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CONFERENCE COMMITTEE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

SENATE COMMITTEE SUBSTITUTE

FOR

SENATE BILL NO. 718

AN ACT

To repeal sections 191.227, 192.947, 195.070, 210.070, 334.036, 334.037, 334.104, 334.735, 334.747, 337.025, 337.029, 337.033, 338.202, 374.426, 376.811, 376.1237, 376.1550, and 632.005, RSMo, and to enact in lieu thereof twenty-four new sections relating to health care, with an emergency clause for certain sections.

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

1 Section A. Sections 191.227, 192.947, 195.070, 210.070,
2 334.036, 334.037, 334.104, 334.735, 334.747, 337.025, 337.029,
3 337.033, 338.202, 374.426, 376.811, 376.1237, 376.1550, and
4 632.005, RSMo, are repealed and twenty-four new sections enacted
5 in lieu thereof, to be known as sections 9.158, 9.192, 191.227,
6 191.1150, 192.947, 195.070, 195.265, 208.183, 210.070, 334.036,
7 334.037, 334.104, 334.735, 334.747, 337.025, 337.029, 337.033,
8 338.202, 374.426, 376.811, 376.1237, 376.1550, 630.875, and
9 632.005, to read as follows:

10 9.158. The month of November shall be known and designated
11 as "Diabetes Awareness Month". The citizens of the state of
12 Missouri are encouraged to participate in appropriate activities

1 and events to increase awareness of diabetes. Diabetes is a
2 group of metabolic diseases in which the body has elevated blood
3 sugar levels over a prolonged period of time and affects
4 Missourians of all ages.
5 9.192. The years of 2018 to 2028 shall hereby be designated
6 as the "Show-Me Freedom from Opioid Addiction Decade".
7 191.227. 1. All physicians, chiropractors, hospitals,
8 dentists, and other duly licensed practitioners in this state,
9 herein called "providers", shall, upon written request of a
10 patient, or guardian or legally authorized representative of a
11 patient, furnish a copy of his or her record of that patient's
12 health history and treatment rendered to the person submitting a
13 written request, except that such right shall be limited to
14 access consistent with the patient's condition and sound
15 therapeutic treatment as determined by the provider. Beginning
16 August 28, 1994, such record shall be furnished within a
17 reasonable time of the receipt of the request therefor and upon
18 payment of a fee as provided in this section.
19 2. Health care providers may condition the furnishing of
20 the patient's health care records to the patient, the patient's
21 authorized representative or any other person or entity
22 authorized by law to obtain or reproduce such records upon
23 payment of a fee for:
24 (1) (a) Search and retrieval, in an amount not more than
25 twenty-four dollars and eighty-five cents plus copying in the
26 amount of fifty-seven cents per page for the cost of supplies and
27 labor plus, if the health care provider has contracted for off-
28 site records storage and management, any additional labor costs

of outside storage retrieval, not to exceed twenty-three dollars and 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;

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

3. For purposes of subsections 1 and 2 of this section, "a copy of his or her record of that patient's health history and treatment rendered" or "the patient's health care records" include a statement or record that no such health history or treatment record responsive to the request exists.

4. 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.**]** 5. 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.**]** 6. 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.**]** 7. 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

1 that is known to the health care provider, a deceased patient's
2 health care records may be released upon written request of a
3 person who is deemed as the personal representative of the
4 deceased person under this subsection. Priority shall be given
5 to the deceased patient's spouse and the records shall be
6 released on the affidavit of the surviving spouse that he or she
7 is the surviving spouse. If there is no surviving spouse, the
8 health care records may be released to one of the following
9 persons:
10 (1) The acting trustee of a trust created by the deceased
11 patient either alone or with the deceased patient's spouse;
12 (2) An adult child of the deceased patient on the affidavit
13 of the adult child that he or she is the adult child of the
14 deceased;
15 (3) A parent of the deceased patient on the affidavit of
16 the parent that he or she is the parent of the deceased;
17 (4) An adult brother or sister of the deceased patient on
18 the affidavit of the adult brother or sister that he or she is
19 the adult brother or sister of the deceased;
20 (5) A guardian or conservator of the deceased patient at
21 the time of the patient's death on the affidavit of the guardian
22 or conservator that he or she is the guardian or conservator of
23 the deceased; or
24 (6) A guardian ad litem of the deceased's minor child based
25 on the affidavit of the guardian that he or she is the guardian
26 ad litem of the minor child of the deceased.
27 191.1150. 1. This section shall be known as the
28 "Caregiver, Advise, Record, and Enable (CARE) Act".

1 2. As used in this section, the following terms shall mean:
2 (1) "Admission", a patient's admission into a hospital as
3 an in-patient;
4 (2) "After-care", assistance that is provided by a
5 caregiver to a patient after the patient's discharge from a
6 hospital that is related to the condition of the patient at the
7 time of discharge, including assisting with activities of daily
8 living, as defined in section 198.006; instrumental activities of
9 daily living, as defined in section 198.006; or carrying out
10 medical or nursing tasks as permitted by law;
11 (3) "Ambulatory surgical center", the same as defined in
12 section 197.200;
13 (4) "Caregiver", an individual who is eighteen years of age
14 or older, is duly designated as a caregiver by a patient under
15 this section, and who provides after-care assistance to such
16 patient in the patient's residence;
17 (5) "Discharge", a patient's release from a hospital or an
18 ambulatory surgical center to the patient's residence following
19 an admission;
20 (6) "Hospital", the same as defined in section 197.020;
21 (7) "Residence", a dwelling that the patient considers to
22 be his or her home. "Residence" shall not include:
23 (a) A facility, the same as defined in section 198.006;
24 (b) A hospital, the same as defined in section 197.020;
25 (c) A prison, jail, or other detention or correctional
26 facility operated by the state or a political subdivision;
27 (d) A residential facility, the same as defined in section
28 630.005;

1 (e) A group home or developmental disability facility, the
2 same as defined in section 633.005; or
3 (f) Any other place of habitation provided by a public or
4 private entity which bears legal or contractual responsibility
5 for the care, control, or custody of the patient and which is
6 compensated for doing so.
7 3. A hospital or ambulatory surgical center shall provide
8 each patient or, if applicable, the patient's legal guardian with
9 an opportunity to designate a caregiver following the patient's
10 admission into a hospital or entry into an ambulatory surgical
11 center and prior to the patient's discharge. Such designation
12 shall include a written consent of the patient or the patient's
13 legal guardian to release otherwise confidential medical
14 information to the designated caregiver if such medical record
15 would be needed to enable the completion of after-care tasks.
16 The written consent shall be in compliance with federal and state
17 laws concerning the release of personal health information.
18 Prior to discharge, a patient may elect to change his or her
19 caregiver in the event that the original designated caregiver
20 becomes unavailable, unwilling, or unable to care for the
21 patient. Designation of a caregiver by a patient or a patient's
22 legal guardian does not obligate any person to arrange or perform
23 any after-care tasks for the patient.
24 4. The hospital or ambulatory surgical center shall
25 document the patient's or the patient's legal guardian's
26 designation of caregiver, the relationship of the caregiver to
27 the patient, and the caregiver's available contact information.
28 5. If the patient or the patient's legal guardian declines

1 to designate a caregiver, the hospital or ambulatory surgical
2 center shall document such information.
3 6. The hospital or ambulatory surgical center shall notify
4 a patient's caregiver of the patient's discharge or transfer to
5 another facility as soon as practicable, which may be after the
6 patient's physician issues a discharge order. In the event that
7 the hospital or ambulatory surgical center is unable to contact
8 the designated caregiver, the lack of contact shall not interfere
9 with, delay, or otherwise affect the medical care provided to the
10 patient or an appropriate discharge of the patient. The hospital
11 or ambulatory surgical center shall document the attempt to
12 contact the caregiver.
13 7. Prior to being discharged, if the hospital or ambulatory
14 surgical center is able to contact the caregiver and the
15 caregiver is willing to assist, the hospital or ambulatory
16 surgical center shall provide the caregiver with the patient's
17 discharge plan, if such plan exists, or instructions for the
18 after-care needs of the patient and give the caregiver the
19 opportunity to ask questions about the after-care needs of the
20 patient.
21 8. A hospital or ambulatory surgical center is not required
22 nor obligated to determine the ability of a caregiver to
23 understand or perform any of the after-care tasks outlined in
24 this section.
25 9. Nothing in this section shall authorize or require
26 compensation of a caregiver by a state agency or a health
27 carrier, as defined in section 376.1350.
28 10. Nothing in this section shall require a hospital or

1 ambulatory surgical center to take actions that are inconsistent
2 with or duplicative of the standards of the federal Medicare
3 program under Title XVIII of the Social Security Act and its
4 conditions of participation in the Code of Federal Regulations or
5 the standards of a national accrediting organization with deeming
6 authority under Section 1865(a)(1) of the Social Security Act.
7 11. Nothing in this section shall create a private right of
8 action against a hospital, ambulatory surgical center, a hospital
9 or ambulatory surgical center employee, or an individual with
10 whom a hospital or ambulatory surgical center has a contractual
11 relationship.
12 12. A hospital, ambulatory surgical center, hospital or
13 ambulatory surgical center employee, or an individual with whom a
14 hospital or ambulatory surgical center has a contractual
15 relationship shall not be liable in any way for an act or
16 omission of the caregiver.
17 13. No act or omission under this section by a hospital,
18 ambulatory surgical center, hospital or ambulatory surgical
19 center employee, or an individual with whom a hospital or
20 ambulatory surgical center has a contractual relationship shall
21 give rise to a citation, sanction, or any other adverse action by
22 any licensing authority to whom such individual or entity is
23 subject.
24 14. Nothing in this section shall be construed to interfere
25 with the rights of an attorney-in-fact under a durable power of
26 health care under sections 404.800 to 404.872.
27 15. The department of health and senior services shall
28 provide ambulatory surgical centers and hospitals a standard form

that may be used to satisfy the requirements of this section. Nothing in this section shall prohibit a hospital or ambulatory surgical center from continuing the use of a current patient communication or disclosure form to satisfy the requirements of this section, provided that the facility's current form is compliant with Centers for Medicare and Medicaid Services (CMS) standards and regulations.

