or the equivalent modified adjusted gross income, unless the income eligibility is set lower by the general assembly through appropriations. In calculating family size as it relates to income eligibility, the family shall include, in addition to other family members, the unborn child, or in the case of a mother with a multiple pregnancy, all unborn children.

3. Coverage for an unborn child enrolled in the show-me healthy babies program shall include all prenatal care and pregnancy-related services that benefit the health of the unborn child and that promote healthy labor, delivery, and birth**, including childbirth education classes**. Coverage need not include services that are solely for the benefit of the pregnant mother, that are unrelated to maintaining or promoting a healthy pregnancy, and that provide no benefit to the unborn child. However, the department may include pregnancy-related assistance as defined in 42 U.S.C. Section 1397ll.

4. There shall be no waiting period before an unborn child may be enrolled in the show-me healthy babies program. In accordance with the definition of child in 42 CFR 457.10, coverage shall include the period from conception to birth. The department shall develop a presumptive eligibility procedure for enrolling an unborn child. There shall be verification of the pregnancy.

5. Coverage for the child shall continue for up to one year after birth, unless otherwise prohibited by law or unless otherwise limited by the general assembly through appropriations.

6. (1) Pregnancy-related and postpartum coverage for the mother shall begin on the day the pregnancy ends and extend through the last day of the month that includes the sixtieth day after the pregnancy ends, unless otherwise prohibited by law or unless otherwise limited by the general assembly through appropriations. The department may include pregnancy-related assistance as defined in 42 U.S.C. Section 1397ll.

(2) (a) Subject to approval of any necessary state plan amendments or waivers, beginning on July 6, 2023, mothers eligible to receive coverage under this section shall receive medical assistance benefits during the pregnancy and during the twelve-month period

that begins on the last day of the woman's pregnancy and ends on the last day of the month in which such twelve-month period ends, consistent with the provisions of 42 U.S.C. Section 1397gg(e)(1)(J). The department shall seek any necessary state plan amendments or waivers to implement the provisions of this subdivision when the number of ineligible MO HealthNet participants removed from the program in 2023 pursuant to section 208.239 exceeds the projected number of beneficiaries likely to enroll in benefits in 2023 under this subdivision and subdivision (28) of subsection 1 of section 208.151, as determined by the department, by at least one hundred individuals.

(b) The provisions of this subdivision shall remain in effect for any period of time during which the federal authority under 42 U.S.C. Section 1397gg(e)(1)(J), as amended, or any successor statutes or implementing regulations, is in effect.

7. The department shall provide coverage for an unborn child enrolled in the show-me healthy babies program in the same manner in which the department provides coverage for the children's health insurance program (CHIP) in the county of the primary residence of the mother.

8. The department shall provide information about the show-me healthy babies program to maternity homes as defined in section 135.600, pregnancy resource centers as defined in section 135.630, and other similar agencies and programs in the state that assist unborn children and their mothers. The department shall consider allowing such agencies and programs to assist in the enrollment of unborn children in the program, and in making determinations about presumptive eligibility and verification of the pregnancy.

9. Within sixty days after August 28, 2014, the department shall submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the show-me healthy babies program.

10. At least annually, the department shall prepare and submit a report to the governor, the speaker of the house of representatives, and the president pro tempore of the senate analyzing and projecting the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement agencies, correctional centers, health care providers, employers, other public and private entities, and persons by enrolling unborn children in the show-me healthy babies program. The analysis and projection of cost savings and benefits, if any, may include but need not be limited to:

(1) The higher federal matching rate for having an unborn child enrolled in the show-me healthy babies program versus the lower federal matching rate for a pregnant woman being enrolled in MO HealthNet or other federal programs;

(2) The efficacy in providing services to unborn children through managed care organizations, group or individual health insurance providers or premium assistance, or through other nontraditional arrangements of providing health care;

(3) The change in the proportion of unborn children who receive care in the first trimester of pregnancy due to a lack of waiting periods, by allowing presumptive eligibility, or by removal of other barriers, and any resulting or projected decrease in health problems and other problems for unborn children and women throughout pregnancy; at labor, delivery, and birth; and during infancy and childhood;

(4) The change in healthy behaviors by pregnant women, such as the cessation of the use of tobacco, alcohol, illicit drugs, or other harmful practices, and any resulting or projected short-term and long-term decrease in birth defects; poor motor skills; vision, speech, and hearing problems; breathing and respiratory problems; feeding and digestive problems; and other physical, mental, educational, and behavioral problems; and

(5) The change in infant and maternal mortality, preterm births and low birth weight babies and any resulting or projected decrease in short-term and long-term medical and other interventions.

11. The show-me healthy babies program shall not be deemed an entitlement program, but instead shall be subject to a federal allotment or other federal appropriations and matching state appropriations.

12. Nothing in this section shall be construed as obligating the state to continue the show-me healthy babies program if the allotment or payments from the federal government end or are not sufficient for the program to operate, or if the general assembly does not appropriate funds for the program.

13. Nothing in this section shall be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state.

208.1400. Sections 208.1400 to 208.1425 shall be known and may be cited as the "Missouri Doula Reimbursement Act".

208.1405. For purposes of sections 208.1400 to 208.1425, the following terms mean:

(1) "Community-based network", a network that is representative of a community or significant segments of a community and engaged in meeting that community's needs in the area of social, human, or health services;

(2) "Community navigation services", services that connect pregnant individuals and their families with available resources using a community-based approach including, but not limited to, an approach that understands the services and supports available to pregnant and postpartum individuals receiving MO HealthNet benefits and facilitates access to those resources based upon an assessment of social service needs;

(3) "Doula", a trained professional providing continuous physical, emotional, and informational support to a pregnant individual, from the prenatal, the intrapartum,

and up to the first twelve months of the postpartum periods. Doulas also provide assistance by referring pregnant individuals to community-based networks and certified and licensed perinatal professionals in multiple disciplines;

(4) "Doula services", services provided by a doula;

(5) "Fee-for-service", a payment model where services are unbundled and paid for separately;

(6) "Intrapartum", the period of pregnancy during labor and delivery or childbirth. Services provided during this period are rendered to the pregnant individual;

(7) "Managed care", the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations that accept a set per member per month (capitation) payment for these services;

(8) "Postpartum", the one-year period after a pregnancy ends;

(9) "Prenatal", the period of pregnancy before labor or childbirth. Services provided during this period are rendered to the pregnant individual.

208.1410. The following doula services shall be covered by the MO HealthNet program:

(1) A combined total of six prenatal and postpartum support sessions;

(2) One birth attendance;

(3) Up to two visits for general consultation on lactation at any time during the prenatal and postpartum periods; and

(4) Community navigation services, except that any community navigation services provided outside any visit or session billed under subdivisions (1) to (3) of this section shall be billed only up to ten times total over the course of the pregnancy and postpartum period.

208.1415. A doula shall be eligible for participation as a provider of doula services covered by the MO HealthNet program only if the doula:

(1) Is enrolled as a MO HealthNet provider;

(2) Is eighteen years of age or older;

(3) Holds liability insurance as an individual or through a supervising organization; and

(4) Either:

(a) Possesses a current certificate issued by a national or Missouri-based doula training organization whose curriculum meets guidelines established by the MO HealthNet division by rule; or

(b) Received training from a source not described in paragraph (a) of this subdivision, or from multiple sources, whose curriculum meets the guidelines established under paragraph (a) of this subdivision as verified by a public roster maintained by a statewide organization composed of doula trainers from three or more independent, well-established doula training organizations located in Missouri whose purpose includes the validation of core competencies of training.

208.1420. 1. Once enrolled as a MO HealthNet provider, a doula shall be eligible to enroll as a provider with fee-for-service and managed care payers affiliated with the MO HealthNet program.

2. Doula services shall be reimbursed on a fee-for-service schedule.

208.1425. The MO HealthNet division shall promulgate all necessary rules and regulations for the administration of sections 208.1400 to 208.1425. 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, 2025, shall be invalid and void.

210.030. 1. Every licensed physician, midwife, registered nurse and all persons who may undertake, in a professional way, the obstetrical and gynecological care of a pregnant woman in the state of Missouri shall, if the woman consents, take or cause to be taken a sample of venous blood of such woman at the time of the first prenatal examination, or not later than twenty days after the first prenatal examination, **another sample at twenty-eight weeks of pregnancy, and another sample immediately after birth** and subject such **[**~~sample~~**] samples** to an approved and standard serological test for syphilis**[**~~, an~~**] and** approved serological **[**~~test~~**] tests** for hepatitis B**, hepatitis C, human immunodeficiency virus (HIV),** and such other treatable diseases and metabolic disorders as are prescribed by the department of health and senior services. **[**~~In any area of the state designated as a syphilis outbreak area by the department of health and senior services, if the mother consents, a sample of her venous blood shall be taken later in the course of pregnancy and at delivery for additional testing for syphilis as may be prescribed by the department~~**] If a mother tests positive for syphilis, hepatitis B, hepatitis C, or HIV, or any combination of such diseases, the physician or person providing care shall administer treatment in accordance with the most recent accepted medical practice**. If a mother tests positive for hepatitis B, the physician or person who professionally undertakes the pediatric care of a newborn shall also administer the appropriate doses of hepatitis B vaccine and hepatitis B immune globulin

(HBIG) in accordance with the current recommendations of the Advisory Committee on Immunization Practices (ACIP). If the mother's hepatitis B status is unknown, the appropriate dose of hepatitis B vaccine shall be administered to the newborn in accordance with the current ACIP recommendations. If the mother consents, a sample of her venous blood shall be taken. If she tests positive for hepatitis B, hepatitis B immune globulin (HBIG) shall be administered to the newborn in accordance with the current ACIP recommendations.

