2231S.03S

CONFERENCE COMMITTEE SUBSTITUTE
FOR
HOUSE COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 501

AN ACT

To repeal sections 191.227, 195.206, 197.040, 197.050, 197.070, 197.071, 197.080, 197.100, 334.010, 334.036, 334.735, 337.010, 337.025, 338.010, and 345.051, RSMo, and to enact in lieu thereof twenty-four new sections relating to health care, with an effective date for certain sections.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 191.227, 195.206, 197.040, 197.050, 197.070, 197.071, 197.080, 197.100, 334.010, 334.036, 334.735, 337.010, 337.025, 338.010, and 345.051, RSMo, are repealed and twenty-four new sections enacted in lieu thereof, to be known as sections 191.227, 194.600, 195.205, 195.206, 196.990, 197.005, 197.040, 197.050, 197.070, 197.071, 197.080, 197.100, 198.053, 324.003, 334.010, 334.036, 334.735, 337.010, 337.025, 338.010, 345.051, 478.004, 487.200, and 1, to read as follows:

191.227. 1. All physicians, chiropractors, hospitals, dentists, and other duly licensed practitioners in this state, herein called "providers", shall, upon written request of a patient, or guardian or legally authorized representative of a patient, furnish a copy of his or her record of that patient's health history and treatment rendered to the person submitting a written request, except that such right shall be limited to access consistent with the patient's condition and sound therapeutic treatment as determined by the provider. Beginning August 28, 1994, such record shall be furnished within a

reasonable time of the receipt of the request therefor and upon payment of a fee as provided in this section.

2. Health care providers may condition the furnishing of the patient's health care records to the patient, the patient's authorized representative or any other person or entity authorized by law to obtain or reproduce such records upon payment of a fee for:

(1) (a) Search and retrieval, in an amount not more than **[**twenty-two**]** twenty-four dollars and **[**eighty-two**]** eighty-five cents plus copying in the amount of **[**fifty-three**]** fifty-seven cents per page for the cost of supplies and labor plus, if the health care provider has contracted for off-site records storage and management, any additional labor costs of outside storage retrieval, not to exceed **[**twenty-one**]** twenty-three dollars and **[**thirty-six**]** twenty-six cents, as adjusted annually pursuant to subsection 5 of this section; or

(b) The records shall be furnished electronically upon payment of the search, retrieval, and copying fees set under this section at the time of the request or one hundred eight dollars and eighty-eight cents total, whichever is less, if such person:

a. Requests health records to be delivered electronically in a format of the health care provider's choice;

b. The health care provider stores such records completely in an electronic health record; and

c. The health care provider is capable of providing the requested records and affidavit, if requested, in an electronic format;

(2) Postage, to include packaging and delivery cost; and

(3) Notary fee, not to exceed two dollars, if requested.

3. Notwithstanding provisions of this section to the contrary, providers may charge for the reasonable cost of all duplications of health care record material or information which cannot routinely be copied or duplicated on a standard commercial photocopy machine.

4. The transfer of the patient's record done in good faith shall not render the provider liable to the patient or any other person for any consequences which resulted or may result from disclosure of the patient's record as required by this section.

5. Effective February first of each year, the fees listed in subsection 2 of this section shall be increased or decreased annually based on the annual percentage change in the unadjusted, U.S. city average, annual average inflation rate of the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). The current reference base of the index, as published by the Bureau of Labor Statistics of the United States Department of Labor, shall be used as the reference base. For purposes of this subsection, the annual average inflation rate shall be based on a twelve-month calendar year beginning in January and ending in December of each preceding calendar year. The department of health and senior services shall report the annual adjustment and the adjusted fees authorized in this section on the department's internet website by February first of each year.

6. A health care provider may disclose a deceased patient's health care records or payment records to the executor or administrator of the deceased person's estate, or pursuant to a

valid, unrevoked power of attorney for health care that specifically directs that the deceased person's health care records be released to the agent after death. If an executor, administrator, or agent has not been appointed, the deceased prior to death did not specifically object to disclosure of his or her records in writing, and such disclosure is not inconsistent with any prior expressed preference of the deceased that is known to the health care provider, a deceased patient's health care records may be released upon written request of a person who is deemed as the personal representative of the deceased person under this subsection. Priority shall be given to the deceased patient's spouse and the records shall be released on the affidavit of the surviving spouse that he or she is the surviving spouse. If there is no surviving spouse, the health care records may be released to one of the following persons:

(1) The acting trustee of a trust created by the deceased patient either alone or with the deceased patient's spouse;

(2) An adult child of the deceased patient on the affidavit of the adult child that he or she is the adult child of the deceased;

(3) A parent of the deceased patient on the affidavit of the parent that he or she is the parent of the deceased;

(4) An adult brother or sister of the deceased patient on the affidavit of the adult brother or sister that he or she is the adult brother or sister of the deceased;

(5) A guardian or conservator of the deceased patient at the time of the patient's death on the affidavit of the guardian

or conservator that he or she is the guardian or conservator of the deceased; or

(6) A guardian ad litem of the deceased's minor child based on the affidavit of the guardian that he or she is the guardian ad litem of the minor child of the deceased.