192.947. 1. No individual or health care entity organized under the laws of this state shall be subject to any adverse action by the state or any agency, board, or subdivision thereof, including civil or criminal prosecution, denial of any right or privilege, the imposition of a civil or administrative penalty or sanction, or disciplinary action by any accreditation or licensing board or commission if such individual or health care entity, in its normal course of business and within its applicable licenses and regulations, acts in good faith upon or in furtherance of any order or recommendation by a neurologist authorized under section 192.945 relating to the medical use and administration of hemp extract with respect to an eligible patient.

2. The provisions of subsection 1 of this section shall apply to the recommendation, possession, handling, storage, transfer, destruction, dispensing, or administration of hemp extract, including any act in preparation of such dispensing or administration.

3. **[**This section shall not be construed to limit the rights provided under law for a patient to bring a civil action for damages against a physician, hospital, registered or licensed

1 practical nurse, pharmacist, any other individual or entity
2 providing health care services, or an employee of any entity
3 listed in this subsection.] Notwithstanding the provisions of
4 section 538.210 or any other law to the contrary, any physician
5 licensed under chapter 334, any hospital licensed under chapter
6 197, any pharmacist licensed under chapter 338, any nurse
7 licensed under chapter 335, or any other person employed or
8 directed by any of the above, which provides care, treatment or
9 professional services to any patient under section 192.945 shall
10 not be liable for any civil damages for acts or omissions unless
11 the damages were occasioned by gross negligence or by willful or
12 wanton acts or omissions by such physician, hospital, pharmacist,
13 nurse, or person in rendering such care and treatment.
14 195.070. 1. A physician, podiatrist, dentist, a registered
15 optometrist certified to administer pharmaceutical agents as
16 provided in section 336.220, or an assistant physician in
17 accordance with section 334.037 or a physician assistant in
18 accordance with section 334.747 in good faith and in the course
19 of his or her professional practice only, may prescribe,
20 administer, and dispense controlled substances or he or she may
21 cause the same to be administered or dispensed by an individual
22 as authorized by statute.
23 2. An advanced practice registered nurse, as defined in
24 section 335.016, but not a certified registered nurse anesthetist
25 as defined in subdivision (8) of section 335.016, who holds a
26 certificate of controlled substance prescriptive authority from
27 the board of nursing under section 335.019 and who is delegated
28 the authority to prescribe controlled substances under a

1 collaborative practice arrangement under section 334.104 may
2 prescribe any controlled substances listed in Schedules III, IV,
3 and V of section 195.017, and may have restricted authority in
4 Schedule II. Prescriptions for Schedule II medications
5 prescribed by an advanced practice registered nurse who has a
6 certificate of controlled substance prescriptive authority are
7 restricted to only those medications containing hydrocodone.
8 However, no such certified advanced practice registered nurse
9 shall prescribe controlled substance for his or her own self or
10 family. Schedule III narcotic controlled substance and Schedule
11 II - hydrocodone prescriptions shall be limited to a one hundred
12 twenty-hour supply without refill.

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

19 4. A practitioner shall not accept any portion of a
20 controlled substance unused by a patient, for any reason, if such
21 practitioner did not originally dispense the drug, except as
22 provided in section 195.265.

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

26 195.265. 1. Unused controlled substances may be accepted
27 from ultimate users, from hospice or home health care providers
28 on behalf of ultimate users to the extent federal law allows, or

any person lawfully entitled to dispose of a decedent's property if the decedent was an ultimate user who died while in lawful possession of a controlled substance, through:

(1) Collection receptacles, drug disposal boxes, mail back packages, and other means by a Drug Enforcement Agency-authorized collector in accordance with federal regulations even if the authorized collector did not originally dispense the drug; or

(2) Drug take back programs conducted by federal, state, tribal, or local law enforcement agencies in partnership with any person or entity.

This subsection shall supersede and preempt any local ordinances or regulations, including any ordinances or regulations enacted by any political subdivision of the state, regarding the disposal of unused controlled substances. For the purposes of this section, the term "ultimate user" shall mean a person who has lawfully obtained and possesses a controlled substance for his or her own use or for the use of a member of his or her household or for an animal owned by him or her or a member of his or her household.

2. By August 28, 2019, the department of health and senior services shall develop an education and awareness program regarding drug disposal, including controlled substances. The education and awareness program may include, but not be limited to:

(1) A web-based resource that:

(a) Describes available drug disposal options including take back, take back events, mail back packages, in-home disposal

1 options that render a product safe from misuse, or any other
2 methods that comply with state and federal laws and regulations,
3 may reduce the availability of unused controlled substances, and
4 may minimize the potential environmental impact of drug disposal;
5 (b) Provides a list of drug disposal take back sites, which
6 may be sorted and searched by name or location and is updated
7 every six months by the department;
8 (c) Provides a list of take back events and mail back
9 events in the state, including the date, time, and location
10 information for each event and is updated every six months by the
11 department; and
12 (d) Provides information for authorized collectors
13 regarding state and federal requirements to comply with the
14 provisions of subsection 1 of this section; and
15 (2) Promotional activities designed to ensure consumer
16 awareness of proper storage and disposal of prescription drugs,
17 including controlled substances.
18 208.183. 1. There shall be established an "Advisory
19 Council on Rare Diseases and Personalized Medicine" within the MO
20 HealthNet division. The advisory council shall serve as an
21 expert advisory committee to the drug utilization review board,
22 providing necessary consultation to the board when the board
23 makes recommendations or determinations regarding beneficiary
24 access to drugs or biological products for rare diseases, or when
25 the board itself determines that it lacks the specific
26 scientific, medical, or technical expertise necessary for the
27 proper performance of its responsibilities and such necessary
28 expertise can be provided by experts outside the board.

"Beneficiary access", as used in this section, shall mean developing prior authorization and reauthorization criteria for a rare disease drug, including placement on a preferred drug list or a formulary, as well as payment, cost-sharing, drug utilization review, or medication therapy management.

2. The advisory council on rare diseases and personalized medicine shall be composed of the following health care professionals, who shall be appointed by the director of the department of social services:

(1) Two physicians affiliated with a public school of medicine who are licensed and practicing in this state with experience researching, diagnosing, or treating rare diseases;

(2) Two physicians affiliated with private schools of medicine headquartered in this state who are licensed and practicing in this state with experience researching, diagnosing, or treating rare diseases;

(3) A physician who holds a doctor of osteopathy degree, who is active in medical practice, and who is affiliated with a school of medicine in this state with experience researching, diagnosing, or treating rare diseases;

(4) Two medical researchers from either academic research institutions or medical research organizations in this state who have received federal or foundation grant funding for rare disease research;

(5) A registered nurse or advanced practice registered nurse licensed and practicing in this state with experience treating rare diseases;

(6) A pharmacist practicing in a hospital in this state

1 which has a designated orphan disease center;
2 (7) A professor employed by a pharmacy program in this
3 state that is fully accredited by the Accreditation Council for
4 Pharmacy Education and who has advanced scientific or medical
5 training in orphan and rare disease treatments;
6 (8) One individual representing the rare disease community
7 or who is living with a rare disease;
8 (9) One member who represents a rare disease foundation;
9 (10) A representative from a rare disease center located
10 within one of the state's comprehensive pediatric hospitals;
11 (11) The chairperson of the joint committee on the life
12 sciences or the chairperson's designee; and
13 (12) The chairperson of the drug utilization review board,
14 or the chairperson's designee, who shall serve as an ex officio,
15 nonvoting member of the advisory council.
16 3. The director shall convene the first meeting of the
17 advisory council on rare diseases and personalized medicine no
18 later than February 28, 2019. Following the first meeting, the
19 advisory council shall meet upon the call of the chairperson of
20 the drug utilization review board or upon the request of a
21 majority of the council members.
22 4. The drug utilization review board, when making
23 recommendations or determinations regarding beneficiary access to
24 drugs and biological products for rare diseases, as defined in
25 the federal Orphan Drug Act of 1983, P.L. 97-414, and drugs and
26 biological products that are approved by the U.S. Food and Drug
27 Administration and within the emerging fields of personalized
28 medicine and noninheritable gene editing therapeutics, shall

1 request and consider information from the advisory council on
2 rare diseases and personalized medicine.
3 5. The drug utilization review board shall seek the input
4 of the advisory council on rare diseases and personalized
5 medicine to address topics for consultation under this section
6 including, but not limited to:
7 (1) Rare diseases;
8 (2) The severity of rare diseases;
9 (3) The unmet medical need associated with rare diseases;
10 (4) The impact of particular coverage, cost-sharing,
11 tiering, utilization management, prior authorization, medication
12 therapy management, or other Medicaid policies on access to rare
13 disease therapies;
14 (5) An assessment of the benefits and risks of therapies to
15 treat rare diseases;
16 (6) The impact of particular coverage, cost-sharing,
17 tiering, utilization management, prior authorization, medication
18 therapy management, or other Medicaid policies on patients'
19 adherence to the treatment regimen prescribed or otherwise
20 recommended by their physicians;
21 (7) Whether beneficiaries who need treatment from or a
22 consultation with a rare disease specialist have adequate access
23 and, if not, what factors are causing the limited access; and
24 (8) The demographics and the clinical description of
25 patient populations.
26 6. Nothing in this section shall be construed to create a
27 legal right for a consultation on any matter or to require the
28 drug utilization review board to meet with any particular expert

or stakeholder.