2. The department of health and senior services shall**[**~~, in consultation with the Missouri genetic disease advisory committee,~~**]** make such rules pertaining to such tests as shall be dictated by accepted medical practice, and tests shall be of the types approved **or accepted** by the **[**~~department of health and senior services. An approved and standard test for syphilis, hepatitis B, and other treatable diseases and metabolic disorders shall mean a test made in a laboratory approved by the department of health and senior services~~**] United States Food and Drug Administration**. No individual shall be denied testing by the department of health and senior services because of inability to pay.

3. Health care providers shall receive informed consent prior to administering any treatment or procedure.

210.225. 1. This section shall be known and may be cited as "Elijah's Law".

2. (1) Before July 1, 2027, each licensed child care provider shall adopt a policy on allergy prevention and response with priority given to addressing potentially deadly food-borne allergies. Such policy shall contain, but shall not be limited to, the following elements:

(a) Distinguishing between building-wide, room-level, and individual approaches to allergy prevention and management;

(b) Providing an age-appropriate response to building-level and room-level allergy education and prevention;

(c) Describing the role of child care facility staff in determining how to manage an allergy problem, whether through a plan prepared for a child under Section 504 of the Rehabilitation Act of 1973, as amended, for a child with an allergy that has been determined to be a disability, an individualized health plan for a child who has an allergy that is not disabling, or another allergy management plan;

(d) Describing the role of other children and parents in cooperating to prevent and mitigate allergies;

(e) Addressing confidentiality issues involved with sharing medical information, including specifying when parental permission is required to make medical information available; and

(f) Coordinating with the department of elementary and secondary education, local health authorities, and other appropriate entities to ensure efficient promulgation

of accurate information and to ensure that existing child care facility safety and environmental policies do not conflict.

(2) Such policies may contain information from or links to child care facility allergy prevention information furnished by the Food Allergy Research & Education organization or equivalent organization with a medical advisory board that has allergy specialists.

3. The department of elementary and secondary education shall, in cooperation with any appropriate professional association, develop a model policy or policies before July 1, 2026.

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

(1) "Epinephrine delivery device", a single-use device approved by the United States Food and Drug Administration that is used for the delivery of a premeasured dose of epinephrine into the human body;

(2) "Qualified first responder" **[**~~shall mean~~**],** any state and local law enforcement agency staff, fire department personnel, fire district personnel, or licensed emergency medical technician who is acting under the directives and established protocols of a medical director who comes in contact with a person suffering from an anaphylactic reaction and who has received training in recognizing and responding to anaphylactic reactions and the administration of epinephrine **[**~~auto-injector~~**] delivery** devices to a person suffering from an apparent anaphylactic reaction**[**~~.~~**];**

(3) "Qualified first responder agencies" **[**~~shall mean~~**],** any state or local law enforcement agency, fire department, or ambulance service that provides documented training to its staff related to the administration of epinephrine **[**~~auto-injector~~**] delivery** devices in an apparent anaphylactic reaction.

2. The director of the department of health and senior services, if a licensed physician, may issue a statewide standing order for epinephrine **[**~~auto-injector~~**] delivery** devices for adult patients to fire protection districts in nonmetropolitan areas in Missouri as such areas are determined according to the United States Census Bureau's American Community Survey, based on the most recent of five-year period estimate data in which the final year of the estimate ends in either zero or five. If the director of the department of health and senior services is not a licensed physician, the department of health and senior services may employ or contract with a licensed physician who may issue such a statewide order with the express consent of the director.

3. Possession and use of epinephrine **[**~~auto-injector~~**] delivery** devices for adult patients shall be limited as follows:

(1) No person shall use an epinephrine **[**~~auto-injector~~**] delivery** device pursuant to this section unless such person has successfully completed a training course in the use of

epinephrine **[**~~auto-injector~~**] delivery** devices for adult patients approved by the director of the department of health and senior services. Nothing in this section shall prohibit the use of an epinephrine **[**~~auto-injector~~**] delivery** device:

(a) By a health care professional licensed or certified by this state who is acting within the scope of his or her practice; or

(b) By a person acting pursuant to a lawful prescription;

(2) Every person, firm, organization and entity authorized to possess and use epinephrine **[**~~auto-injector~~**] delivery** devices for adult patients pursuant to this section shall use, maintain and dispose of such devices for adult patients in accordance with the rules of the department; **and**

(3) Every use of an epinephrine **[**~~auto-injector~~**] delivery** device pursuant to this section shall immediately be reported to the emergency health care provider as defined in section 190.246.

4. (1) Use of an epinephrine **[**~~auto-injector~~**] delivery** device pursuant to this section shall be considered first aid or emergency treatment for the purpose of any law relating to liability.

(2) Purchase, acquisition, possession or use of an epinephrine **[**~~auto-injector~~**] delivery** device pursuant to this section shall not constitute the unlawful practice of medicine or the unlawful practice of a profession.

(3) Any person otherwise authorized to sell or provide an epinephrine **[**~~auto-injector~~**] delivery** device may sell or provide it to a person authorized to possess it pursuant to this section.

5. (1) There is hereby created in the state treasury the "Epinephrine **[**~~Auto-injector~~**] Delivery** Devices for Fire Personnel Fund", which shall consist of **[**~~money collected under this section~~**] moneys appropriated to the fund**. 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 moneys in the fund as set forth in this section shall be subject to appropriation by the general assembly for the particular purpose for which collected. The fund shall be a dedicated fund and money in the fund shall be used solely by the department of health and senior services for the purposes of providing epinephrine **[**~~auto-injector~~**] delivery** devices for adult patients to qualified first responder agencies as used in 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.

332.211. **[**~~The board shall grant without examination a certificate of registration and a license to a dentist who has been licensed in another state for at least five consecutive years immediately preceding his applying, if the board is satisfied by proof adduced by the applicant that his qualifications are at least equivalent to the requirements for initial registration as a dentist in Missouri under the provisions of this chapter, that he is at least twenty one years of age and is of good moral character and reputation; provided that the board may by rule require an applicant under this section to take any examination over Missouri laws given to dentists initially seeking licensure under section 332.151 and to take a practical examination if his licensure in any state was ever denied, revoked or suspended for incompetency or inability to practice in a safe manner, or if he has failed any practical examination given as a prerequisite to licensure as a dentist in any state. Any such dentist applying to be so registered and licensed shall accompany his application with a fee not greater than the dental examination and license fees and if registered and licensed shall renew his license as provided in section 332.181.~~**]** **1. For purposes of this section, the following terms mean:**

(1) "License", a license, certificate, registration, permit, accreditation, or military occupational specialty that enables a person to legally practice an occupation or profession in a particular jurisdiction;

(2) "Military", the Armed Forces of the United States, including the Air Force, Army, Coast Guard, Marine Corps, Navy, Space Force, National Guard, and any other military branch that is designated by Congress as part of the Armed Forces of the United States, and all reserve components and auxiliaries. The term "military" also includes the military reserves and militia of any United States territory or state;

(3) "Nonresident military spouse", a nonresident spouse of an active duty member of the Armed Forces of the United States who has been transferred or is scheduled to be transferred to the state of Missouri, or who has been transferred or is scheduled to be transferred to an adjacent state and is or will be domiciled in the state of Missouri, or has moved to the state of Missouri on a permanent change-of-station basis;

(4) "Oversight body", any board, department, agency, or office of a jurisdiction that issues licenses;

(5) "Resident military spouse", a spouse of an active duty member of the Armed Forces of the United States who has been transferred or is scheduled to be transferred to the state of Missouri or an adjacent state and who is a permanent resident of the state of Missouri, who is domiciled in the state of Missouri, or who has Missouri as his or her home of record.

2. Any person who holds a valid current dentist license issued by another state, a branch or unit of the military, a territory of the United States, or the District of

Columbia, and who has been licensed for at least one year in such other jurisdiction, may submit to the board an application for a dentist license in Missouri along with proof of current licensure and proof of licensure for at least one year in the other jurisdiction.

3. The board shall:

(1) Within six months of receiving an application described in subsection 2 of this section, waive any examination, educational, or experience requirements for licensure in this state for the applicant if it determines that there were minimum education requirements and, if applicable, work experience and clinical supervision requirements in effect and the other jurisdiction verifies that the person met those requirements in order to be licensed or certified in that jurisdiction. The board may require an applicant to take and pass an examination specific to the laws of this state; or

(2) Within thirty days of receiving an application described in subsection 2 of this section from a nonresident military spouse or a resident military spouse, waive any examination, educational, or experience requirements for licensure in this state for the applicant and issue such applicant a license under this section if such applicant otherwise meets the requirements of this section.