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

(1) "Adult", an individual who is eighteen years of age or older;

(2) "Advance health care directive", a power of attorney for health care or a declaration signed or authorized by an adult, containing the person's direction concerning a health care decision;

(3) "Declaration", a record, including but not limited to a living will or a do-not-resuscitate order, signed by an adult specifying the circumstances under which a life support system may be withheld or withdrawn;

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

(5) "Health care decision", any decision regarding the health care of the person;

(6) "Intake point", any licensed health care provider or licensed attorney.

2. The department shall issue a request for proposals and contract with a third party for the establishment of a secure online central registry for individuals to be known as the "Advance Health Care Directives Registry" to store advance health care directives and to give authorized health care providers

access to such directives.

3. An adult declarant may submit an advance health care directive or declaration and the revocations of such documents to the registry established under subsection 2 of this section.

4. Any document and any revocation of a document submitted for filing in the registry shall be submitted electronically at an intake point and signed electronically with a unique identifier, such as a social security number, a driver's license number, or another unique government-issued identifier. The electronic submission of the document shall be accompanied by a fee not to exceed ten dollars.

5. All data and information contained in the registry shall remain confidential and shall be exempt from the provisions of chapter 610.

6. The third party awarded a contract pursuant to subsection 2 of this section shall be solely responsible for all issues applicable to the registry, including, but not limited to, the development and operation of the registry; educating the general public, licensed health care providers, and legal professionals about the registry; responding to questions; providing technical assistance to users; and collection of user fees not to exceed ten dollars.

7. The department may promulgate rules to carry out the provisions of this section which may include, but not be limited to:

(1) A determination of who may access the registry, including physicians, other licensed health care providers, the declarant, and his or her legal representatives or designees; and

(2) A means for the contracting third party to annually remind registry users of which documents they have registered.

8. 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, 2017, shall be invalid and void.

9. Failure to register a document with the registry maintained under this section shall not affect the document's validity. Failure to notify the registry of the revocation of a document previously filed with the registry shall not affect the validity of a revocation that meets the statutory requirements for such revocation to be valid.

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

(1) "Drug or alcohol overdose", a condition including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, mania, or death which is the result of consumption or use of a controlled substance or alcohol or a substance with which the controlled substance or alcohol was combined, or that a person would reasonably believe to be a drug or alcohol overdose that requires

medical assistance;

(2) "Medical assistance", includes, but is not limited to, reporting a drug or alcohol overdose or other medical emergency to law enforcement, the 911 system, a poison control center, or a medical provider; assisting someone so reporting; or providing care to someone who is experiencing a drug or alcohol overdose or other medical emergency while awaiting the arrival of medical assistance.

2. A person who, in good faith, seeks or obtains medical assistance for someone who is experiencing a drug or alcohol overdose or other medical emergency or a person experiencing a drug or alcohol overdose or other medical emergency who seeks medical assistance for himself or herself or is the subject of a good faith request shall not be arrested, charged, prosecuted, convicted, or have his or her property subject to civil forfeiture or otherwise be penalized for the following if the evidence for the arrest, charge, prosecution, conviction, seizure, or penalty was gained as a result of seeking or obtaining medical assistance:

(1) Committing a prohibited act under sections 579.015, 579.074, 579.078, or 579.105;

(2) Committing a prohibited act under sections 311.310, 311.320, or 311.325;

(3) Violating a restraining order; or

(4) Violating probation or parole.

3. (1) This section shall not prohibit a police officer from arresting a person for an outstanding warrant under subsection 1 of section 221.510.

(2) This section shall not prohibit a person from being arrested, charged, or prosecuted based on an offense other than an offense under subsection 2 of this section, whether the offense arises from the same circumstances as the seeking of medical assistance.

(3) The protection of prosecution under this section for possession offenses shall not be grounds for suppression of evidence or dismissal in charges unrelated to this section.

4. Any police officer who is in contact with any person or persons in need of emergency medical assistance under this section shall provide appropriate information and resources for substance-related assistance.