7. Recommendations of the advisory council on rare diseases and personalized medicine on an applicable treatment of a rare disease shall be explained in writing to members of the drug utilization review board during public hearings.

8. For purposes of this section, a "rare disease drug" shall mean a drug used to treat a rare medical condition, defined as any disease or condition that affects fewer than two hundred thousand persons in the United States, such as cystic fibrosis, hemophilia, and multiple myeloma.

9. All members of the advisory council on rare diseases and personalized medicine shall annually sign a conflict of interest statement revealing economic or other relationships with entities that could influence a member's decisions, and at least twenty percent of the advisory council members shall not have a conflict of interest with respect to any insurer, pharmaceutical benefits manager, or pharmaceutical manufacturer.

210.070. **[**Every**]** 1. A physician, midwife, or nurse who shall be in attendance upon a newborn infant or its mother**[**,**]** shall drop into the eyes of such infant **[**immediately after delivery,**]** a prophylactic **[**solution**]** medication approved by the state department of health and senior services**[**, and shall within forty-eight hours thereafter, report in writing to the board of health or county physician of the city, town or county where such birth occurs, his or her compliance with this section, stating the solution used by him or her**]**.

2. Administration of such eye drops shall not be required if a parent or legal guardian of such infant objects to the

treatment because it is against the religious beliefs of the parent or legal guardian.

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

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

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

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

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

(d) Has proficiency in the English language.

Any medical school graduate who could have applied for licensure and complied with the provisions of this subdivision at any time

1 between August 28, 2014, and August 28, 2017, may apply for
2 licensure and shall be deemed in compliance with the provisions
3 of this subdivision;
4 (2) "Assistant physician collaborative practice
5 arrangement", an agreement between a physician and an assistant
6 physician that meets the requirements of this section and section
7 334.037;
8 (3) "Medical school graduate", any person who has graduated
9 from a medical college or osteopathic medical college described
10 in section 334.031.
11 2. (1) An assistant physician collaborative practice
12 arrangement shall limit the assistant physician to providing only
13 primary care services and only in medically underserved rural or
14 urban areas of this state or in any pilot project areas
15 established in which assistant physicians may practice.
16 (2) For a physician-assistant physician team working in a
17 rural health clinic under the federal Rural Health Clinic
18 Services Act, P.L. 95-210, as amended:
19 (a) An assistant physician shall be considered a physician
20 assistant for purposes of regulations of the Centers for Medicare
21 and Medicaid Services (CMS); and
22 (b) No supervision requirements in addition to the minimum
23 federal law shall be required.
24 3. (1) For purposes of this section, the licensure of
25 assistant physicians shall take place within processes
26 established by rules of the state board of registration for the
27 healing arts. The board of healing arts is authorized to
28 establish rules under chapter 536 establishing licensure and

1 renewal procedures, supervision, collaborative practice
2 arrangements, fees, and addressing such other matters as are
3 necessary to protect the public and discipline the profession.
4 No licensure fee for an assistant physician shall exceed the
5 amount of any licensure fee for a physician assistant. An
6 application for licensure may be denied or the licensure of an
7 assistant physician may be suspended or revoked by the board in
8 the same manner and for violation of the standards as set forth
9 by section 334.100, or such other standards of conduct set by the
10 board by rule. No rule or regulation shall require an assistant
11 physician to complete more hours of continuing medical education
12 than that of a licensed physician.
13 (2) Any rule or portion of a rule, as that term is defined
14 in section 536.010, that is created under the authority delegated
15 in this section shall become effective only if it complies with
16 and is subject to all of the provisions of chapter 536 and, if
17 applicable, section 536.028. This section and chapter 536 are
18 nonseverable and if any of the powers vested with the general
19 assembly under chapter 536 to review, to delay the effective
20 date, or to disapprove and annul a rule are subsequently held
21 unconstitutional, then the grant of rulemaking authority and any
22 rule proposed or adopted after August 28, 2014, shall be invalid
23 and void.
24 (3) Any rules or regulations regarding assistant physicians
25 in effect as of the effective date of this section that conflict
26 with the provisions of this section and section 334.037 shall be
27 null and void as of the effective date of this section.
28 4. An assistant physician shall clearly identify himself or

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

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

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

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

334.037. 1. A physician may enter into collaborative

1 practice arrangements with assistant physicians. Collaborative
2 practice arrangements shall be in the form of written agreements,
3 jointly agreed-upon protocols, or standing orders for the
4 delivery of health care services. Collaborative practice
5 arrangements, which shall be in writing, may delegate to an
6 assistant physician the authority to administer or dispense drugs
7 and provide treatment as long as the delivery of such health care
8 services is within the scope of practice of the assistant
9 physician and is consistent with that assistant physician's
10 skill, training, and competence and the skill and training of the
11 collaborating physician.
12 2. The written collaborative practice arrangement shall
13 contain at least the following provisions:
14 (1) Complete names, home and business addresses, zip codes,
15 and telephone numbers of the collaborating physician and the
16 assistant physician;
17 (2) A list of all other offices or locations besides those
18 listed in subdivision (1) of this subsection where the
19 collaborating physician authorized the assistant physician to
20 prescribe;
21 (3) A requirement that there shall be posted at every
22 office where the assistant physician is authorized to prescribe,
23 in collaboration with a physician, a prominently displayed
24 disclosure statement informing patients that they may be seen by
25 an assistant physician and have the right to see the
26 collaborating physician;
27 (4) All specialty or board certifications of the
28 collaborating physician and all certifications of the assistant

physician;

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

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

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

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

(6) A description of the assistant physician's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the assistant physician to prescribe and

1 documentation that it is consistent with each professional's
2 education, knowledge, skill, and competence;
3 (7) A list of all other written practice agreements of the
4 collaborating physician and the assistant physician;
5 (8) The duration of the written practice agreement between
6 the collaborating physician and the assistant physician;
7 (9) A description of the time and manner of the
8 collaborating physician's review of the assistant physician's
9 delivery of health care services. The description shall include
10 provisions that the assistant physician shall submit a minimum of
11 ten percent of the charts documenting the assistant physician's
12 delivery of health care services to the collaborating physician
13 for review by the collaborating physician, or any other physician
14 designated in the collaborative practice arrangement, every
15 fourteen days; and
16 (10) The collaborating physician, or any other physician
17 designated in the collaborative practice arrangement, shall
18 review every fourteen days a minimum of twenty percent of the
19 charts in which the assistant physician prescribes controlled
20 substances. The charts reviewed under this subdivision may be
21 counted in the number of charts required to be reviewed under
22 subdivision (9) of this subsection.
23 3. The state board of registration for the healing arts
24 under section 334.125 shall promulgate rules regulating the use
25 of collaborative practice arrangements for assistant physicians.
26 Such rules shall specify:
27 (1) Geographic areas to be covered;
28 (2) The methods of treatment that may be covered by

collaborative practice arrangements;

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

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

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

1 by 20 CSR 2150-5.100 as of April 30, 2008.

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

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

19 6. A collaborating physician or supervising physician shall
20 not enter into a collaborative practice arrangement or
21 supervision agreement with more than **[**three**]** six full-time
22 equivalent assistant physicians, full-time equivalent physician
23 assistants, or full-time equivalent advance practice registered
24 nurses, or any combination thereof. Such limitation shall not
25 apply to collaborative arrangements of hospital employees
26 providing inpatient care service in hospitals as defined in
27 chapter 197 or population-based public health services as defined
28 by 20 CSR 2150-5.100 as of April 30, 2008, or to a certified

registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of section 334.104.

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

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

9. No contract or other agreement shall require a physician to act as a collaborating physician for an assistant physician against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular assistant physician. No contract or other agreement shall limit the collaborating physician's ultimate

1 authority over any protocols or standing orders or in the
2 delegation of the physician's authority to any assistant
3 physician, but such requirement shall not authorize a physician
4 in implementing such protocols, standing orders, or delegation to
5 violate applicable standards for safe medical practice
6 established by a hospital's medical staff.
7 10. No contract or other agreement shall require any
8 assistant physician to serve as a collaborating assistant
9 physician for any collaborating physician against the assistant
10 physician's will. An assistant physician shall have the right to
11 refuse to collaborate, without penalty, with a particular
12 physician.
13 11. All collaborating physicians and assistant physicians
14 in collaborative practice arrangements shall wear identification
15 badges while acting within the scope of their collaborative
16 practice arrangement. The identification badges shall
17 prominently display the licensure status of such collaborating
18 physicians and assistant physicians.
19 12. (1) An assistant physician with a certificate of
20 controlled substance prescriptive authority as provided in this
21 section may prescribe any controlled substance listed in Schedule
22 III, IV, or V of section 195.017, and may have restricted
23 authority in Schedule II, when delegated the authority to
24 prescribe controlled substances in a collaborative practice
25 arrangement. Prescriptions for Schedule II medications
26 prescribed by an assistant physician who has a certificate of
27 controlled substance prescriptive authority are restricted to
28 only those medications containing hydrocodone. Such authority

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

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

1 addiction treatment.

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

6 334.104. 1. A physician may enter into collaborative
7 practice arrangements with registered professional nurses.
8 Collaborative practice arrangements shall be in the form of
9 written agreements, jointly agreed-upon protocols, or standing
10 orders for the delivery of health care services. Collaborative
11 practice arrangements, which shall be in writing, may delegate to
12 a registered professional nurse the authority to administer or
13 dispense drugs and provide treatment as long as the delivery of
14 such health care services is within the scope of practice of the
15 registered professional nurse and is consistent with that nurse's
16 skill, training and competence.