4. (1) The board shall not waive any examination, educational, or experience requirements for any applicant who has had his or her license revoked by an oversight body outside the state; who is currently under investigation, who has a complaint pending, or who is currently under disciplinary action, except as provided in subdivision (2) of this subsection, with an oversight body outside the state; who does not hold a license in good standing with an oversight body outside the state; who has a criminal record that would disqualify him or her for licensure in Missouri; or who does not hold a valid current license in the other jurisdiction on the date the board receives his or her application under this section.

(2) If another jurisdiction has taken disciplinary action against an applicant, the board shall determine if the cause for the action was corrected and the matter resolved. If the matter has not been resolved by that jurisdiction, the board may deny a license until the matter is resolved.

5. Nothing in this section shall prohibit the board from denying a license to an applicant under this section for any reason described in section 332.321.

6. Any person who is licensed under the provisions of this section shall be subject to the board's jurisdiction and all rules and regulations pertaining to the practice as a dentist in this state.

7. This section shall not be construed to waive any requirement for an applicant to pay any fees.

332.281. **[**~~The board shall grant without examination a certificate of registration and license to a dental hygienist who has been licensed in another state for at least two consecutive years immediately preceding his application to practice in Missouri if the board is satisfied by proof adduced by the applicant that his qualifications are at least equivalent to the requirements for initial registration as a dental hygienist in Missouri under the provisions of this chapter; provided that the board may by rule require an applicant under this section to take any examination over Missouri laws given to dental hygienist initially seeking licensure under section 332.251 and to take a practical examination if his licensure in any state was ever denied, revoked or suspended for incompetency or inability to practice in a safe manner, or if he has failed any practical examination given as a prerequisite to licensure as a dental hygienist in any state. Any such dental hygienist applying to be so registered and licensed shall accompany his application with a fee not greater than the dental hygienist examination and license fees and if registered and licensed shall renew his license as provided in section 332.261.~~**] 1. For purposes of this section, the following terms mean:**

(1) "License", a license, certificate, registration, permit, accreditation, or military occupational specialty that enables a person to legally practice an occupation or profession in a particular jurisdiction;

(2) "Military", the Armed Forces of the United States, including the Air Force, Army, Coast Guard, Marine Corps, Navy, Space Force, National Guard, and any other military branch that is designated by Congress as part of the Armed Forces of the United States, and all reserve components and auxiliaries. The term "military" also includes the military reserves and militia of any United States territory or state;

(3) "Nonresident military spouse", a nonresident spouse of an active duty member of the Armed Forces of the United States who has been transferred or is scheduled to be transferred to the state of Missouri, or who has been transferred or is scheduled to be transferred to an adjacent state and is or will be domiciled in the state of Missouri, or has moved to the state of Missouri on a permanent change-of-station basis;

(4) "Oversight body", any board, department, agency, or office of a jurisdiction that issues licenses;

(5) "Resident military spouse", a spouse of an active duty member of the Armed Forces of the United States who has been transferred or is scheduled to be transferred to the state of Missouri or an adjacent state and who is a permanent resident of the state of Missouri, who is domiciled in the state of Missouri, or who has Missouri as his or her home of record.

2. Any person who holds a valid current dental hygienist license issued by another state, a branch or unit of the military, a territory of the United States, or the District of Columbia, and who has been licensed for at least one year in such other

jurisdiction, may submit to the board an application for a dental hygienist license in Missouri along with proof of current licensure and proof of licensure for at least one year in the other jurisdiction.

3. The board shall:

(1) Within six months of receiving an application described in subsection 2 of this section, waive any examination, educational, or experience requirements for licensure in this state for the applicant if it determines that there were minimum education requirements and, if applicable, work experience and clinical supervision requirements in effect and the other jurisdiction verifies that the person met those requirements in order to be licensed or certified in that jurisdiction. The board may require an applicant to take and pass an examination specific to the laws of this state; or

(2) Within thirty days of receiving an application described in subsection 2 of this section from a nonresident military spouse or a resident military spouse, waive any examination, educational, or experience requirements for licensure in this state for the applicant and issue such applicant a license under this section if such applicant otherwise meets the requirements of this section.

4. (1) The board shall not waive any examination, educational, or experience requirements for any applicant who has had his or her license revoked by an oversight body outside the state; who is currently under investigation, who has a complaint pending, or who is currently under disciplinary action, except as provided in subdivision (2) of this subsection, with an oversight body outside the state; who does not hold a license in good standing with an oversight body outside the state; who has a criminal record that would disqualify him or her for licensure in Missouri; or who does not hold a valid current license in the other jurisdiction on the date the board receives his or her application under this section.

(2) If another jurisdiction has taken disciplinary action against an applicant, the board shall determine if the cause for the action was corrected and the matter resolved. If the matter has not been resolved by that jurisdiction, the board may deny a license until the matter is resolved.

5. Nothing in this section shall prohibit the board from denying a license to an applicant under this section for any reason described in section 332.321.

6. Any person who is licensed under the provisions of this section shall be subject to the board's jurisdiction and all rules and regulations pertaining to the practice as a dental hygienist in this state.

7. This section shall not be construed to waive any requirement for an applicant to pay any fees.

332.700. Sections 332.700 to 332.760 shall be known and cited as the Dentist and Dental Hygienist Compact. The purposes of this Compact are to facilitate the interstate practice of dentistry and dental hygiene and improve public access to dentistry and dental hygiene services by providing Dentists and Dental Hygienists licensed in a Participating State the ability to practice in Participating States in which they are not licensed. The Compact does this by establishing a pathway for Dentists and Dental Hygienists licensed in a Participating State to obtain a Compact Privilege that authorizes them to practice in another Participating State in which they are not licensed. The Compact enables Participating States to protect the public health and safety with respect to the practice of such Dentists and Dental Hygienists, through the State's authority to regulate the practice of dentistry and dental hygiene in the State. The Compact:

(1) Enables Dentists and Dental Hygienists who qualify for a Compact Privilege to practice in other Participating States without satisfying burdensome and duplicative requirements associated with securing a License to practice in those States;

(2) Promotes mobility and addresses workforce shortages through each Participating State's acceptance of a Compact Privilege to practice in that State;

(3) Increases public access to qualified, licensed Dentists and Dental Hygienists by creating a responsible, streamlined pathway for Licensees to practice in Participating States;

(4) Enhances the ability of Participating States to protect the public's health and safety;

(5) Does not interfere with licensure requirements established by a Participating State;

(6) Facilitates the sharing of licensure and disciplinary information among Participating States;

(7) Requires Dentists and Dental Hygienists who practice in a Participating State pursuant to a Compact Privilege to practice within the Scope of Practice authorized in that State;

(8) Extends the authority of a Participating State to regulate the practice of dentistry and dental hygiene within its borders to Dentists and Dental Hygienists who practice in the State through a Compact Privilege;

(9) Promotes the cooperation of Participating States in regulating the practice of dentistry and dental hygiene within those States;

(10) Facilitates the relocation of military members and their spouses who are licensed to practice dentistry or dental hygiene.

332.705. As used in this Compact, unless the context requires otherwise, the following definitions shall apply:

(1) "Active Military Member" means any person with full-time duty status in the armed forces of the United States, including members of the National Guard and Reserve.

(2) "Adverse Action" means disciplinary action or encumbrance imposed on a License or Compact Privilege by a State Licensing Authority.

(3) "Alternative Program" means a non-disciplinary monitoring or practice remediation process applicable to a Dentist or Dental Hygienist approved by a State Licensing Authority of a Participating State in which the Dentist or Dental Hygienist is licensed. This includes, but is not limited to, programs to which Licensees with substance abuse or addiction issues are referred in lieu of Adverse Action.

(4) "Clinical Assessment" means examination or process, required for licensure as a Dentist or Dental Hygienist as applicable, that provides evidence of clinical competence in dentistry or dental hygiene.

(5) "Commissioner" means the individual appointed by a Participating State to serve as the member of the Commission for that Participating State.

(6) "Compact" means this Dentist and Dental Hygienist Compact.

(7) "Compact Privilege" means the authorization granted by a Remote State to allow a Licensee from a Participating State to practice as a Dentist or Dental Hygienist in a Remote State.

(8) "Continuing Professional Development" means a requirement, as a condition of License renewal to provide evidence of successful participation in educational or professional activities relevant to practice or area of work.

(9) "Criminal Background Check" means the submission of fingerprints or other biometric-based information for a License applicant for the purpose of obtaining that applicant's criminal history record information, as defined in 28 C.F.R. § 20.3(d) from the Federal Bureau of Investigation and the State's criminal history record repository as defined in 28 C.F.R. § 20.3(f).

(10) "Data System" means the Commission's repository of information about Licensees, including but not limited to examination, licensure, investigative, Compact Privilege, Adverse Action, and Alternative Program.

(11) "Dental Hygienist" means an individual who is licensed by a State Licensing Authority to practice dental hygiene.

(12) "Dentist" means an individual who is licensed by a State Licensing Authority to practice dentistry.

(13) "Dentist and Dental Hygienist Compact Commission" or "Commission" means a joint government agency established by this Compact comprised of each State that has enacted the Compact and a national administrative body comprised of a Commissioner from each State that has enacted the Compact.

(14) "Encumbered License" means a License that a State Licensing Authority has limited in any way other than through an Alternative Program.

(15) "Executive Board" means the Chair, Vice Chair, Secretary and Treasurer and any other Commissioners as may be determined by Commission Rule or bylaw.