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

(1) "**[**Emergency**]** Opioid antagonist", naloxone hydrochloride that blocks the effects of an opioid overdose that is administered in a manner approved by the United States Food and Drug Administration or any accepted medical practice method of administering;

(2) "Opioid-related drug overdose", a condition including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death resulting from the consumption or use of an opioid or other substance with which an opioid was combined or a condition that a layperson would reasonably believe to be an opioid-related drug overdose that requires medical assistance.

2. Notwithstanding any other law or regulation to the contrary:

(1) The director of the department of health and senior services, if a licensed physician, may issue a statewide standing order for an opioid antagonist;

(2) In the alternative, the department may employ or contract with a licensed physician who may issue a statewide standing order for an opioid antagonist with the express written consent of the department director.

3. Notwithstanding any other law or regulation to the contrary, any licensed pharmacist in Missouri may sell and dispense an opioid antagonist under physician protocol or under a statewide standing order issued under subsection 2 of this section.

[3.**]** 4. A licensed pharmacist who, acting in good faith and with reasonable care, sells or dispenses an opioid antagonist and appropriate device to administer the drug, and the protocol physician, shall not be subject to any criminal or civil liability or any professional disciplinary action for prescribing or dispensing the opioid antagonist or any outcome resulting from the administration of the opioid antagonist. A physician issuing a statewide standing order under subsection 2 of this section shall not be subject to any criminal or civil liability or any professional disciplinary action for issuing the standing order or for any outcome related to the order or the administration of the opioid antagonist.

[4.**]** 5. Notwithstanding any other law or regulation to the contrary, it shall be permissible for any person to possess an opioid antagonist.

[5.**]** 6. Any person who administers an opioid antagonist to

another person shall, immediately after administering the drug, contact emergency personnel. Any person who, acting in good faith and with reasonable care, administers an opioid antagonist to another person whom the person believes to be suffering an opioid-related overdose shall be immune from criminal prosecution, disciplinary actions from his or her professional licensing board, and civil liability due to the administration of the opioid antagonist.

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

(1) "Administer", the direct application of an epinephrine auto-injector 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, restaurants, recreation camps, youth sports leagues, amusement parks, and sports arenas. "Authorized entity" shall not include any public school or public charter school;

(3) "Epinephrine auto-injector", a single-use device used for the automatic injection 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 to an individual;

(6) "Self-administration", a person's discretionary use of an epinephrine auto-injector.

2. A physician may prescribe epinephrine auto-injectors 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 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 under a prescription issued in accordance with this section. Such epinephrine auto-injectors shall be stored in a location readily accessible in an emergency and in accordance with the epinephrine auto-injector'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 acquired by the authorized entity.

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

(1) Expected epinephrine auto-injector users receive training in recognizing symptoms of severe allergic reactions including anaphylaxis and the use of epinephrine auto-injectors 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 are maintained and stored according to the epinephrine auto-injector's instructions for use;

(3) Any person who provides or administers an epinephrine auto-injector 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 is used to render emergency care is conducted.

5. Any authorized entity that acquires a supply of epinephrine auto-injectors 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 are to be located within the entity's facility.

6. No person shall provide or administer an epinephrine auto-injector 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 is needed. Provided, however, that a person may provide or administer an epinephrine auto-injector 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.

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 in accordance with this section that may constitute ordinary negligence:

(1) An authorized entity that possesses and makes available epinephrine auto-injectors and its employees, agents, and other trained persons;

(2) Any person who uses an epinephrine auto-injector made available under this section;

(3) A physician that prescribes epinephrine auto-injectors 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 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 by its employees or agents outside of this state if the entity or its employee or agent are 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 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 and be staffed by at least one individual trained in the use of epinephrine auto-injectors.

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.

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

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

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

4. Regulations promulgated by the department of health and senior services to establish and enforce hospital licensure

regulations under this chapter that duplicate or conflict with the Medicare conditions of participation shall lapse and expire on and after July 1, 2018.

197.040. After ninety days from the date this law becomes effective, no person or governmental unit, acting severally or jointly with any other person or governmental unit, shall establish, conduct or maintain a hospital in this state without a license under this law and section 197.005 issued by the department of health and senior services.

197.050. Application for a license shall be made to the department of health and senior services upon forms provided by it and shall contain such information as the department of health and senior services requires, which may include affirmative evidence of ability to comply with such reasonable standards, rules and regulations as are lawfully prescribed hereunder in compliance with section 197.005. Until June 30, 1989, each application for a license, except applications from governmental units, shall be accompanied by an annual license fee of two hundred dollars plus two dollars per bed for the first one hundred beds and one dollar per bed for each additional bed. Beginning July 1, 1989, each application for a license, except applications from governmental units, shall be accompanied by an annual license fee of two hundred fifty dollars plus three dollars per bed for the first four hundred beds and two dollars per bed for each additional bed. All license fees shall be paid to the director of revenue and deposited in the state treasury to the credit of the general revenue fund.