17 2. Collaborative practice arrangements, which shall be in
18 writing, may delegate to a registered professional nurse the
19 authority to administer, dispense or prescribe drugs and provide
20 treatment if the registered professional nurse is an advanced
21 practice registered nurse as defined in subdivision (2) of
22 section 335.016. Collaborative practice arrangements may
23 delegate to an advanced practice registered nurse, as defined in
24 section 335.016, the authority to administer, dispense, or
25 prescribe controlled substances listed in Schedules III, IV, and
26 V of section 195.017, and Schedule II - hydrocodone; except that,
27 the collaborative practice arrangement shall not delegate the
28 authority to administer any controlled substances listed in

Schedules III, IV, and V of section 195.017, or Schedule II - hydrocodone for the purpose of inducing sedation or general anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic controlled substance and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill. Such collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols or standing orders for the delivery of health care services. An advanced practice registered nurse may prescribe buprenorphine for up to a thirty-day supply without refill for patient's receiving medication assisted treatment for substance use disorders under the direction of the collaborating physician.

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

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

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

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

1 (4) All specialty or board certifications of the
2 collaborating physician and all certifications of the advanced
3 practice registered nurse;
4 (5) The manner of collaboration between the collaborating
5 physician and the advanced practice registered nurse, including
6 how the collaborating physician and the advanced practice
7 registered nurse will:
8 (a) Engage in collaborative practice consistent with each
9 professional's skill, training, education, and competence;
10 (b) Maintain geographic proximity, except the collaborative
11 practice arrangement may allow for geographic proximity to be
12 waived for a maximum of twenty-eight days per calendar year for
13 rural health clinics as defined by P.L. 95-210, as long as the
14 collaborative practice arrangement includes alternative plans as
15 required in paragraph (c) of this subdivision. This exception to
16 geographic proximity shall apply only to independent rural health
17 clinics, provider-based rural health clinics where the provider
18 is a critical access hospital as provided in 42 U.S.C. Section
19 1395i-4, and provider-based rural health clinics where the main
20 location of the hospital sponsor is greater than fifty miles from
21 the clinic. The collaborating physician is required to maintain
22 documentation related to this requirement and to present it to
23 the state board of registration for the healing arts when
24 requested; and
25 (c) Provide coverage during absence, incapacity, infirmity,
26 or emergency by the collaborating physician;
27 (6) A description of the advanced practice registered
28 nurse's controlled substance prescriptive authority in

1 collaboration with the physician, including a list of the
2 controlled substances the physician authorizes the nurse to
3 prescribe and documentation that it is consistent with each
4 professional's education, knowledge, skill, and competence;
5 (7) A list of all other written practice agreements of the
6 collaborating physician and the advanced practice registered
7 nurse;
8 (8) The duration of the written practice agreement between
9 the collaborating physician and the advanced practice registered
10 nurse;
11 (9) A description of the time and manner of the
12 collaborating physician's review of the advanced practice
13 registered nurse's delivery of health care services. The
14 description shall include provisions that the advanced practice
15 registered nurse shall submit a minimum of ten percent of the
16 charts documenting the advanced practice registered nurse's
17 delivery of health care services to the collaborating physician
18 for review by the collaborating physician, or any other physician
19 designated in the collaborative practice arrangement, every
20 fourteen days; and
21 (10) The collaborating physician, or any other physician
22 designated in the collaborative practice arrangement, shall
23 review every fourteen days a minimum of twenty percent of the
24 charts in which the advanced practice registered nurse prescribes
25 controlled substances. The charts reviewed under this
26 subdivision may be counted in the number of charts required to be
27 reviewed under subdivision (9) of this subsection.
28 4. The state board of registration for the healing arts

1 pursuant to section 334.125 and the board of nursing pursuant to
2 section 335.036 may jointly promulgate rules regulating the use
3 of collaborative practice arrangements. Such rules shall be
4 limited to specifying geographic areas to be covered, the methods
5 of treatment that may be covered by collaborative practice
6 arrangements and the requirements for review of services provided
7 pursuant to collaborative practice arrangements including
8 delegating authority to prescribe controlled substances. Any
9 rules relating to dispensing or distribution of medications or
10 devices by prescription or prescription drug orders under this
11 section shall be subject to the approval of the state board of
12 pharmacy. Any rules relating to dispensing or distribution of
13 controlled substances by prescription or prescription drug orders
14 under this section shall be subject to the approval of the
15 department of health and senior services and the state board of
16 pharmacy. In order to take effect, such rules shall be approved
17 by a majority vote of a quorum of each board. Neither the state
18 board of registration for the healing arts nor the board of
19 nursing may separately promulgate rules relating to collaborative
20 practice arrangements. Such jointly promulgated rules shall be
21 consistent with guidelines for federally funded clinics. The
22 rulemaking authority granted in this subsection shall not extend
23 to collaborative practice arrangements of hospital employees
24 providing inpatient care within hospitals as defined pursuant to
25 chapter 197 or population-based public health services as defined
26 by 20 CSR 2150-5.100 as of April 30, 2008.
27 5. The state board of registration for the healing arts
28 shall not deny, revoke, suspend or otherwise take disciplinary

1 action against a physician for health care services delegated to
2 a registered professional nurse provided the provisions of this
3 section and the rules promulgated thereunder are satisfied. Upon
4 the written request of a physician subject to a disciplinary
5 action imposed as a result of an agreement between a physician
6 and a registered professional nurse or registered physician
7 assistant, whether written or not, prior to August 28, 1993, all
8 records of such disciplinary licensure action and all records
9 pertaining to the filing, investigation or review of an alleged
10 violation of this chapter incurred as a result of such an
11 agreement shall be removed from the records of the state board of
12 registration for the healing arts and the division of
13 professional registration and shall not be disclosed to any
14 public or private entity seeking such information from the board
15 or the division. The state board of registration for the healing
16 arts shall take action to correct reports of alleged violations
17 and disciplinary actions as described in this section which have
18 been submitted to the National Practitioner Data Bank. In
19 subsequent applications or representations relating to his
20 medical practice, a physician completing forms or documents shall
21 not be required to report any actions of the state board of
22 registration for the healing arts for which the records are
23 subject to removal under this section.
24 6. Within thirty days of any change and on each renewal,
25 the state board of registration for the healing arts shall
26 require every physician to identify whether the physician is
27 engaged in any collaborative practice agreement, including
28 collaborative practice agreements delegating the authority to

1 prescribe controlled substances, or physician assistant agreement
2 and also report to the board the name of each licensed
3 professional with whom the physician has entered into such
4 agreement. The board may make this information available to the
5 public. The board shall track the reported information and may
6 routinely conduct random reviews of such agreements to ensure
7 that agreements are carried out for compliance under this
8 chapter.
9 7. Notwithstanding any law to the contrary, a certified
10 registered nurse anesthetist as defined in subdivision (8) of
11 section 335.016 shall be permitted to provide anesthesia services
12 without a collaborative practice arrangement provided that he or
13 she is under the supervision of an anesthesiologist or other
14 physician, dentist, or podiatrist who is immediately available if
15 needed. Nothing in this subsection shall be construed to
16 prohibit or prevent a certified registered nurse anesthetist as
17 defined in subdivision (8) of section 335.016 from entering into
18 a collaborative practice arrangement under this section, except
19 that the collaborative practice arrangement may not delegate the
20 authority to prescribe any controlled substances listed in
21 Schedules III, IV, and V of section 195.017, or Schedule II -
22 hydrocodone.
23 8. A collaborating physician or supervising physician shall
24 not enter into a collaborative practice arrangement or
25 supervision agreement with more than **[**three**]** six full-time
26 equivalent advanced practice registered nurses, full-time
27 equivalent licensed physician assistants, or full-time equivalent
28 assistant physicians, or any combination thereof. This

1 limitation shall not apply to collaborative arrangements of
2 hospital employees providing inpatient care service in hospitals
3 as defined in chapter 197 or population-based public health
4 services as defined by 20 CSR 2150-5.100 as of April 30, 2008<u>, or</u>
5 <u>to a certified registered nurse anesthetist providing anesthesia</u>
6 <u>services under the supervision of an anesthesiologist or other</u>
7 <u>physician, dentist, or podiatrist who is immediately available if</u>
8 <u>needed as set out in subsection 7 of this section</u>.
9 9. It is the responsibility of the collaborating physician
10 to determine and document the completion of at least a one-month
11 period of time during which the advanced practice registered
12 nurse shall practice with the collaborating physician
13 continuously present before practicing in a setting where the
14 collaborating physician is not continuously present. This
15 limitation shall not apply to collaborative arrangements of
16 providers of population-based public health services as defined
17 by 20 CSR 2150-5.100 as of April 30, 2008.
18 10. No agreement made under this section shall supersede
19 current hospital licensing regulations governing hospital
20 medication orders under protocols or standing orders for the
21 purpose of delivering inpatient or emergency care within a
22 hospital as defined in section 197.020 if such protocols or
23 standing orders have been approved by the hospital's medical
24 staff and pharmaceutical therapeutics committee.
25 11. No contract or other agreement shall require a
26 physician to act as a collaborating physician for an advanced
27 practice registered nurse against the physician's will. A
28 physician shall have the right to refuse to act as a