(16) "Jurisprudence Requirement" means the assessment of an individual's knowledge of the laws and Rules governing the practice of dentistry or dental hygiene, as applicable, in a State.

(17) "License" means current authorization by a State, other than authorization pursuant to a Compact Privilege, or other privilege, for an individual to practice as a Dentist or Dental Hygienist in that State.

(18) "Licensee" means an individual who holds an unrestricted License from a Participating State to practice as a Dentist or Dental Hygienist in that State.

(19) "Model Compact" means the model for the Dentist and Dental Hygienist Compact on file with the Council of State Governments or other entity as designated by the Commission.

(20) "Participating State" means a State that has enacted the Compact and been admitted to the Commission in accordance with the provisions herein and Commission Rules.

(21) "Qualifying License" means a License that is not an Encumbered License issued by a Participating State to practice dentistry or dental hygiene.

(22) "Remote State" means a Participating State where a Licensee who is not licensed as a Dentist or Dental Hygienist is exercising or seeking to exercise the Compact Privilege.

(23) "Rule" means a regulation promulgated by an entity that has the force of law.

(24) "Scope of Practice" means the procedures, actions, and processes a Dentist or Dental Hygienist licensed in a State is permitted to undertake in that State and the circumstances under which the Licensee is permitted to undertake those procedures, actions and processes. Such procedures, actions and processes and the circumstances under which they may be undertaken may be established through means, including, but not limited to, statute, regulations, case law, and other processes available to the State Licensing Authority or other government agency.

(25) "Significant Investigative Information" means information, records, and documents received or generated by a State Licensing Authority pursuant to an investigation for which a determination has been made that there is probable cause to believe that the Licensee has violated a statute or regulation that is considered more than a minor infraction for which the State Licensing Authority could pursue Adverse Action against the Licensee.

(26) "State" means any state, commonwealth, district, or territory of the United States of America that regulates the practices of dentistry and dental hygiene.

(27) "State Licensing Authority" means an agency or other entity of a State that is responsible for the licensing and regulation of Dentists or Dental Hygienists.

332.710. 1. In order to join the Compact and thereafter continue as a Participating State, a State must:

(1) Enact a compact that is not materially different from the Model Compact as determined in accordance with Commission Rules;

(2) Participate fully in the Commission's Data System;

(3) Have a mechanism in place for receiving and investigating complaints about its Licensees and License applicants;

(4) Notify the Commission, in compliance with the terms of the Compact and Commission Rules, of any Adverse Action or the availability of Significant Investigative Information regarding a Licensee and License applicant;

(5) Fully implement a Criminal Background Check requirement, within a time frame established by Commission Rule, by receiving the results of a qualifying Criminal Background Check;

(6) Comply with the Commission Rules applicable to a Participating State;

(7) Accept the National Board Examinations of the Joint Commission on National Dental Examinations or another examination accepted by Commission Rule as a licensure examination;

(8) Accept for licensure that applicants for a Dentist License graduate from a predoctoral dental education program accredited by the Commission on Dental Accreditation, or another accrediting agency recognized by the United States Department of Education for the accreditation of dentistry and dental hygiene education programs, leading to the Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) degree;

(9) Accept for licensure that applicants for a Dental Hygienist License graduate from a dental hygiene education program accredited by the Commission on Dental Accreditation or another accrediting agency recognized by the United States

Department of Education for the accreditation of dentistry and dental hygiene education programs;

(10) Require for licensure that applicants successfully complete a Clinical Assessment;

(11) Have Continuing Professional Development requirements as a condition for License renewal; and

(12) Pay a participation fee to the Commission as established by Commission Rule.

2. Providing alternative pathways for an individual to obtain an unrestricted License does not disqualify a State from participating in the Compact.

3. When conducting a Criminal Background Check the State Licensing Authority shall:

(1) Consider that information in making a licensure decision;

(2) Maintain documentation of completion of the Criminal Background Check and background check information to the extent allowed by State and federal law; and

(3) Report to the Commission whether it has completed the Criminal Background Check and whether the individual was granted or denied a License.

4. A Licensee of a Participating State who has a Qualifying License in that State and does not hold an Encumbered License in any other Participating State, shall be issued a Compact Privilege in a Remote State in accordance with the terms of the Compact and Commission Rules. If a Remote State has a Jurisprudence Requirement a Compact Privilege will not be issued to the Licensee unless the Licensee has satisfied the Jurisprudence Requirement.

332.715. 1. To obtain and exercise the Compact Privilege under the terms and provisions of the Compact, the Licensee shall:

(1) Have a Qualifying License as a Dentist or Dental Hygienist in a Participating State;

(2) Be eligible for a Compact Privilege in any Remote State in accordance with subsections 4, 7, and 8 of this section;

(3) Submit to an application process whenever the Licensee is seeking a Compact Privilege;

(4) Pay any applicable Commission and Remote State fees for a Compact Privilege in the Remote State;

(5) Meet any Jurisprudence Requirement established by a Remote State in which the Licensee is seeking a Compact Privilege;

(6) Have passed a National Board Examination of the Joint Commission on National Dental Examinations or another examination accepted by Commission Rule;

(7) For a Dentist, have graduated from a predoctoral dental education program accredited by the Commission on Dental Accreditation, or another accrediting agency recognized by the United States Department of Education for the accreditation of dentistry and dental hygiene education programs, leading to the Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) degree;

(8) For a Dental Hygienist, have graduated from a dental hygiene education program accredited by the Commission on Dental Accreditation or another accrediting agency recognized by the United States Department of Education for the accreditation of dentistry and dental hygiene education programs;

(9) Have successfully completed a Clinical Assessment for licensure;

(10) Report to the Commission Adverse Action taken by any non-Participating State when applying for a Compact Privilege and, otherwise, within thirty (30) days from the date the Adverse Action is taken;

(11) Report to the Commission when applying for a Compact Privilege the address of the Licensee's primary residence and thereafter immediately report to the Commission any change in the address of the Licensee's primary residence; and

(12) Consent to accept service of process by mail at the Licensee's primary residence on record with the Commission with respect to any action brought against the Licensee by the Commission or a Participating State, and consent to accept service of a subpoena by mail at the Licensee's primary residence on record with the Commission with respect to any action brought or investigation conducted by the Commission or a Participating State.

2. The Licensee must comply with the requirements of subsection 1 of this section to maintain the Compact Privilege in the Remote State. If those requirements are met, the Compact Privilege will continue as long as the Licensee maintains a Qualifying License in the State through which the Licensee applied for the Compact Privilege and pays any applicable Compact Privilege renewal fees.

3. A Licensee providing dentistry or dental hygiene in a Remote State under the Compact Privilege shall function within the Scope of Practice authorized by the Remote State for a Dentist or Dental Hygienist licensed in that State.

4. A Licensee providing dentistry or dental hygiene pursuant to a Compact Privilege in a Remote State is subject to that State's regulatory authority. A Remote State may, in accordance with due process and that State's laws, by Adverse Action revoke or remove a Licensee's Compact Privilege in the Remote State for a specific period of time and impose fines or take any other necessary actions to protect the health and safety of its citizens. If a Remote State imposes an Adverse Action against a Compact Privilege that limits the Compact Privilege, that Adverse Action applies to all

Compact Privileges in all Remote States. A Licensee whose Compact Privilege in a Remote State is removed for a specified period of time is not eligible for a Compact Privilege in any other Remote State until the specific time for removal of the Compact Privilege has passed and all encumbrance requirements are satisfied.

5. If a License in a Participating State is an Encumbered License, the Licensee shall lose the Compact Privilege in a Remote State and shall not be eligible for a Compact Privilege in any Remote State until the License is no longer encumbered.

6. Once an Encumbered License in a Participating State is restored to good standing, the Licensee must meet the requirements of subsection 1 of this section to obtain a Compact Privilege in a Remote State.

7. If a Licensee's Compact Privilege in a Remote State is removed by the Remote State, the individual shall lose or be ineligible for the Compact Privilege in any Remote State until the following occur:

(1) The specific period of time for which the Compact Privilege was removed has ended; and

(2) All conditions for removal of the Compact Privilege have been satisfied.

8. Once the requirements of subsection 7 of this section have been met, the Licensee must meet the requirements in subsection 1 of this section to obtain a Compact Privilege in a Remote State.

332.720. An Active Military Member and their spouse shall not be required to pay to the Commission for a Compact Privilege the fee otherwise charged by the Commission. If a Remote State chooses to charge a fee for a Compact Privilege, it may choose to charge a reduced fee or no fee to an Active Military Member and their spouse for a Compact Privilege.

332.725. 1. A Participating State in which a Licensee is licensed shall have exclusive authority to impose Adverse Action against the Qualifying License issued by that Participating State.

2. A Participating State may take Adverse Action based on the Significant Investigative Information of a Remote State, so long as the Participating State follows its own procedures for imposing Adverse Action.

3. Nothing in this Compact shall override a Participating State's decision that participation in an Alternative Program may be used in lieu of Adverse Action and that such participation shall remain non-public if required by the Participating State's laws. Participating States must require Licensees who enter any Alternative Program in lieu of discipline to agree not to practice pursuant to a Compact Privilege in any other Participating State during the term of the Alternative Program without prior authorization from such other Participating State.