197.070. The department of health and senior services may

deny, suspend or revoke a license in any case in which it finds that there has been a substantial failure to comply with the requirements established under this law and section 197.005.

197.071. Any person aggrieved by an official action of the department of health and senior services affecting the licensed status of a person under the provisions of sections [197.010] 197.005 to 197.120, including the refusal to grant, the grant, the revocation, the suspension, or the failure to renew a license, may seek a determination thereon by the administrative hearing commission pursuant to the provisions of section 621.045, and it shall not be a condition to such determination that the person aggrieved seek a reconsideration, a rehearing, or exhaust any other procedure within the department of health and senior services.

197.080. 1. The department of health and senior services, with the advice of the state advisory council and pursuant to the provisions of this section, section 197.005, and chapter 536, shall adopt, amend, promulgate and enforce such rules, regulations and standards with respect to all hospitals or different types of hospitals to be licensed hereunder as may be designed to further the accomplishment of the purposes of this law in promoting safe and adequate treatment of individuals in hospitals in the interest of public health, safety and welfare. No rule or portion of a rule promulgated under the authority of sections 197.010 to 197.280 shall become effective unless it has been promulgated pursuant to the provisions of section 536.024.

2. The department shall review and revise regulations governing hospital licensure and enforcement to promote hospital

and regulatory efficiencies [and]. The department shall eliminate all duplicative regulations and inspections by or on behalf of state agencies and the Centers for Medicare and Medicaid Services (CMS). The hospital licensure regulations adopted under this [section] chapter shall incorporate standards which shall include, but not be limited to, the following:

(1) Each citation or finding of a regulatory deficiency shall refer to the specific written regulation, any state associated written interpretive guidance developed by the department and any publicly available, professionally recognized standards of care that are the basis of the citation or finding;

(2) Subject to appropriations, the department shall ensure that its hospital licensure regulatory standards are consistent with and do not contradict the CMS Conditions of Participation (COP) and associated interpretive guidance. However, this shall not preclude the department from enforcing standards produced by the department which exceed the federal CMS' COP and associated interpretive guidance, so long as such standards produced by the department promote a higher degree of patient safety and do not contradict the federal CMS' COP and associated interpretive guidance;

(3) The department shall establish and publish guidelines for complaint investigation, including but not limited to:

(a) The department's process for reviewing and determining which complaints warrant an on-site investigation based on a preliminary review of available information from the complainant, other appropriate sources, and when not prohibited by CMS, the hospital. For purposes of providing hospitals with information

necessary to improve processes and patient care, the number and nature of complaints filed and the recommended actions by the department and, as appropriate CMS, shall be disclosed upon request to hospitals so long as the otherwise confidential identity of the complainant or the patient for whom the complaint was filed is not disclosed;

(b) A departmental investigation of a complaint shall be focused on the specific regulatory standard and departmental written interpretive guidance and publicly available professionally recognized standard of care related to the complaint. During the course of any complaint investigation, the department shall cite any serious and immediate threat discovered that may potentially jeopardize the health and safety of patients;

(c) A hospital shall be provided with a report of all complaints made against the hospital. Such report shall include the nature of the complaint, the date of the complaint, the department conclusions regarding the complaint, the number of investigators and days of investigation resulting from each complaint;

(4) Hospitals and hospital personnel shall have the opportunity to participate in annual continuing training sessions when such training is provided to state licensure surveyors with prior approval from the department director and CMS when appropriate. Hospitals and hospital personnel shall assume all costs associated with facilitating the training sessions and use of curriculum materials, including but not limited to the location for training, food, and printing costs;

(5) Time lines for the department to provide responses to hospitals regarding the status and outcome of pending investigations and regulatory actions and questions about interpretations of regulations shall be identical to, to the extent practicable, the time lines established for the federal hospital certification and enforcement system in the CMS State Operations Manual, as amended. These time lines shall be the guide for the department to follow. Every reasonable attempt shall be made to meet the time lines. However, failure to meet the established time lines shall in no way prevent the department from performing any necessary inspections to ensure the health and safety of patients.