1 collaborating physician, without penalty, for a particular
2 advanced practice registered nurse. No contract or other
3 agreement shall limit the collaborating physician's ultimate
4 authority over any protocols or standing orders or in the
5 delegation of the physician's authority to any advanced practice
6 registered nurse, but this requirement shall not authorize a
7 physician in implementing such protocols, standing orders, or
8 delegation to violate applicable standards for safe medical
9 practice established by hospital's medical staff.
10 12. No contract or other agreement shall require any
11 advanced practice registered nurse to serve as a collaborating
12 advanced practice registered nurse for any collaborating
13 physician against the advanced practice registered nurse's will.
14 An advanced practice registered nurse shall have the right to
15 refuse to collaborate, without penalty, with a particular
16 physician.
17 334.735. 1. As used in sections 334.735 to 334.749, the
18 following terms mean:
19 (1) "Applicant", any individual who seeks to become
20 licensed as a physician assistant;
21 (2) "Certification" or "registration", a process by a
22 certifying entity that grants recognition to applicants meeting
23 predetermined qualifications specified by such certifying entity;
24 (3) "Certifying entity", the nongovernmental agency or
25 association which certifies or registers individuals who have
26 completed academic and training requirements;
27 (4) "Department", the department of insurance, financial
28 institutions and professional registration or a designated agency

1 thereof;

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

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

18 (7) "Recognition", the formal process of becoming a
19 certifying entity as required by the provisions of sections
20 334.735 to 334.749;

21 (8) "Supervision", control exercised over a physician
22 assistant working with a supervising physician and oversight of
23 the activities of and accepting responsibility for the physician
24 assistant's delivery of care. The physician assistant shall only
25 practice at a location where the physician routinely provides
26 patient care, except existing patients of the supervising
27 physician in the patient's home and correctional facilities. The
28 supervising physician must be immediately available in person or

1 via telecommunication during the time the physician assistant is
2 providing patient care. Prior to commencing practice, the
3 supervising physician and physician assistant shall attest on a
4 form provided by the board that the physician shall provide
5 supervision appropriate to the physician assistant's training and
6 that the physician assistant shall not practice beyond the
7 physician assistant's training and experience. Appropriate
8 supervision shall require the supervising physician to be working
9 within the same facility as the physician assistant for at least
10 four hours within one calendar day for every fourteen days on
11 which the physician assistant provides patient care as described
12 in subsection 3 of this section. Only days in which the
13 physician assistant provides patient care as described in
14 subsection 3 of this section shall be counted toward the
15 fourteen-day period. The requirement of appropriate supervision
16 shall be applied so that no more than thirteen calendar days in
17 which a physician assistant provides patient care shall pass
18 between the physician's four hours working within the same
19 facility. The board shall promulgate rules pursuant to chapter
20 536 for documentation of joint review of the physician assistant
21 activity by the supervising physician and the physician
22 assistant.
23 2. (1) A supervision agreement shall limit the physician
24 assistant to practice only at locations described in subdivision
25 (8) of subsection 1 of this section, **[**where the supervising
26 physician is no further than fifty miles by road using the most
27 direct route available and where the location is not so situated
28 as to create an impediment to effective intervention and

supervision of patient care or adequate review of services] within a geographic proximity to be determined by the board of registration for the healing arts.

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

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

(1) Taking patient histories;

(2) Performing physical examinations of a patient;

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

(4) Performing routine therapeutic procedures;

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

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

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

1 a licensed physician;
2 (8) Assisting in surgery;
3 (9) Performing such other tasks not prohibited by law under
4 the supervision of a licensed physician as the physician's
5 assistant has been trained and is proficient to perform; and
6 (10) Physician assistants shall not perform or prescribe
7 abortions.
8 4. Physician assistants shall not prescribe any drug,
9 medicine, device or therapy unless pursuant to a physician
10 supervision agreement in accordance with the law, nor prescribe
11 lenses, prisms or contact lenses for the aid, relief or
12 correction of vision or the measurement of visual power or visual
13 efficiency of the human eye, nor administer or monitor general or
14 regional block anesthesia during diagnostic tests, surgery or
15 obstetric procedures. Prescribing of drugs, medications, devices
16 or therapies by a physician assistant shall be pursuant to a
17 physician assistant supervision agreement which is specific to
18 the clinical conditions treated by the supervising physician and
19 the physician assistant shall be subject to the following:
20 (1) A physician assistant shall only prescribe controlled
21 substances in accordance with section 334.747;
22 (2) The types of drugs, medications, devices or therapies
23 prescribed by a physician assistant shall be consistent with the
24 scopes of practice of the physician assistant and the supervising
25 physician;
26 (3) All prescriptions shall conform with state and federal
27 laws and regulations and shall include the name, address and
28 telephone number of the physician assistant and the supervising

1 physician;

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

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

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

25 6. For purposes of this section, the licensing of physician
26 assistants shall take place within processes established by the
27 state board of registration for the healing arts through rule and
28 regulation. The board of healing arts is authorized to establish

1 rules pursuant to chapter 536 establishing licensing and renewal
2 procedures, supervision, supervision agreements, fees, and
3 addressing such other matters as are necessary to protect the
4 public and discipline the profession. An application for
5 licensing may be denied or the license of a physician assistant
6 may be suspended or revoked by the board in the same manner and
7 for violation of the standards as set forth by section 334.100,
8 or such other standards of conduct set by the board by rule or
9 regulation. Persons licensed pursuant to the provisions of
10 chapter 335 shall not be required to be licensed as physician
11 assistants. All applicants for physician assistant licensure who
12 complete a physician assistant training program after January 1,
13 2008, shall have a master's degree from a physician assistant
14 program.
15 7. "Physician assistant supervision agreement" means a
16 written agreement, jointly agreed-upon protocols or standing
17 order between a supervising physician and a physician assistant,
18 which provides for the delegation of health care services from a
19 supervising physician to a physician assistant and the review of
20 such services. The agreement shall contain at least the
21 following provisions:
22 (1) Complete names, home and business addresses, zip codes,
23 telephone numbers, and state license numbers of the supervising
24 physician and the physician assistant;
25 (2) A list of all offices or locations where the physician
26 routinely provides patient care, and in which of such offices or
27 locations the supervising physician has authorized the physician
28 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

1 conditions as soon as practical, but in no case more than two
2 weeks after the patient has been seen by the physician assistant.
3 9. At all times the physician is responsible for the
4 oversight of the activities of, and accepts responsibility for,
5 health care services rendered by the physician assistant.
6 10. It is the responsibility of the supervising physician
7 to determine and document the completion of at least a one-month
8 period of time during which the licensed physician assistant
9 shall practice with a supervising physician continuously present
10 before practicing in a setting where a supervising physician is
11 not continuously present.
12 11. No contract or other agreement shall require a
13 physician to act as a supervising physician for a physician
14 assistant against the physician's will. A physician shall have
15 the right to refuse to act as a supervising physician, without
16 penalty, for a particular physician assistant. No contract or
17 other agreement shall limit the supervising physician's ultimate
18 authority over any protocols or standing orders or in the
19 delegation of the physician's authority to any physician
20 assistant, but this requirement shall not authorize a physician
21 in implementing such protocols, standing orders, or delegation to
22 violate applicable standards for safe medical practice
23 established by the hospital's medical staff.
24 12. Physician assistants shall file with the board a copy
25 of their supervising physician form.
26 13. No physician shall be designated to serve as
27 supervising physician or collaborating physician for more than
28 **[**three**]** six full-time equivalent licensed physician assistants,

full-time equivalent advanced practice registered nurses, or full-time equivalent assistant physicians, or any combination thereof. This limitation shall not apply to physician assistant agreements of hospital employees providing inpatient care service in hospitals as defined in chapter 197, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of section 334.104.

334.747. 1. A physician assistant with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to prescribe controlled substances in a supervision agreement. Such authority shall be listed on the supervision verification form on file with the state board of healing arts. The supervising physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the physician assistant is permitted to prescribe. Any limitations shall be listed on the supervision form. Prescriptions for Schedule II medications prescribed by a physician assistant with authority to prescribe delegated in a supervision agreement are restricted to only those medications containing hydrocodone. Physician assistants shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill, except that buprenorphine may be

1 prescribed for up to a thirty-day supply without refill for
2 patients receiving medication assisted treatment for substance
3 use disorders under the direction of the supervising physician.
4 Physician assistants who are authorized to prescribe controlled
5 substances under this section shall register with the federal
6 Drug Enforcement Administration and the state bureau of narcotics
7 and dangerous drugs, and shall include the Drug Enforcement
8 Administration registration number on prescriptions for
9 controlled substances.

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

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

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

1 agency shall satisfy such requirement;

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

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

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

22 337.025. 1. The provisions of this section shall govern
23 the education and experience requirements for initial licensure
24 as a psychologist for the following persons:

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

28 (2) A person who is matriculated after August 28, 1990, in

a graduate degree program designed to train professional psychologists.