4. Any Participating State in which a Licensee is applying to practice or is practicing pursuant to a Compact Privilege may investigate actual or alleged violations of the statutes and regulations authorizing the practice of dentistry or dental hygiene in any other Participating State in which the Dentist or Dental Hygienist holds a License or Compact Privilege.

5. A Remote State shall have the authority to:

(1) Take Adverse Actions as set forth in subsection 4 of section 332.715 against a Licensee's Compact Privilege in the State;

(2) In furtherance of its rights and responsibilities under the Compact and the Commission's Rules issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a State Licensing Authority in a Participating State for the attendance and testimony of witnesses, or the production of evidence from another Participating State, shall be enforced in the latter State by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the State where the witnesses or evidence are located; and

(3) If otherwise permitted by State law, recover from the Licensee the costs of investigations and disposition of cases resulting from any Adverse Action taken against that Licensee.

6. (1) In addition to the authority granted to a Participating State by its Dentist or Dental Hygienist licensure act or other applicable State law, a Participating State may jointly investigate Licensees with other Participating States.

(2) Participating States shall share any Significant Investigative Information, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

7. (1) After a Licensee's Compact Privilege in a Remote State is terminated, the Remote State may continue an investigation of the Licensee that began when the Licensee had a Compact Privilege in that Remote State.

(2) If the investigation yields what would be Significant Investigative Information had the Licensee continued to have a Compact Privilege in that Remote State, the Remote State shall report the presence of such information to the Data System as required by subdivision (6) of subsection 2 of section 332.735 as if it was Significant Investigative Information.

332.730. 1. The Compact Participating States hereby create and establish a joint government agency whose membership consists of all Participating States that have

enacted the Compact. The Commission is an instrumentality of the Participating States acting jointly and not an instrumentality of any one State. The Commission shall come into existence on or after the effective date of the Compact as set forth in subsection 1 of section 332.750.

2. (1) Each Participating State shall have and be limited to one (1) Commissioner selected by that Participating State's State Licensing Authority or, if the State has more than one State Licensing Authority, selected collectively by the State Licensing Authorities.

(2) The Commissioner shall be a member or designee of such Authority or Authorities.

(3) The Commission may by Rule or bylaw establish a term of office for Commissioners and may by Rule or bylaw establish term limits.

(4) The Commission may recommend to a State Licensing Authority or Authorities, as applicable, removal or suspension of an individual as the State's Commissioner.

(5) A Participating State's State Licensing Authority, or Authorities, as applicable, shall fill any vacancy of its Commissioner on the Commission within sixty (60) days of the vacancy.

(6) Each Commissioner shall be entitled to one vote on all matters that are voted upon by the Commission.

(7) The Commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws. The Commission may meet by telecommunication, video conference or other similar electronic means.

3. The Commission shall have the following powers:

(1) Establish the fiscal year of the Commission;

(2) Establish a code of conduct and conflict of interest policies;

(3) Adopt Rules and bylaws;

(4) Maintain its financial records in accordance with the bylaws;

(5) Meet and take such actions as are consistent with the provisions of this Compact, the Commission's Rules, and the bylaws;

(6) Initiate and conclude legal proceedings or actions in the name of the Commission, provided that the standing of any State Licensing Authority to sue or be sued under applicable law shall not be affected;

(7) Maintain and certify records and information provided to a Participating State as the authenticated business records of the Commission, and designate a person to do so on the Commission's behalf;

(8) Purchase and maintain insurance and bonds;

(9) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Participating State;

(10) Conduct an annual financial review;

(11) Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

(12) As set forth in the Commission Rules, charge a fee to a Licensee for the grant of a Compact Privilege in a Remote State and thereafter, as may be established by Commission Rule, charge the Licensee a Compact Privilege renewal fee for each renewal period in which that Licensee exercises or intends to exercise the Compact Privilege in that Remote State. Nothing herein shall be construed to prevent a Remote State from charging a Licensee a fee for a Compact Privilege or renewals of a Compact Privilege, or a fee for the Jurisprudence Requirement if the Remote State imposes such a requirement for the grant of a Compact Privilege;

(13) Accept any and all appropriate gifts, donations, grants of money, other sources of revenue, equipment, supplies, materials, and services, and receive, utilize, and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety and/or conflict of interest;

(14) Lease, purchase, retain, own, hold, improve, or use any property, real, personal, or mixed, or any undivided interest therein;

(15) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

(16) Establish a budget and make expenditures;

(17) Borrow money;

(18) Appoint committees, including standing committees, which may be composed of members, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

(19) Provide and receive information from, and cooperate with, law enforcement agencies;

(20) Elect a Chair, Vice Chair, Secretary and Treasurer and such other officers of the Commission as provided in the Commission's bylaws;

(21) Establish and elect an Executive Board;

(22) Adopt and provide to the Participating States an annual report;

(23) Determine whether a State's enacted compact is materially different from the Model Compact language such that the State would not qualify for participation in the Compact; and

(24) Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact.

4. (1) All meetings of the Commission that are not closed pursuant to this subsection shall be open to the public. Notice of public meetings shall be posted on the Commission's website at least thirty (30) days prior to the public meeting.

(2) Notwithstanding subdivision (1) of this subsection, the Commission may convene an emergency public meeting by providing at least twenty-four (24) hours prior notice on the Commission's website, and any other means as provided in the Commission's Rules, for any of the reasons it may dispense with notice of proposed rulemaking under subsection 12 of section 332.740. The Commission's legal counsel shall certify that one of the reasons justifying an emergency public meeting has been met.

(3) Notice of all Commission meetings shall provide the time, date, and location of the meeting, and if the meeting is to be held or accessible via telecommunication, video conference, or other electronic means, the notice shall include the mechanism for access to the meeting through such means.

(4) The Commission may convene in a closed, non-public meeting for the Commission to receive legal advice or to discuss:

(a) Non-compliance of a Participating State with its obligations under the Compact;

(b) The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

(c) Current or threatened discipline of a Licensee or Compact Privilege holder by the Commission or by a Participating State's Licensing Authority;

(d) Current, threatened, or reasonably anticipated litigation;

(e) Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

(f) Accusing any person of a crime or formally censuring any person;

(g) Trade secrets or commercial or financial information that is privileged or confidential;

(h) Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(i) Investigative records compiled for law enforcement purposes;

(j) Information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact;

(k) Legal advice;

(l) Matters specifically exempted from disclosure to the public by federal or Participating State law; and

(m) Other matters as promulgated by the Commission by Rule.

(5) If a meeting, or portion of a meeting, is closed, the presiding officer shall state that the meeting will be closed and reference each relevant exempting provision, and such reference shall be recorded in the minutes.

(6) The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

5. (1) The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate sources of revenue, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Participating State and impose fees on Licensees of Participating States when a Compact Privilege is granted, to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each fiscal year for which sufficient revenue is not provided by other sources. The aggregate annual assessment amount for Participating States shall be allocated based upon a formula that the Commission shall promulgate by Rule.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any Participating State, except by and with the authority of the Participating State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the financial review and accounting procedures established under its bylaws. All receipts and disbursements of funds handled by the Commission shall be subject to an annual financial review by a certified or licensed public accountant, and the report of

the financial review shall be included in and become part of the annual report of the Commission.

6. (1) The Executive Board shall have the power to act on behalf of the Commission according to the terms of this Compact. The powers, duties, and responsibilities of the Executive Board shall include:

(a) Overseeing the day-to-day activities of the administration of the Compact including compliance with the provisions of the Compact, the Commission's Rules and bylaws;

(b) Recommending to the Commission changes to the Rules or bylaws, changes to this Compact legislation, fees charged to Compact Participating States, fees charged to Licensees, and other fees;

(c) Ensuring Compact administration services are appropriately provided, including by contract;

(d) Preparing and recommending the budget;

(e) Maintaining financial records on behalf of the Commission;

(f) Monitoring Compact compliance of Participating States and providing compliance reports to the Commission;

(g) Establishing additional committees as necessary;

(h) Exercising the powers and duties of the Commission during the interim between Commission meetings, except for adopting or amending Rules, adopting or amending bylaws, and exercising any other powers and duties expressly reserved to the Commission by Rule or bylaw; and

(i) Other duties as provided in the Rules or bylaws of the Commission.

(2) The Executive Board shall be composed of up to seven (7) members:

(a) The Chair, Vice Chair, Secretary and Treasurer of the Commission and any other members of the Commission who serve on the Executive Board shall be voting members of the Executive Board; and

(b) Other than the Chair, Vice Chair, Secretary, and Treasurer, the Commission may elect up to three (3) voting members from the current membership of the Commission.

(3) The Commission may remove any member of the Executive Board as provided in the Commission's bylaws.

(4) The Executive Board shall meet at least annually.

(a) An Executive Board meeting at which it takes or intends to take formal action on a matter shall be open to the public, except that the Executive Board may meet in a closed, non-public session of a public meeting when dealing with any of the matters covered under subdivision (4) of subsection 4 of this section.

(b) The Executive Board shall give five (5) business days' notice of its public meetings, posted on its website and as it may otherwise determine to provide notice to persons with an interest in the public matters the Executive Board intends to address at those meetings.