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

197.100. 1. Any provision of chapter 198 and chapter 338 to the contrary notwithstanding, the department of health and senior services shall have sole authority, and responsibility for inspection and licensure of hospitals in this state including, but not limited to, all parts, services, functions, support

functions and activities which contribute directly or indirectly to patient care of any kind whatsoever. The department of health and senior services shall annually inspect each licensed hospital and shall make any other inspections and investigations as it deems necessary for good cause shown. The department of health and senior services shall accept reports of hospital inspections from or on behalf of governmental agencies, the joint commission, and the American Osteopathic Association Healthcare Facilities Accreditation Program, provided the accreditation inspection was conducted within one year of the date of license renewal. Prior to granting acceptance of any other accrediting organization reports in lieu of the required licensure survey, the accrediting organization's survey process must be deemed appropriate and found to be comparable to the department's licensure survey. It shall be the accrediting organization's responsibility to provide the department any and all information necessary to determine if the accrediting organization's survey process is comparable and fully meets the intent of the licensure regulations. The department of health and senior services shall attempt to schedule inspections and evaluations required by this section so as not to cause a hospital to be subject to more than one inspection in any twelve-month period from the department of health and senior services or any agency or accreditation organization the reports of which are accepted for licensure purposes pursuant to this section, except for good cause shown.

2. Other provisions of law to the contrary notwithstanding, the department of health and senior services shall be the only state agency to determine life safety and building codes for

hospitals defined or licensed pursuant to the provisions of this chapter, including but not limited to sprinkler systems, smoke detection devices and other fire safety-related matters so long as any new standards shall apply only to new construction.

198.053. No later than October first of each year, in accordance with the latest recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, each assisted living facility, as such term is defined in section 198.006, shall notify residents and staff where in the facility that the latest edition of the Vaccine Informational Sheet published by the Centers for Disease Control and Prevention has been posted. Nothing in this section shall be construed to require any assisted living facility to provide or pay for any vaccination against influenza, allow the department of health to promulgate any rules to implement this section, or cite any facility for acting in good faith to post the Vaccine Informational Sheet.

324.003. Notwithstanding any other provision of law or administrative rule to the contrary, the division of professional registration and its component boards, committees, offices, and commissions shall permit:

(1) Any licensee to submit payment for fees so established in the form of personal check, money order, cashier's check, credit card, or electronic check as defined by section 407.432;

(2) Any applicant or licensee to apply for licensure or renew their license in writing or electronically; and

(3) Any licensee to make requests of their license-granting board or commission for extensions of time to complete continuing

education, notify their license-granting board or commission of changes to name, business name, home address, or work address, and provide any other items required as part of licensure to their licensure board in writing or electronically.

334.010. 1. It shall be unlawful for any person not now a registered physician within the meaning of the law to practice medicine or surgery in any of its departments, to engage in the practice of medicine across state lines or to profess to cure and attempt to treat the sick and others afflicted with bodily or mental infirmities, or engage in the practice of midwifery in this state, except as herein provided.

2. For the purposes of this chapter, the "practice of medicine across state lines" shall mean:

(1) The rendering of a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient within this state by a physician located outside this state as a result of transmission of individual patient data by electronic or other means from within this state to such physician or physician's agent; or

(2) The rendering of treatment to a patient within this state by a physician located outside this state as a result of transmission of individual patient data by electronic or other means from within this state to such physician or physician's agent.

3. A physician located outside of this state shall not be required to obtain a license when:

(1) In consultation with a physician licensed to practice medicine in this state; and

(2) The physician licensed in this state retains ultimate authority and responsibility for the diagnosis or diagnoses and treatment in the care of the patient located within this state; or

(3) Evaluating a patient or rendering an oral, written or otherwise documented medical opinion, or when providing testimony or records for the purpose of any civil or criminal action before any judicial or administrative proceeding of this state or other forum in this state; or

(4) Participating in a utilization review pursuant to section 376.1350.

4. This section shall not apply to a person who holds a current, unrestricted license to practice medicine in another state when the person, under a written agreement with an athletic team located in the state in which the person is licensed, provides sports-related medical services to any of the following individuals if the team is traveling to or from, or participating in, a sporting event in this state:

(1) A member of an athletic team;

(2) A member of an athletic team's coaching, communications, equipment, or sports medicine staff;

(3) A member of a band, dance team, or cheerleading squad accompanying an athletic team; or

(4) An athletic team's mascot.

5. In providing sports-related medical services under subsection 4 of this section, the person shall not provide medical services at a health care facility, including a hospital, ambulatory surgical center, or any other facility in which

medical care, diagnosis, or treatment is provided on an inpatient or outpatient basis.

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

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

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

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

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

(d) Has proficiency in the English language**[;]**.

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

licensure and shall be deemed in compliance with the provisions of this subdivision;

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

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

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

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

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

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

3. (1) For purposes of this section, the licensure of assistant physicians shall take place within processes established by rules of the state board of registration for the healing arts. The board of healing arts is authorized to establish rules under chapter 536 establishing licensure and renewal procedures, supervision, collaborative practice

arrangements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensure may be denied or the licensure of an assistant physician may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule.