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

3. A doctoral degree in psychology is defined as:

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

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

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

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

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

1 (c) There shall be a clear authority and primary
2 responsibility for the core and specialty areas whether or not
3 the program cuts across administrative lines;
4 (d) The program shall be an integrated, organized, sequence
5 of study;
6 (e) There shall be an identifiable psychology faculty and a
7 psychologist responsible for the program;
8 (f) The program shall have an identifiable body of students
9 who are matriculated in that program for a degree;
10 (g) The program shall include a supervised practicum,
11 internship, field, or laboratory training appropriate to the
12 practice of psychology;
13 (h) The curriculum shall encompass a minimum of three
14 academic years of full-time graduate study, with a minimum of one
15 year's residency at the educational institution granting the
16 doctoral degree; and
17 (i) Require the completion by the applicant of a core
18 program in psychology which shall be met by the completion and
19 award of at least one three-semester-hour graduate credit course
20 or a combination of graduate credit courses totaling three
21 semester hours or five quarter hours in each of the following
22 areas:
23 a. The biological bases of behavior such as courses in:
24 physiological psychology, comparative psychology,
25 neuropsychology, sensation and perception, psychopharmacology;
26 b. The cognitive-affective bases of behavior such as
27 courses in: learning, thinking, motivation, emotion, and
28 cognitive psychology;

1 c. The social bases of behavior such as courses in: social
2 psychology, group processes/dynamics, interpersonal
3 relationships, and organizational and systems theory;
4 d. Individual differences such as courses in: personality
5 theory, human development, abnormal psychology, developmental
6 psychology, child psychology, adolescent psychology, psychology
7 of aging, and theories of personality;
8 e. The scientific methods and procedures of understanding,
9 predicting and influencing human behavior such as courses in:
10 statistics, experimental design, psychometrics, individual
11 testing, group testing, and research design and methodology.
12 4. Acceptable supervised professional experience may be
13 accrued through preinternship, internship, predoctoral
14 postinternship, or postdoctoral experiences. The academic
15 training director or the postdoctoral training supervisor shall
16 attest to the hours accrued to meet the requirements of this
17 section. Such hours shall consist of:
18 (1) A minimum of fifteen hundred hours of experience in a
19 successfully completed internship to be completed in not less
20 than twelve nor more than twenty-four months; and
21 (2) A minimum of two thousand hours of experience
22 consisting of any combination of the following:
23 (a) Preinternship and predoctoral postinternship
24 professional experience that occurs following the completion of
25 the first year of the doctoral program or at any time while in a
26 doctoral program after completion of a master's degree in
27 psychology or equivalent as defined by rule by the committee;
28 (b) Up to seven hundred fifty hours obtained while on the

internship under subdivision (1) of this subsection but beyond the fifteen hundred hours identified in subdivision (1) of this subsection; or

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

5. Experience for those applicants who intend to seek health service provider certification and who have completed a program in one or more of the American Psychological Association designated health service provider delivery areas shall be obtained under the primary supervision of a licensed psychologist who is also a health service provider or who otherwise meets the requirements for health service provider certification. Experience for those applicants who do not intend to seek health service provider certification shall be obtained under the primary supervision of a licensed psychologist or such other qualified mental health professional approved by the committee.

6. For postinternship and postdoctoral hours, the psychological activities of the applicant shall be performed pursuant to the primary supervisor's order, control, and full professional responsibility. The primary supervisor shall maintain a continuing relationship with the applicant and shall meet with the applicant a minimum of one hour per month in face-

1 to-face individual supervision. Clinical supervision may be
2 delegated by the primary supervisor to one or more secondary
3 supervisors who are qualified psychologists. The secondary
4 supervisors shall retain order, control, and full professional
5 responsibility for the applicant's clinical work under their
6 supervision and shall meet with the applicant a minimum of one
7 hour per week in face-to-face individual supervision. If the
8 primary supervisor is also the clinical supervisor, meetings
9 shall be a minimum of one hour per week. Group supervision shall
10 not be acceptable for supervised professional experience. The
11 primary supervisor shall certify to the committee that the
12 applicant has complied with these requirements and that the
13 applicant has demonstrated ethical and competent practice of
14 psychology. The changing by an agency of the primary supervisor
15 during the course of the supervised experience shall not
16 invalidate the supervised experience.
17 7. The committee by rule shall provide procedures for
18 exceptions and variances from the requirements for once a week
19 face-to-face supervision due to vacations, illness, pregnancy,
20 and other good causes.
21 337.029. 1. A psychologist licensed in another
22 jurisdiction who has had no violations and no suspensions and no
23 revocation of a license to practice psychology in any
24 jurisdiction may receive a license in Missouri, provided the
25 psychologist passes a written examination on Missouri laws and
26 regulations governing the practice of psychology and meets one of
27 the following criteria:
28 (1) Is a diplomate of the American Board of Professional

Psychology;

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

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

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

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

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

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

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

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

3. A psychologist who receives a license for the practice of psychology in the state of Missouri on the basis of reciprocity as listed in subsection 1 of this section or by endorsement of the score from the examination of professional practice in psychology score will also be eligible for and shall

1 receive certification from the committee as a health service
2 provider if the psychologist meets one or more of the following
3 criteria:
4 (1) Is a diplomate of the American Board of Professional
5 Psychology in one or more of the specialties recognized by the
6 American Board of Professional Psychology as pertaining to health
7 service delivery;
8 (2) Is a member of the National Register of Health Service
9 Providers in Psychology; or
10 (3) Has completed or obtained through education, training,
11 or experience the requisite knowledge comparable to that which is
12 required pursuant to section 337.033.
13 337.033. 1. A licensed psychologist shall limit his or her
14 practice to demonstrated areas of competence as documented by
15 relevant professional education, training, and experience. A
16 psychologist trained in one area shall not practice in another
17 area without obtaining additional relevant professional
18 education, training, and experience through an acceptable program
19 of respecialization.
20 2. A psychologist may not represent or hold himself or
21 herself out as a state certified or registered psychological
22 health service provider unless the psychologist has first
23 received the psychologist health service provider certification
24 from the committee; provided, however, nothing in this section
25 shall be construed to limit or prevent a licensed, whether
26 temporary, provisional or permanent, psychologist who does not
27 hold a health service provider certificate from providing
28 psychological services so long as such services are consistent

1 with subsection 1 of this section.

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

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

24 (1) A doctoral degree or completion of a recognized
25 respecialization program in one or more of the American
26 Psychological Association designated health service provider
27 delivery areas which is accredited, or provisionally accredited,
28 <u>either</u> by the American Psychological Association <u>or the</u>

1 Psychological Clinical Science Accreditation System; or
2 (2) A clinical or counseling psychology doctoral degree
3 program or respecialization program designated, or provisionally
4 approved, by the Association of State and Provincial Psychology
5 Boards or the Council for the National Register of Health Service
6 Providers in Psychology, or both; or
7 (3) A doctoral degree or completion of a respecialization
8 program in one or more of the American Psychological Association
9 designated health service provider delivery areas that meets the
10 following criteria:
11 (a) The program, wherever it may be administratively
12 housed, shall be clearly identified and labeled as being in one
13 or more of the American Psychological Association designated
14 health service provider delivery areas;
15 (b) Such a program shall specify in pertinent institutional
16 catalogues and brochures its intent to educate and train
17 professional psychologists in one or more of the American
18 Psychological Association designated health service provider
19 delivery areas.
20 5. A person who is lawfully licensed as a psychologist
21 pursuant to the provisions of this chapter on August 28, 1989, or
22 who has been approved to sit for examination prior to August 28,
23 1989, and who subsequently passes the examination shall be deemed
24 to have met all requirements for health service provider
25 certification; provided, however, that such person shall be
26 governed by the provisions of subsection 1 of this section with
27 respect to limitation of practice.
28 6. Any person who is lawfully licensed as a psychologist in

1 this state and who meets one or more of the following criteria
2 shall automatically, upon payment of the requisite fee, be
3 entitled to receive a health service provider certification from
4 the committee:
5 (1) Is a diplomate of the American Board of Professional
6 Psychology in one or more of the specialties recognized by the
7 American Board of Professional Psychology as pertaining to health
8 service delivery; or
9 (2) Is a member of the National Register of Health Service
10 Providers in Psychology.
11 338.202. 1. Notwithstanding any other provision of law to
12 the contrary, unless the prescriber has specified on the
13 prescription that dispensing a prescription for a maintenance
14 medication in an initial amount followed by periodic refills is
15 medically necessary, a pharmacist may exercise his or her
16 professional judgment to dispense varying quantities of
17 maintenance medication per fill, up to the total number of dosage
18 units as authorized by the prescriber on the original
19 prescription, including any refills. Dispensing of the
20 maintenance medication based on refills authorized by the
21 physician or prescriber on the prescription shall be limited to
22 no more than a ninety-day supply of the medication, and the
23 maintenance medication shall have been previously prescribed to
24 the patient for at least a three-month period. The supply
25 limitations provided in this subsection shall not apply if the
26 prescription is issued by a practitioner located in another state
27 according to and in compliance with the applicable laws of that
28 state and the United States or dispensed to a patient who is a

1 member of the United States Armed Forces serving outside the
2 United States.
3 2. For the purposes of this section, "maintenance
4 medication" is and means a medication prescribed for chronic
5 long-term conditions and that is taken on a regular, recurring
6 basis; except that, it shall not include controlled substances,
7 as defined in and under section 195.010.
8 374.426. 1. Any entity in the business of delivering or
9 financing health care shall provide data regarding quality of
10 patient care and patient satisfaction to the director of the
11 department of insurance, financial institutions and professional
12 registration. Failure to provide such data as required by the
13 director of the department of insurance, financial institutions
14 and professional registration shall constitute grounds for
15 violation of the unfair trade practices act, sections 375.930 to
16 375.948.
17 2. In defining data standards for quality of care and
18 patient satisfaction, the director of the department of
19 insurance, financial institutions and professional registration
20 shall:
21 (1) Use as the initial data set the HMO Employer Data and
22 Information Set developed by the National Committee for Quality
23 Assurance;
24 (2) Consult with nationally recognized accreditation
25 organizations, including but not limited to the National
26 Committee for Quality Assurance and the Joint Committee on
27 Accreditation of Health Care Organizations; and
28 (3) Consult with a state committee of a national committee