(5) The Executive Board may hold an emergency meeting when acting for the Commission to:

(a) Meet an imminent threat to public health, safety, or welfare;

(b) Prevent a loss of Commission or Participating State funds; or

(c) Protect public health and safety.

7. (1) The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, both personally and in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this subdivision shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person. The procurement of insurance of any type by the Commission shall not in any way compromise or limit the immunity granted hereunder.

(2) The Commission shall defend any member, officer, executive director, employee, and representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or as determined by the Commission that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining their own counsel at their own expense; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) Notwithstanding subdivision (1) of this subsection, should any member, officer, executive director, employee, or representative of the Commission be held liable for the amount of any settlement or judgment arising out of any actual or alleged act, error, or omission that occurred within the scope of that individual's employment, duties, or responsibilities for the Commission, or that the person to whom that individual is liable had a reasonable basis for believing occurred within the scope of the individual's employment, duties, or responsibilities for the Commission, the

Commission shall indemnify and hold harmless such individual, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of the individual.

(4) Nothing herein shall be construed as a limitation on the liability of any Licensee for professional malpractice or misconduct, which shall be governed solely by any other applicable State laws.

(5) Nothing in this Compact shall be interpreted to waive or otherwise abrogate a Participating State's state action immunity or state action affirmative defense with respect to antitrust claims under the Sherman Act, Clayton Act, or any other State or federal antitrust or anticompetitive law or regulation.

(6) Nothing in this Compact shall be construed to be a waiver of sovereign immunity by the Participating States or by the Commission.

332.735. 1. The Commission shall provide for the development, maintenance, operation, and utilization of a coordinated database and reporting system containing licensure, Adverse Action, and the presence of Significant Investigative Information on all Licensees and applicants for a License in Participating States.

2. Notwithstanding any other provision of State law to the contrary, a Participating State shall submit a uniform data set to the Data System on all individuals to whom this Compact is applicable as required by the Rules of the Commission, including:

(1) Identifying information;

(2) Licensure data;

(3) Adverse Actions against a Licensee, License applicant or Compact Privilege and information related thereto;

(4) Non-confidential information related to Alternative Program participation, the beginning and ending dates of such participation, and other information related to such participation;

(5) Any denial of an application for licensure, and the reason or reasons for such denial, (excluding the reporting of any criminal history record information where prohibited by law);

(6) The presence of Significant Investigative Information; and

(7) Other information that may facilitate the administration of this Compact or the protection of the public, as determined by the Rules of the Commission.

3. The records and information provided to a Participating State pursuant to this Compact or through the Data System, when certified by the Commission or an agent thereof, shall constitute the authenticated business records of the Commission,

and shall be entitled to any associated hearsay exception in any relevant judicial, quasi-judicial or administrative proceedings in a Participating State.

4. Significant Investigative Information pertaining to a Licensee in any Participating State will only be available to other Participating States.

5. It is the responsibility of the Participating States to monitor the database to determine whether Adverse Action has been taken against a Licensee or License applicant. Adverse Action information pertaining to a Licensee or License applicant in any Participating State will be available to any other Participating State.

6. Participating States contributing information to the Data System may designate information that may not be shared with the public without the express permission of the contributing State.

7. Any information submitted to the Data System that is subsequently expunged pursuant to federal law or the laws of the Participating State contributing the information shall be removed from the Data System.

332.740. 1. The Commission shall promulgate reasonable Rules in order to effectively and efficiently implement and administer the purposes and provisions of the Compact. A Commission Rule shall be invalid and have no force or effect only if a court of competent jurisdiction holds that the Rule is invalid because the Commission exercised its rulemaking authority in a manner that is beyond the scope and purposes of the Compact, or the powers granted hereunder, or based upon another applicable standard of review.

2. The Rules of the Commission shall have the force of law in each Participating State, provided however that where the Rules of the Commission conflict with the laws of the Participating State that establish the Participating State's Scope of Practice as held by a court of competent jurisdiction, the Rules of the Commission shall be ineffective in that State to the extent of the conflict.

3. The Commission shall exercise its Rulemaking powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules shall become binding as of the date specified by the Commission for each Rule.

4. If a majority of the legislatures of the Participating States rejects a Commission Rule or portion of a Commission Rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, within four (4) years of the date of adoption of the Rule, then such Rule shall have no further force and effect in any Participating State or to any State applying to participate in the Compact.

5. Rules shall be adopted at a regular or special meeting of the Commission.

6. Prior to adoption of a proposed Rule, the Commission shall hold a public hearing and allow persons to provide oral and written comments, data, facts, opinions, and arguments.

7. Prior to adoption of a proposed Rule by the Commission, and at least thirty (30) days in advance of the meeting at which the Commission will hold a public hearing on the proposed Rule, the Commission shall provide a Notice of Proposed Rulemaking:

(1) On the website of the Commission or other publicly accessible platform;

(2) To persons who have requested notice of the Commission's notices of proposed rulemaking; and

(3) In such other way or ways as the Commission may by Rule specify.

8. The Notice of Proposed Rulemaking shall include:

(1) The time, date, and location of the public hearing at which the Commission will hear public comments on the proposed Rule and, if different, the time, date, and location of the meeting where the Commission will consider and vote on the proposed Rule;

(2) If the hearing is held via telecommunication, video conference, or other electronic means, the Commission shall include the mechanism for access to the hearing in the Notice of Proposed Rulemaking;

(3) The text of the proposed Rule and the reason therefor;

(4) A request for comments on the proposed Rule from any interested person; and

(5) The manner in which interested persons may submit written comments.

9. All hearings will be recorded. A copy of the recording and all written comments and documents received by the Commission in response to the proposed Rule shall be available to the public.

10. Nothing in this section shall be construed as requiring a separate hearing on each Commission Rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

11. The Commission shall, by majority vote of all Commissioners, take final action on the proposed Rule based on the rulemaking record.

(1) The Commission may adopt changes to the proposed Rule provided the changes do not enlarge the original purpose of the proposed Rule.

(2) The Commission shall provide an explanation of the reasons for substantive changes made to the proposed Rule as well as reasons for substantive changes not made that were recommended by commenters.

(3) The Commission shall determine a reasonable effective date for the Rule. Except for an emergency as provided in subsection 12 of this section, the effective date

of the Rule shall be no sooner than thirty (30) days after the Commission issuing the notice that it adopted or amended the Rule.

12. Upon determination that an emergency exists, the Commission may consider and adopt an emergency Rule with 24 hours' notice, with opportunity to comment, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the Rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the Rule. For the purposes of this provision, an emergency Rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;

(2) Prevent a loss of Commission or Participating State funds;

(3) Meet a deadline for the promulgation of a Rule that is established by federal law or rule; or

(4) Protect public health and safety.

13. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted Rule for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a Rule. A challenge shall be made in writing and delivered to the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

14. No Participating State's rulemaking requirements shall apply under this Compact.

332.745. 1. (1) The executive and judicial branches of State government in each Participating State shall enforce this Compact and take all actions necessary and appropriate to implement the Compact.

(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings. Nothing herein shall affect or limit the selection or propriety of venue in any action against a Licensee for professional malpractice, misconduct or any such similar matter.

(3) The Commission shall be entitled to receive service of process in any proceeding regarding the enforcement or interpretation of the Compact or Commission

Rule and shall have standing to intervene in such a proceeding for all purposes. Failure to provide the Commission service of process shall render a judgment or order void as to the Commission, this Compact, or promulgated Rules.

2. (1) If the Commission determines that a Participating State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated Rules, the Commission shall provide written notice to the defaulting State. The notice of default shall describe the default, the proposed means of curing the default, and any other action that the Commission may take, and shall offer training and specific technical assistance regarding the default.

(2) The Commission shall provide a copy of the notice of default to the other Participating States.

3. If a State in default fails to cure the default, the defaulting State may be terminated from the Compact upon an affirmative vote of a majority of the Commissioners, and all rights, privileges and benefits conferred on that State by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending State of obligations or liabilities incurred during the period of default.

4. Termination of participation in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting State's legislature, the defaulting State's State Licensing Authority or Authorities, as applicable, and each of the Participating States' State Licensing Authority or Authorities, as applicable.

5. A State that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

6. Upon the termination of a State's participation in this Compact, that State shall immediately provide notice to all Licensees of the State, including Licensees of other Participating States issued a Compact Privilege to practice within that State, of such termination. The terminated State shall continue to recognize all Compact Privileges then in effect in that State for a minimum of one hundred eighty (180) days after the date of said notice of termination.

7. The Commission shall not bear any costs related to a State that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting State.

8. The defaulting State may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the

Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

9. (1) Upon request by a Participating State, the Commission shall attempt to resolve disputes related to the Compact that arise among Participating States and between Participating States and non-Participating States.

(2) The Commission shall promulgate a Rule providing for both mediation and binding dispute resolution for disputes as appropriate.

10. (1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions of this Compact and the Commission's Rules.

(2) By majority vote, the Commission may initiate legal action against a Participating State in default in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of the Compact and its promulgated Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or the defaulting Participating State's law.

(3) A Participating State may initiate legal action against the Commission in the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of the Compact and its promulgated Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

(4) No individual or entity other than a Participating State may enforce this Compact against the Commission.

332.750. 1. The Compact shall come into effect on the date on which the Compact statute is enacted into law in the seventh Participating State.