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

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

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

6. The provisions of section 334.037 shall apply to all

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

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

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

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

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

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

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

(6) "Physician assistant", a person who has graduated from a physician assistant program accredited by the American Medical

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

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

(8) "Supervision", control exercised over a physician assistant working with a supervising physician and oversight of the activities of and accepting responsibility for the physician assistant's delivery of care. The physician assistant shall only practice at a location where the physician routinely provides patient care, except existing patients of the supervising physician in the patient's home and correctional facilities. The supervising physician must be immediately available in person or via telecommunication during the time the physician assistant is providing patient care. Prior to commencing practice, the supervising physician and physician assistant shall attest on a form provided by the board that the physician shall provide supervision appropriate to the physician assistant's training and that the physician assistant shall not practice beyond the

physician assistant's training and experience. Appropriate supervision shall require the supervising physician to be working within the same facility as the physician assistant for at least four hours within one calendar day for every fourteen days on which the physician assistant provides patient care as described in subsection 3 of this section. Only days in which the physician assistant provides patient care as described in subsection 3 of this section shall be counted toward the fourteen-day period. The requirement of appropriate supervision shall be applied so that no more than thirteen calendar days in which a physician assistant provides patient care shall pass between the physician's four hours working within the same facility. The board shall promulgate rules pursuant to chapter 536 for documentation of joint review of the physician assistant activity by the supervising physician and the physician assistant.

2. (1) A supervision agreement shall limit the physician assistant to practice only at locations described in subdivision (8) of subsection 1 of this section, where the supervising physician is no further than fifty miles by road using the most direct route available and where the location is not so situated as to create an impediment to effective intervention and supervision of patient care or adequate review of services.

(2) For a physician-physician assistant team working in a rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended, no supervision requirements in addition to the minimum federal law shall be required.

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

(1) Taking patient histories;

(2) Performing physical examinations of a patient;

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

(4) Performing routine therapeutic procedures;

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

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

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

(8) Assisting in surgery;

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

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

4. Physician assistants shall not prescribe **[**nor dispense**]** any drug, medicine, device or therapy unless pursuant to a physician supervision agreement in accordance with the law, nor prescribe lenses, prisms or contact lenses for the aid, relief or

correction of vision or the measurement of visual power or visual efficiency of the human eye, nor administer or monitor general or regional block anesthesia during diagnostic tests, surgery or obstetric procedures. Prescribing **[**and dispensing**]** of drugs, medications, devices or therapies by a physician assistant shall be pursuant to a physician assistant supervision agreement which is specific to the clinical conditions treated by the supervising physician and the physician assistant shall be subject to the following:

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

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

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

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

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

(6) A physician assistant may only dispense starter doses of medication to cover a period of time for seventy-two hours or

less**]**.

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

6. For purposes of this section, the licensing of physician assistants shall take place within processes established by the state board of registration for the healing arts through rule and regulation. The board of healing arts is authorized to establish rules pursuant to chapter 536 establishing licensing and renewal procedures, supervision, supervision agreements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensing may be denied or the license of a physician assistant may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100,

or such other standards of conduct set by the board by rule or regulation. Persons licensed pursuant to the provisions of chapter 335 shall not be required to be licensed as physician assistants. All applicants for physician assistant licensure who complete a physician assistant training program after January 1, 2008, shall have a master's degree from a physician assistant program.

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

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

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

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

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

(a) Attest on a form provided by the board that the physician shall provide supervision appropriate to the physician

assistant's training and experience and that the physician assistant shall not practice beyond the scope of the physician assistant's training and experience nor the supervising physician's capabilities and training; and

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

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

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

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

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

10. It is the responsibility of the supervising physician to determine and document the completion of at least a one-month

period of time during which the licensed physician assistant shall practice with a supervising physician continuously present before practicing in a setting where a supervising physician is not continuously present.

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

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

13. No physician shall be designated to serve as supervising physician for more than three full-time equivalent licensed physician assistants. This limitation shall not apply to physician assistant agreements of hospital employees providing inpatient care service in hospitals as defined in chapter 197.

337.010. As used in sections 337.010 to 337.090 the following terms mean:

(1) "Committee", the state committee of psychologists;

(2) "Department", the department of insurance, financial institutions and professional registration;

(3) "Division", the division of professional registration;

(4) "Internship", any supervised hours that occur during a formal internship of twelve to twenty-four months after all academic course work toward a doctorate has been completed but prior to completion of the full degree. Internship is part of successful completion of a doctorate in psychology, and a person cannot earn his or her doctorate without completion of an internship;

(5) "Licensed psychologist", any person who offers to render psychological services to individuals, groups, organizations, institutions, corporations, schools, government agencies or the general public for a fee, monetary or otherwise, implying that such person is trained, experienced and licensed to practice psychology and who holds a current and valid, whether temporary, provisional or permanent, license in this state to practice psychology;