1 convened to develop standards regarding uniform billing of health
2 care claims.
3 3. In defining data standards for quality of care and
4 patient satisfaction, the director of the department of
5 insurance, financial institutions and professional registration
6 shall not require patient scoring of pain control.
7 4. Beginning August 28, 2018, the director of the
8 department of insurance, financial institutions and professional
9 registration shall discontinue the use of patient satisfaction
10 scores and shall not make them available to the public to the
11 extent allowed by federal law.
12 376.811. 1. Every insurance company and health services
13 corporation doing business in this state shall offer in all
14 health insurance policies benefits or coverage for chemical
15 dependency meeting the following minimum standards:
16 (1) Coverage for outpatient treatment through a
17 nonresidential treatment program, or through partial- or full-day
18 program services, of not less than twenty-six days per policy
19 benefit period;
20 (2) Coverage for residential treatment program of not less
21 than twenty-one days per policy benefit period;
22 (3) Coverage for medical or social setting detoxification
23 of not less than six days per policy benefit period;
24 (4) Coverage for medication-assisted treatment for
25 substance use disorders for use in treating such patient's
26 condition, including opioid-use and heroin-use disorders;
27 **[**(4)**]** (5) The coverages set forth in this subsection may be
28 subject to a separate lifetime frequency cap of not less than ten

1 episodes of treatment, except that such separate lifetime
2 frequency cap shall not apply to medical detoxification in a
3 life-threatening situation as determined by the treating
4 physician and subsequently documented within forty-eight hours of
5 treatment to the reasonable satisfaction of the insurance company
6 or health services corporation; and

7 **[**(5)**]** (6) The coverages set forth in this subsection:

8 (a) Shall be subject to the same coinsurance, co-payment
9 and deductible factors as apply to physical illness;

10 (b) May be administered pursuant to a managed care program
11 established by the insurance company or health services
12 corporation; and

13 (c) May deliver covered services through a system of
14 contractual arrangements with one or more providers, hospitals,
15 nonresidential or residential treatment programs, or other mental
16 health service delivery entities certified by the department of
17 mental health, or accredited by a nationally recognized
18 organization, or licensed by the state of Missouri.

19 2. In addition to the coverages set forth in subsection 1
20 of this section, every insurance company, health services
21 corporation and health maintenance organization doing business in
22 this state shall offer in all health insurance policies, benefits
23 or coverages for recognized mental illness, excluding chemical
24 dependency, meeting the following minimum standards:

25 (1) Coverage for outpatient treatment, including treatment
26 through partial- or full-day program services, for mental health
27 services for a recognized mental illness rendered by a licensed
28 professional to the same extent as any other illness;

1 (2) Coverage for residential treatment programs for the
2 therapeutic care and treatment of a recognized mental illness
3 when prescribed by a licensed professional and rendered in a
4 psychiatric residential treatment center licensed by the
5 department of mental health or accredited by the Joint Commission
6 on Accreditation of Hospitals to the same extent as any other
7 illness;
8 (3) Coverage for inpatient hospital treatment for a
9 recognized mental illness to the same extent as for any other
10 illness, not to exceed ninety days per year;
11 (4) The coverages set forth in this subsection shall be
12 subject to the same coinsurance, co-payment, deductible, annual
13 maximum and lifetime maximum factors as apply to physical
14 illness; and
15 (5) The coverages set forth in this subsection may be
16 administered pursuant to a managed care program established by
17 the insurance company, health services corporation or health
18 maintenance organization, and covered services may be delivered
19 through a system of contractual arrangements with one or more
20 providers, community mental health centers, hospitals,
21 nonresidential or residential treatment programs, or other mental
22 health service delivery entities certified by the department of
23 mental health, or accredited by a nationally recognized
24 organization, or licensed by the state of Missouri.
25 3. The offer required by sections 376.810 to 376.814 may be
26 accepted or rejected by the group or individual policyholder or
27 contract holder and, if accepted, shall fully and completely
28 satisfy and substitute for the coverage under section 376.779.

1 Nothing in sections 376.810 to 376.814 shall prohibit an
2 insurance company, health services corporation or health
3 maintenance organization from including all or part of the
4 coverages set forth in sections 376.810 to 376.814 as standard
5 coverage in their policies or contracts issued in this state.
6 4. Every insurance company, health services corporation and
7 health maintenance organization doing business in this state
8 shall offer in all health insurance policies mental health
9 benefits or coverage as part of the policy or as a supplement to
10 the policy. Such mental health benefits or coverage shall
11 include at least two sessions per year to a licensed
12 psychiatrist, licensed psychologist, licensed professional
13 counselor, licensed clinical social worker, or, subject to
14 contractual provisions, a licensed marital and family therapist,
15 acting within the scope of such license and under the following
16 minimum standards:
17 (1) Coverage and benefits in this subsection shall be for
18 the purpose of diagnosis or assessment, but not dependent upon
19 findings; and
20 (2) Coverage and benefits in this subsection shall not be
21 subject to any conditions of preapproval, and shall be deemed
22 reimbursable as long as the provisions of this subsection are
23 satisfied; and
24 (3) Coverage and benefits in this subsection shall be
25 subject to the same coinsurance, co-payment and deductible
26 factors as apply to regular office visits under coverages and
27 benefits for physical illness.
28 5. If the group or individual policyholder or contract

holder rejects the offer required by this section, then the coverage shall be governed by the mental health and chemical dependency insurance act as provided in sections 376.825 to 376.836.

6. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1237. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2014, and that provides coverage for prescription eye drops shall provide coverage for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period without regard to a coverage restriction for early refill of prescription renewals as long as the prescribing health care provider authorizes such early refill, and the health carrier or the health benefit plan is notified.

2. For the purposes of this section, health carrier and health benefit plan shall have the same meaning as defined in section 376.1350.

3. The coverage required by 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.

1 4. The provisions of this section shall not apply to a
2 supplemental insurance policy, including a life care contract,
3 accident-only policy, specified disease policy, hospital policy
4 providing a fixed daily benefit only, Medicare supplement policy,
5 long-term care policy, short-term major medical policies of six
6 months' or less duration, or any other supplemental policy as
7 determined by the director of the department of insurance,
8 financial institutions and professional registration.
9 **[**5. The provisions of this section shall terminate on
10 January 1, 2020.**]**
11 376.1550. 1. Notwithstanding any other provision of law to
12 the contrary, each health carrier that offers or issues health
13 benefit plans which are delivered, issued for delivery,
14 continued, or renewed in this state on or after January 1, 2005,
15 shall provide coverage for a mental health condition, as defined
16 in this section, and shall comply with the following provisions:
17 (1) A health benefit plan shall provide coverage for
18 treatment of a mental health condition and shall not establish
19 any rate, term, or condition that places a greater financial
20 burden on an insured for access to treatment for a mental health
21 condition than for access to treatment for a physical health
22 condition. Any deductible or out-of-pocket limits required by a
23 health carrier or health benefit plan shall be comprehensive for
24 coverage of all health conditions, whether mental or physical;
25 (2) The coverages set forth is this subsection:
26 (a) May be administered pursuant to a managed care program
27 established by the health carrier; and
28 (b) May deliver covered services through a system of

1 contractual arrangements with one or more providers, hospitals,
2 nonresidential or residential treatment programs, or other mental
3 health service delivery entities certified by the department of
4 mental health, or accredited by a nationally recognized
5 organization, or licensed by the state of Missouri;
6 (3) A health benefit plan that does not otherwise provide
7 for management of care under the plan or that does not provide
8 for the same degree of management of care for all health
9 conditions may provide coverage for treatment of mental health
10 conditions through a managed care organization; provided that the
11 managed care organization is in compliance with rules adopted by
12 the department of insurance, financial institutions and
13 professional registration that assure that the system for
14 delivery of treatment for mental health conditions does not
15 diminish or negate the purpose of this section. The rules
16 adopted by the director shall assure that:
17 (a) Timely and appropriate access to care is available;
18 (b) The quantity, location, and specialty distribution of
19 health care providers is adequate; and
20 (c) Administrative or clinical protocols do not serve to
21 reduce access to medically necessary treatment for any insured;
22 (4) Coverage for treatment for chemical dependency shall
23 comply with sections 376.779, 376.810 to 376.814, and 376.825 to
24 376.836 and for the purposes of this subdivision the term "health
25 insurance policy" as used in sections 376.779, 376.810 to
26 376.814, and 376.825 to 376.836, the term "health insurance
27 policy" shall include group coverage.
28 2. As used in this section, the following terms mean:

1 (1) "Chemical dependency", the psychological or
2 physiological dependence upon and abuse of drugs, including
3 alcohol, characterized by drug tolerance or withdrawal and
4 impairment of social or occupational role functioning or both;
5 (2) "Health benefit plan", the same meaning as such term is
6 defined in section 376.1350;
7 (3) "Health carrier", the same meaning as such term is
8 defined in section 376.1350;
9 (4) "Mental health condition", any condition or disorder
10 defined by categories listed in the most recent edition of the
11 Diagnostic and Statistical Manual of Mental Disorders **[**except for
12 chemical dependency**]**;
13 (5) "Managed care organization", any financing mechanism or
14 system that manages care delivery for its members or subscribers,
15 including health maintenance organizations and any other similar
16 health care delivery system or organization;
17 (6) "Rate, term, or condition", any lifetime or annual
18 payment limits, deductibles, co-payments, coinsurance, and other
19 cost-sharing requirements, out-of-pocket limits, visit limits,
20 and any other financial component of a health benefit plan that
21 affects the insured.
22 3. This section shall not apply to a health plan or policy
23 that is individually underwritten or provides such coverage for
24 specific individuals and members of their families pursuant to
25 section 376.779, sections 376.810 to 376.814, and sections
26 376.825 to 376.836, a supplemental insurance policy, including a
27 life care contract, accident-only policy, specified disease
28 policy, hospital policy providing a fixed daily benefit only,

1 Medicare supplement policy, long-term care policy,
2 hospitalization-surgical care policy, short-term major medical
3 policies of six months or less duration, or any other
4 supplemental policy as determined by the director of the
5 department of insurance, financial institutions and professional
6 registration.