(1) On or after the effective date of the Compact, the Commission shall convene and review the enactment of each of the States that enacted the Compact prior to the Commission convening ("Charter Participating States") to determine if the statute enacted by each such Charter Participating State is materially different than the Model Compact.

(a) A Charter Participating State whose enactment is found to be materially different from the Model Compact shall be entitled to the default process set forth in section 332.745.

(b) If any Participating State is later found to be in default, or is terminated or withdraws from the Compact, the Commission shall remain in existence and the Compact shall remain in effect even if the number of Participating States should be less than seven (7).

(2) Participating States enacting the Compact subsequent to the Charter Participating States shall be subject to the process set forth in subdivision (23) of subsection 3 of section 332.730 to determine if their enactments are materially different from the Model Compact and whether they qualify for participation in the Compact.

(3) All actions taken for the benefit of the Commission or in furtherance of the purposes of the administration of the Compact prior to the effective date of the Compact or the Commission coming into existence shall be considered to be actions of the Commission unless specifically repudiated by the Commission.

(4) Any State that joins the Compact subsequent to the Commission's initial adoption of the Rules and bylaws shall be subject to the Commission's Rules and bylaws as they exist on the date on which the Compact becomes law in that State. Any Rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that State.

2. Any Participating State may withdraw from this Compact by enacting a statute repealing that State's enactment of the Compact.

(1) A Participating State's withdrawal shall not take effect until one hundred eighty (180) days after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Licensing Authority or Authorities to comply with the investigative and Adverse Action reporting requirements of this Compact prior to the effective date of withdrawal.

(3) Upon the enactment of a statute withdrawing from this Compact, the State shall immediately provide notice of such withdrawal to all Licensees within that State. Notwithstanding any subsequent statutory enactment to the contrary, such withdrawing State shall continue to recognize all Compact Privileges to practice within that State granted pursuant to this Compact for a minimum of one hundred eighty (180) days after the date of such notice of withdrawal.

3. Nothing contained in this Compact shall be construed to invalidate or prevent any licensure agreement or other cooperative arrangement between a Participating State and a non-Participating State that does not conflict with the provisions of this Compact.

4. This Compact may be amended by the Participating States. No amendment to this Compact shall become effective and binding upon any Participating State until it is enacted into the laws of all Participating States.

332.755. 1. This Compact and the Commission's rulemaking authority shall be liberally construed so as to effectuate the purposes, and the implementation and administration of the Compact. Provisions of the Compact expressly authorizing or requiring the promulgation of Rules shall not be construed to limit the Commission's rulemaking authority solely for those purposes.

2. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is held by a court of competent jurisdiction to be contrary to the constitution of any Participating State, a State seeking participation in the Compact, or of the United States, or the applicability thereof to any government, agency, person or circumstance is held to be unconstitutional by a court of competent jurisdiction, the validity of the remainder of this Compact and the applicability thereof to any other government, agency, person or circumstance shall not be affected thereby.

3. Notwithstanding subsection 2 of this section, the Commission may deny a State's participation in the Compact or, in accordance with the requirements of subsection 2 of section 332.745, terminate a Participating State's participation in the Compact, if it determines that a constitutional requirement of a Participating State is a material departure from the Compact. Otherwise, if this Compact shall be held to be contrary to the constitution of any Participating State, the Compact shall remain in full force and effect as to the remaining Participating States and in full force and effect as to the Participating State affected as to all severable matters.

332.760. 1. Nothing herein shall prevent or inhibit the enforcement of any other law of a Participating State that is not inconsistent with the Compact.

2. Any laws, statutes, regulations, or other legal requirements in a Participating State in conflict with the Compact are superseded to the extent of the conflict.

3. All permissible agreements between the Commission and the Participating States are binding in accordance with their terms.

338.333. 1. Except as otherwise provided by the board of pharmacy by rule in the event of an emergency or to alleviate a supply shortage, no person or distribution outlet shall act as a wholesale drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider without first obtaining license to do so from the Missouri board of pharmacy and paying the required fee. The board may grant temporary licenses when the wholesale drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider first applies for a license to operate within the state. Temporary licenses shall remain valid until such time as the board shall find that the applicant meets or fails to meet the requirements for regular licensure. No license shall be issued or renewed for a wholesale drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider to operate unless the same shall be operated in a manner prescribed by law and according to the

rules and regulations promulgated by the board of pharmacy with respect thereto. Separate licenses shall be required for each distribution site owned or operated by a wholesale drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider, unless such drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider meets the requirements of section 338.335.

2. An agent or employee of any licensed or registered wholesale drug distributor, pharmacy distributor, drug outsourcer, or third-party logistics provider need not seek licensure under this section and may lawfully possess pharmaceutical drugs, if the agent or employee is acting in the usual course of his or her business or employment.

3. The board may permit out-of-state wholesale drug distributors, drug outsourcers, third-party logistics **[**~~provider~~**]** **providers**, or out-of-state pharmacy distributors to be licensed as required by sections 338.210 to 338.370 on the basis of reciprocity to the extent that the entity both:

(1) Possesses a valid license granted by another state pursuant to legal standards comparable to those which must be met by a wholesale drug distributor, pharmacy distributor, drug **[**~~outsourcers~~**]** **outsourcer**, or third-party logistics provider of this state as prerequisites for obtaining a license under the laws of this state**. If a state license is not issued by their resident state, out-of-state wholesale drug distributors and third-party logistics providers with a current and valid drug distributor accreditation from the National Association of Boards of Pharmacy or its successor may be eligible for licensure as provided by the board by rule**; and

(2) Distributes into Missouri from a state which would extend reciprocal treatment under its own laws to a wholesale drug distributor, pharmacy distributor, drug outsourcers, or third-party logistics provider of this state.

376.1240. 1. For purposes of this section, terms shall have the same meanings as ascribed to them in section 376.1350, and the term "self-administered hormonal contraceptive" shall mean a drug that is composed of one or more hormones and that is approved by the Food and Drug Administration to prevent pregnancy, excluding emergency contraception. Nothing in this section shall be construed to apply to medications approved by the Food and Drug Administration to terminate an existing pregnancy.

2. Any health benefit plan delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2026, that provides coverage for self-administered hormonal contraceptives shall provide coverage to reimburse a health care provider or dispensing entity for the dispensing of a supply of self-administered hormonal contraceptives intended to last up to one year.

3. The coverage required under this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the health benefit plan.

376.1245. 1. As used in this section, the following terms mean:

(1) "Anesthesia time", the period during which an anesthesia practitioner is present with the patient, starting when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ending when the anesthesia practitioner is no longer furnishing anesthesia services to the patient because the patient may be placed safely under postoperative or postanesthesia care. The term "anesthesia time" includes, if counted by the anesthesia practitioner, blocks of time around an interruption in anesthesia time provided the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption;

(2) "Anesthesia time units", time units recognized with appropriate time intervals that do not exceed fifteen minutes in length for each interval and that, taken together, represent the total anesthesia time for a particular anesthesia service;

(3) "Excepted benefit plan", the same meaning given to the term in section 376.998;

(4) "Health benefit plan", the same meaning given to the term in section 376.1350. The term "health benefit plan" shall also include the Missouri consolidated health care plan established under chapter 103;

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

(6) "Payment of anesthesia services", an amount paid for anesthesia services:

(a) Determined by using prevailing medical coding and billing standards in the professional medical billing community, such as the Current Procedural Terminology code book published by the American Medical Association, the Medicare Claims Processing Manual, or guidance from nationally recognized anesthesia organizations; and

(b) Calculated as the product obtained by multiplying the following together:

a. The sum of the base units for the appropriate medical code plus anesthesia time units and modifying units; and

b. An anesthesia conversion factor that is defined in the individual contract between the health carrier or health benefit plan and the anesthesia practitioner or group.

2. No health carrier or health benefit plan shall establish, implement, or enforce any policy, practice, or procedure that imposes a time limit for the payment of anesthesia services provided during a medical or surgical procedure.

3. No health carrier or health benefit plan shall establish, implement, or enforce any policy, practice, or procedure that restricts or excludes all anesthesia time in calculating the payment of anesthesia services.

4. Excepted benefit plans shall be subject to the requirements of this section.

5. The provisions of this section shall apply to health carriers that offer or issue health benefit plans that are delivered, issued for delivery, continued, or renewed in this state on or after the effective date of this section.

376.2100. 1. Except as otherwise provided in subsection 1 of section 376.2108, as used in sections 376.2100 to 376.2108, terms shall have the same meanings as are ascribed to them under section 376.1350.

2. As used in sections 376.2100 to 376.2108, the following terms mean:

(1) "Evaluation period", any consecutive twelve months;

(2) "Value-based care agreement", a contractual agreement between a health care provider, either directly or indirectly through a health care provider group or organization, and a health carrier that:

(a) Incentivizes or rewards providers based on one or more of the following:

a. Quality of care;

b. Safety;

c. Patient outcomes;

d. Efficiency;

e. Cost reduction; or

f. Other factors; and

(b) May, but is not required to, include shared financial risk and rewards based on performance metrics.