(6) "Postdoctoral experiences", experiences that follow the completion of a person's doctoral degree. Such person shall not be licensed until he or she satisfies additional supervised hours. Postdoctoral experiences shall include any supervised clinical activities following the completion of the doctoral degree;

(7) "Predoctoral postinternship", any supervised hours that occur following completion of the internship but prior to completing the degree. Such person may continue to provide supervised clinical services even after his or her internship is completed and while still completing his or her doctoral degree requirements;

(8) "Preinternship", any supervised hours acquired as a student or in the course of seeking a doctorate in psychology but before the internship, which includes supervised practicum;

[(5)**]** (9) "Provisional licensed psychologist", any person who is a graduate of a recognized educational institution with a doctoral degree in psychology as defined in section 337.025, and who otherwise meets all requirements to become a licensed psychologist except for passage of the licensing exams, oral examination and completion of the required period of postdegree supervised experience as specified in subsection 2 of section 337.025;

[(6)**]** (10) "Recognized educational institution":

(a) A school, college, university or other institution of higher learning in the United States, which, at the time the applicant was enrolled and graduated, had a graduate program in psychology and was accredited by one of the regional accrediting associations approved by the Council on Postsecondary Accreditation; or

(b) A school, college, university or other institution of higher learning outside the United States, which, at the time the applicant was enrolled and graduated, had a graduate program in psychology and maintained a standard of training substantially equivalent to the standards of training of those programs accredited by one of the regional accrediting associations approved by the Council of Postsecondary Accreditation;

[(7)**]** (11) "Temporary license", a license which is issued to a person licensed as a psychologist in another jurisdiction, who has applied for licensure in this state either by reciprocity

or endorsement of the score from the Examination for Professional Practice in Psychology, and who is awaiting either a final determination by the committee relative to such person's eligibility for licensure or who is awaiting the results of the jurisprudence examination or oral examination.

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

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

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

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

3. A doctoral degree in psychology is defined as:

(1) A program accredited, or provisionally accredited, by the American Psychological Association or the Canadian Psychological Association; or

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

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

criteria:

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

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

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

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

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

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

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

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

(i) Require the completion by the applicant of a core program in psychology which shall be met by the completion and award of at least one three-semester-hour graduate credit course

or a combination of graduate credit courses totaling three semester hours or five quarter hours in each of the following areas:

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

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

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

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

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

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

(1) A minimum of fifteen hundred hours of **[**professional**]** experience **[**obtained**]** in a successfully completed internship to

be completed in not less than twelve nor more than twenty-four [consecutive calendar] months; and

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

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

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

(c) Postdoctoral professional experience obtained in no more than twenty-four consecutive calendar months. In no case shall this experience be accumulated at a rate of [less than twenty hours per week nor] more than fifty hours per week. Postdoctoral supervised professional experience for prospective health service providers and other applicants shall involve and relate to the delivery of psychological [health] services[. Postdoctoral supervised professional experience for other applicants shall be] in accordance with professional requirements and relevant to the applicant's intended area of practice.

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

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

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

invalidate the supervised experience.

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

338.010. 1. The "practice of pharmacy" means the interpretation, implementation, and evaluation of medical prescription orders, including any legend drugs under 21 U.S.C. Section 353; receipt, transmission, or handling of such orders or facilitating the dispensing of such orders; the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by the prescription order so long as the prescription order is specific to each patient for care by a pharmacist; the compounding, dispensing, labeling, and administration of drugs and devices pursuant to medical prescription orders and administration of viral influenza, pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, and meningitis vaccines by written protocol authorized by a physician for persons twelve years of age or older as authorized by rule or the administration of pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, and meningitis vaccines by written protocol authorized by a physician for a specific patient as authorized by rule; the participation in drug selection according to state law and participation in drug utilization reviews; the proper and safe storage of drugs and devices and the maintenance of proper records thereof; consultation with patients and other health care practitioners, and veterinarians and their clients about legend

drugs, about the safe and effective use of drugs and devices; and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management and control of a pharmacy. No person shall engage in the practice of pharmacy unless he is licensed under the provisions of this chapter. This chapter shall not be construed to prohibit the use of auxiliary personnel under the direct supervision of a pharmacist from assisting the pharmacist in any of his or her duties. This assistance in no way is intended to relieve the pharmacist from his or her responsibilities for compliance with this chapter and he or she will be responsible for the actions of the auxiliary personnel acting in his or her assistance. This chapter shall also not be construed to prohibit or interfere with any legally registered practitioner of medicine, dentistry, or podiatry, or veterinary medicine only for use in animals, or the practice of optometry in accordance with and as provided in sections 195.070 and 336.220 in the compounding, administering, prescribing, or dispensing of his or her own prescriptions.