376.2102. 1. Except as otherwise provided in this section, beginning January 1, 2026, a health carrier or utilization review entity shall not require a health care provider to obtain prior authorization for a health care service unless the health carrier or utilization review entity makes a determination that in the most recent evaluation period the health carrier or utilization review entity has approved or would have approved less than ninety percent of the prior authorization requests submitted by that provider for that health care service.

2. Beginning January 1, 2026, a health carrier or utilization review entity shall not require a health care provider to obtain prior authorization for any health care services unless the health carrier or utilization review entity makes a determination that in the most recent evaluation period the health carrier or utilization review entity has approved or would have approved less than ninety percent of all prior authorization requests submitted by that provider for health care services.

3. (1) Beginning January 1, 2026, a health carrier or utilization review entity may elect to have a hospital, as that term is defined in section 197.020, determine which of the following conditions that such hospital will comply with to obtain an exemption from prior authorization requirements under subsections 1 and 2 of this section:

(a) The hospital entering into, either directly or indirectly through a health care provider group or organization a value-based care agreement with the health carrier;

(b) The hospital's score of three or higher on the Center for Medicare and Medicaid Services Five-Star Quality Rating System, 42 CFR § 412.190, or its successor rating system; or

(c) At least ninety-one percent of the hospital's prior authorization requests submitted for purposes of eligibility for subsections 1 or 2 of this section were approved or would have been approved by the health carrier or utilization review entity.

(2) Critical access hospitals and hospitals that do not participate in the Center for Medicare and Medicaid Services Five-Star Quality Rating System, or its successor rating system, shall be exempt from the provisions of this subsection.

4. The exemption from prior authorization requirements described in subsections 1, 2, and 3 of this section shall not include:

(1) Pharmacy services, not to exceed the amount of one hundred thousand dollars;

(2) Imaging services, not to exceed the amount of one hundred thousand dollars;

(3) Cosmetic procedures that are not medically necessary; or

(4) Investigative or experimental treatments.

5. The amount of the limitations described in subdivisions (1) and (2) of subsection 4 of this section shall be increased every year, rounded to the nearest thousand dollars, beginning January 1, 2027, based on the Consumer Price Index for All Urban Consumers for the United States (CPI-U), or its successor index, as such index is defined and officially reported by the United States Department of Labor, or its successor agency.

6. In making a determination under this section, the health carrier or utilization review entity shall not count:

(1) Any prior authorization requests denied by a health carrier or utilization review entity and being appealed by the health care provider; or

(2) Any request made by a health care provider for a service that is not included in the health carrier's benefit plan

but shall count as approved any prior authorization request that was denied by a health carrier or utilization review entity but that was subsequently authorized.

7. In making a determination under this section, the health carrier or utilization review entity shall use either the provider's national provider identifier or a taxpayer identification number. Such designation shall remain unless requested to be changed by the provider.

8. The exemption from prior authorization requirements described in subsections 1, 2, and 3 of this section may be subject to internal auditing of the most recent consecutive six months, up to a maximum of two times per year, by the health carrier or utilization review entity and may be rescinded if:

(1) Such carrier or utilization review entity determines that the carrier or utilization review entity would have approved less than ninety percent of prior authorization requests for a health care service that the provider was exempt from the prior authorization requirement under subsection 1 of this section;

(2) Such carrier or utilization review entity determines that the carrier or utilization review entity would have approved less than ninety percent of all prior authorization requests if the provider was exempt from the prior authorization requirement under subsection 2 of this section; or

(3) There has been an increase in the provision of exempt procedures by a health care provider of more than fifty percent or more than twenty procedures, whichever amount is greater.

9. The exemption described in subsections 1, 2, and 3 of this section shall be null and void upon a determination that the health care provider has been found by a court of law to have civilly or criminally engaged in any fraud or abuse after the exemption is granted by a health carrier or utilization review entity.

10. A health carrier or utilization review entity may require health care providers in the health carrier's or utilization review entity's network to use an online portal to submit requests for prior authorization.

11. No adverse determination shall be finalized under subsections 1, 2, 3, or 8 unless reviewed by a clinical peer.

12. Any patient who has received prior authorization for the coverage of a ninety-day supply of medication whose health coverage plan changes following such authorization shall be permitted a ninety-day grace period from the date of such change in order to determine whether such patient's new plan covers the previously authorized medication or whether prior authorization is required.

376.2104. 1. The health carrier or utilization review entity shall notify the health care provider no later than twenty-five days after any determination made under section 376.2102. The notification shall include the statistics, data, and any supporting documentation for making the determination for the relevant evaluation period.

2. The health carrier or utilization review entity shall establish a process for health care providers to appeal any determinations made under section 376.2102.

3. The health carrier or utilization review entity shall maintain an online portal to allow health care providers to access all prior authorization decisions, including determinations made under section 376.2102. For health care providers subject to prior authorizations, the portal shall include the status of each prior authorization request, all notifications to the health care provider, the dates the health care provider received such notifications, and any other information relevant to the determination.

376.2106. No health carrier or utilization review entity shall deny or reduce payment to a health care provider for a health care service for which the provider has a prior authorization unless the provider:

(1) Knowingly and materially misrepresented the health care service in a request for payment submitted to the health carrier or utilization review entity with the specific intent to deceive and obtain an unlawful payment from the carrier or entity; or

(2) Failed to substantially perform the health care service.

376.2108. 1. The provisions of sections 376.2100 to 376.2108 shall not apply to MO HealthNet, except that a Medicaid managed care organization as defined in section 208.431 shall be considered a health carrier for purposes of sections 376.2100 to 376.2108.

2. The provisions of sections 376.2100 to 376.2108 shall not apply to health care providers who have not participated in a health benefit plan offered by the health carrier for at least one full evaluation period.

3. Nothing in sections 376.2100 to 376.2108 shall be construed to:

(1) Authorize a health care provider to provide a health care service outside the scope of his or her applicable license; or

(2) Require a health carrier or utilization review entity to pay for a health care service described in subdivision (1) of this subsection.

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

(1) "Air ambulance membership agreement", an agreement in exchange for consideration to pay for, indemnify, or provide an amount to a person for the cost of air ambulance services. The term "air ambulance membership agreement" shall not include a health insurance plan or policy regulated under chapter 376;

(2) "Air ambulance membership organization", an individual or entity that provides an air ambulance membership agreement.

2. (1) An air ambulance membership organization shall not knowingly sell, offer for sale, or renew an air ambulance membership agreement to an individual who is enrolled in MO HealthNet.

(2) If an individual who has purchased an air ambulance membership agreement subsequently enrolls in MO HealthNet during the duration of the membership agreement, the enrollee may notify the air ambulance membership organization of such enrollment within thirty days following the effective date of the enrollment. If the enrollee timely notifies the air ambulance membership organization of such enrollment, the enrollee may request, and upon such request the air ambulance membership organization shall provide, either a prorated refund of any consideration paid for the period from the effective date of the MO HealthNet enrollment through the expiration date of the air ambulance membership agreement or a transfer of the membership to another individual in the enrollee's household. If the enrollee does not timely notify the air ambulance membership organization of such enrollment, the enrollee is not entitled to a prorated refund, but the air ambulance membership organization shall still disenroll the enrollee within thirty days of receipt of the notice of the enrollee's enrollment in MO HealthNet unless the enrollee's membership is transferred to another individual in the enrollee's household.

3. All air ambulance membership agreement websites, brochures, and marketing material shall include the following disclosures in a clear and conspicuous place:

(1) The air ambulance membership agreement is a membership plan and is not insurance coverage;

(2) Medicaid enrollees are not eligible to purchase this membership; and

(3) Some state laws prohibit Medicaid beneficiaries from being offered air ambulance memberships or being accepted into air ambulance membership programs.

4. An air ambulance membership agreement application shall include the following disclosures in a clear and conspicuous place:

(1) The air ambulance membership agreement is a membership plan and is not insurance coverage;

(2) Medicaid enrollees are not eligible to purchase this membership; and

(3) Some state laws prohibit Medicaid beneficiaries from being offered air ambulance memberships or being accepted into air ambulance membership programs.

5. If an enrollee believes that an individual or entity has violated the provisions of this section, the enrollee may file a complaint with the office of the state attorney general. The attorney general shall have all powers, rights, and duties regarding violations of this section as are provided in sections 407.010 to 407.145.

[~~192.769. 1. On completion of a mammogram, a mammography facility certified by the United States Food and Drug Administration (FDA) or by a certification agency approved by the FDA shall provide to the patient the following notice:~~

~~"If your mammogram demonstrates that you have dense breast tissue, which could hide abnormalities, and you have other risk factors for breast cancer that have been identified, you might benefit from supplemental screening tests that may be suggested by your ordering physician. Dense breast tissue, in and of itself, is a relatively common condition. Therefore, this information is not provided to cause undue concern, but rather to raise your awareness and to promote discussion with your physician regarding the presence of other risk factors, in addition to dense breast tissue. A report of your mammography results will be sent to you and your physician. You should contact your physician if you have any questions or concerns regarding this report.".~~

~~2. Nothing in this section shall be construed to create a duty of care beyond the duty to provide notice as set forth in this section.~~

~~3. The information required by this section or evidence that a person violated this section is not admissible in a civil, judicial, or administrative proceeding.~~

~~4. A mammography facility is not required to comply with the requirements of this section until January 1, 2015.~~**]**

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