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

3. Nothing in this section shall be construed as to prevent

any person, firm or corporation from owning a pharmacy regulated by sections 338.210 to 338.315, provided that a licensed pharmacist is in charge of such pharmacy.

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

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

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

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

rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

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

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

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

protocol or the physician's prescription order.

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

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

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

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

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

13. A pharmacist shall provide a written report within fourteen days of administration of a vaccine to the patient's primary health care provider, if provided by the patient, containing:

(1) The identity of the patient;

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

(3) The route of administration;

(4) The anatomic site of the administration;

(5) The dose administered; and

(6) The date of administration.

345.051. 1. Every person licensed or registered pursuant to the provisions of sections 345.010 to 345.080 shall renew the license or registration on or before the renewal date. Such renewal date shall be determined by the board, but shall be no less than three years. The application shall be made on a form furnished by the board. The application shall include, but not be limited to, disclosure of the applicant's full name and the applicant's office and residence addresses and the date and number of the applicant's license or registration, all final disciplinary actions taken against the applicant by any speech-language-hearing association or society, state, territory or federal agency or country and information concerning the applicant's current physical and mental fitness to practice.

2. A blank form for application for license or registration renewal shall be mailed to each person licensed or registered in this state at the person's last known office or residence address. The failure to mail the form of application or the failure to receive it does not, however, relieve any person of the duty to renew the license or registration and pay the fee required by sections 345.010 to 345.080 for failure to renew the license or registration.

3. An applicant for renewal of a license or registration

under this section shall:

(1) Submit an amount established by the board; and

(2) Meet any other requirements the board establishes as conditions for license or registration renewal, including the demonstration of continued competence to practice the profession for which the license or registration is issued. A requirement of continued competence may include, but is not limited to, up to thirty hours triennially of continuing education, examination, self-evaluation, peer review, performance appraisal or practical simulation.

4. If a license or registration is suspended pursuant to section 345.065, the license or registration expires on the expiration date as established by the board for all licenses and registrations issued pursuant to sections 345.010 to 345.080. Such license or registration may be renewed but does not entitle the licensee to engage in the licensed or registered activity or in any other conduct or activity which violates the order of judgment by which the license or registration was suspended until such license or registration has been reinstated.

5. If a license or registration is revoked on disciplinary grounds pursuant to section 345.065, the license or registration expires on the expiration date as established by the board for all licenses and registrations issued pursuant to sections 345.010 to 345.080. Such license or registration may not be renewed. If a license or registration is reinstated after its expiration, the licensee, as a condition of reinstatement, shall pay a reinstatement fee that is equal to the renewal fee in effect on the last regular renewal date immediately preceding the

date of reinstatement plus any late fee established by the board.

478.004. 1. As used in this section, "medication-assisted treatment" means the use of pharmacological medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders.

2. If a drug court or veterans court participant requires treatment for opioid or other substance misuse or dependence, a drug court or veterans court shall not prohibit such participant from participating in and receiving medication-assisted treatment under the care of a physician licensed in this state to practice medicine. A drug court or veterans court participant shall not be required to refrain from using medication-assisted treatment as a term or condition of successful completion of the drug court program.

3. A drug court or veterans court participant assigned to a treatment program for opioid or other substance misuse or dependence shall not be in violation of the terms or conditions of the drug court or veterans court on the basis of his or her participation in medication-assisted treatment under the care of a physician licensed in this state to practice medicine.

487.200. 1. As used in this section, "medication-assisted treatment" means the use of pharmacological medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders.

2. If a family court participant requires treatment for opioid or other substance misuse or dependence, a family court

shall not prohibit such participant from participating in and receiving medication-assisted treatment under the care of a physician licensed in this state to practice medicine. A family court participant shall not be required to refrain from using medication-assisted treatment as a term or condition of successful completion of the family court program.

3. A family court participant assigned to a treatment program for opioid or other substance misuse or dependence shall not be in violation of the terms or conditions of the family court on the basis of his or her participation in medication-assisted treatment under the care of a physician licensed in this state to practice medicine.

Section 1. The Missouri board of pharmacy, in consultation with the Missouri department of health and senior services, shall be authorized to expend, allocate, or award funds appropriated to the board to private or public entities to develop a drug take-back program. Such program shall collect and dispose of Schedule II and III controlled substances, as described in section 195.017.

Section B. The enactment of section 197.005 and the repeal and reenactment of sections 197.040, 197.050, 197.070, 197.071, 197.080, and 197.100 of this act shall become effective on July 1, 2018.

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David Sater Mike Stephens