7 4. Notwithstanding any other provision of law to the
8 contrary, all health insurance policies that cover state
9 employees, including the Missouri consolidated health care plan,
10 shall include coverage for mental illness. Multiyear group
11 policies need not comply until the expiration of their current
12 multiyear term unless the policyholder elects to comply before
13 that time.

14 5. The provisions of this section shall not be violated if
15 the insurer decides to apply different limits or exclude entirely
16 from coverage the following:

17 (1) Marital, family, educational, or training services
18 unless medically necessary and clinically appropriate;

19 (2) Services rendered or billed by a school or halfway
20 house;

21 (3) Care that is custodial in nature;

22 (4) Services and supplies that are not immediately nor
23 clinically appropriate; or

24 (5) Treatments that are considered experimental.

25 6. The director shall grant a policyholder a waiver from
26 the provisions of this section if the policyholder demonstrates
27 to the director by actual experience over any consecutive twenty-
28 four-month period that compliance with this section has increased

1 the cost of the health insurance policy by an amount that results
2 in a two percent increase in premium costs to the policyholder.
3 The director shall promulgate rules establishing a procedure and
4 appropriate standards for making such a demonstration. Any rule
5 or portion of a rule, as that term is defined in section 536.010,
6 that is created under the authority delegated in this section
7 shall become effective only if it complies with and is subject to
8 all of the provisions of chapter 536 and, if applicable, section
9 536.028. This section and chapter 536 are nonseverable and if
10 any of the powers vested with the general assembly pursuant to
11 chapter 536 to review, to delay the effective date, or to
12 disapprove and annul a rule are subsequently held
13 unconstitutional, then the grant of rulemaking authority and any
14 rule proposed or adopted after August 28, 2004, shall be invalid
15 and void.
16 630.875. 1. This section shall be known and may be cited
17 as the "Improved Access to Treatment for Opioid Addictions Act"
18 or "IATOA Act".
19 2. As used in this section, the following terms mean:
20 (1) "Department", the department of mental health;
21 (2) "IATOA program", the improved access to treatment for
22 opioid addictions program created under subsection 3 of this
23 section.
24 3. Subject to appropriations, the department shall create
25 and oversee an "Improved Access to Treatment for Opioid
26 Addictions Program", which is hereby created and whose purpose is
27 to disseminate information and best practices regarding opioid
28 addiction and to facilitate collaborations to better treat and

1 prevent opioid addiction in this state. The IATOA program shall
2 facilitate partnerships between assistant physicians, physician
3 assistants, and advanced practice registered nurses practicing in
4 federally qualified health centers, rural health clinics, and
5 other health care facilities and physicians practicing at remote
6 facilities located in this state. The IATOA program shall
7 provide resources that grant patients and their treating
8 assistant physicians, physician assistants, advanced practice
9 registered nurses, or physicians access to knowledge and
10 expertise through means such as telemedicine and Extension for
11 Community Healthcare Outcomes (ECHO) programs established under
12 section 191.1140.
13 4. Assistant physicians, physician assistants, and advanced
14 practice registered nurses who participate in the IATOA program
15 shall complete the necessary requirements to prescribe
16 buprenorphine within at least thirty days of joining the IATOA
17 program.
18 5. For the purposes of the IATOA program, a remote
19 collaborating or supervising physician working with an on-site
20 assistant physician, physician assistant, or advanced practice
21 registered nurse shall be considered to be on-site. An assistant
22 physician, physician assistant, or advanced practice registered
23 nurse collaborating with a remote physician shall comply with all
24 laws and requirements applicable to assistant physicians,
25 physician assistants, or advanced practice registered nurses with
26 on-site supervision before providing treatment to a patient.
27 6. An assistant physician, physician assistant, or advanced
28 practice registered nurse collaborating with a physician who is

1 waiver-certified for the use of buprenorphine, may participate in
2 the IATOA program in any area of the state and provide all
3 services and functions of an assistant physician, physician
4 assistant, or advanced practice registered nurse.
5 7. The department may develop curriculum and benchmark
6 examinations on the subject of opioid addiction and treatment.
7 The department may collaborate with specialists, institutions of
8 higher education, and medical schools for such development.
9 Completion of such a curriculum and passing of such an
10 examination by an assistant physician, physician assistant,
11 advanced practice registered nurse, or physician shall result in
12 a certificate awarded by the department or sponsoring
13 institution, if any.
14 8. An assistant physician, physician assistant, or advanced
15 practice registered nurse participating in the IATOA program may
16 also:
17 (1) Engage in community education;
18 (2) Engage in professional education outreach programs with
19 local treatment providers;
20 (3) Serve as a liaison to courts;
21 (4) Serve as a liaison to addiction support organizations;
22 (5) Provide educational outreach to schools;
23 (6) Treat physical ailments of patients in an addiction
24 treatment program or considering entering such a program;
25 (7) Refer patients to treatment centers;
26 (8) Assist patients with court and social service
27 obligations;
28 (9) Perform other functions as authorized by the

department; and

(10) Provide mental health services in collaboration with a qualified licensed physician.

The list of authorizations in this subsection is a nonexclusive list, and assistant physicians, physician assistants, or advanced practice registered nurses participating in the IATOA program may perform other actions.

9. When an overdose survivor arrives in the emergency department, the assistant physician, physician assistant, or advanced practice registered nurse serving as a recovery coach or, if the assistant physician, physician assistant, or advanced practice registered nurse is unavailable, another properly trained recovery coach shall, when reasonably practicable, meet with the overdose survivor and provide treatment options and support available to the overdose survivor. The department shall assist recovery coaches in providing treatment options and support to overdose survivors.

10. The provisions of this section shall supersede any contradictory statutes, rules, or regulations. The department shall implement the improved access to treatment for opioid addictions program as soon as reasonably possible using guidance within this section. Further refinement to the improved access to treatment for opioid addictions program may be done through the rules process.

11. The department shall promulgate rules to implement the provisions of the improved access to treatment for opioid addictions act as soon as reasonably possible. Any rule or

portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void.

632.005. As used in chapter 631 and this chapter, unless the context clearly requires otherwise, the following terms shall mean:

(1) "Comprehensive psychiatric services", any one, or any combination of two or more, of the following services to persons affected by mental disorders other than intellectual disabilities or developmental disabilities: inpatient, outpatient, day program or other partial hospitalization, emergency, diagnostic, treatment, liaison, follow-up, consultation, education, rehabilitation, prevention, screening, transitional living, medical prevention and treatment for alcohol abuse, and medical prevention and treatment for drug abuse;

(2) "Council", the Missouri advisory council for comprehensive psychiatric services;

(3) "Court", the court which has jurisdiction over the respondent or patient;

(4) "Division", the division of comprehensive psychiatric

1 services of the department of mental health;

2 (5) "Division director", director of the division of
3 comprehensive psychiatric services of the department of mental
4 health, or his designee;

5 (6) "Head of mental health facility", superintendent or
6 other chief administrative officer of a mental health facility,
7 or his designee;

8 (7) "Judicial day", any Monday, Tuesday, Wednesday,
9 Thursday or Friday when the court is open for business, but
10 excluding Saturdays, Sundays and legal holidays;

11 (8) "Licensed physician", a physician licensed pursuant to
12 the provisions of chapter 334 or a person authorized to practice
13 medicine in this state pursuant to the provisions of section
14 334.150;

15 (9) "Licensed professional counselor", a person licensed as
16 a professional counselor under chapter 337 and with a minimum of
17 one year training or experience in providing psychiatric care,
18 treatment, or services in a psychiatric setting to individuals
19 suffering from a mental disorder;

20 (10) "Likelihood of serious harm" means any one or more of
21 the following but does not require actual physical injury to have
22 occurred:

23 (a) A substantial risk that serious physical harm will be
24 inflicted by a person upon his own person, as evidenced by recent
25 threats, including verbal threats, or attempts to commit suicide
26 or inflict physical harm on himself. Evidence of substantial
27 risk may also include information about patterns of behavior that
28 historically have resulted in serious harm previously being

1 inflicted by a person upon himself;
2 (b) A substantial risk that serious physical harm to a
3 person will result or is occurring because of an impairment in
4 his capacity to make decisions with respect to his
5 hospitalization and need for treatment as evidenced by his
6 current mental disorder or mental illness which results in an
7 inability to provide for his own basic necessities of food,
8 clothing, shelter, safety or medical care or his inability to
9 provide for his own mental health care which may result in a
10 substantial risk of serious physical harm. Evidence of that
11 substantial risk may also include information about patterns of
12 behavior that historically have resulted in serious harm to the
13 person previously taking place because of a mental disorder or
14 mental illness which resulted in his inability to provide for his
15 basic necessities of food, clothing, shelter, safety or medical
16 or mental health care; or
17 (c) A substantial risk that serious physical harm will be
18 inflicted by a person upon another as evidenced by recent overt
19 acts, behavior or threats, including verbal threats, which have
20 caused such harm or which would place a reasonable person in
21 reasonable fear of sustaining such harm. Evidence of that
22 substantial risk may also include information about patterns of
23 behavior that historically have resulted in physical harm
24 previously being inflicted by a person upon another person;
25 (11) "Mental health coordinator", a mental health
26 professional who has knowledge of the laws relating to hospital
27 admissions and civil commitment and who is authorized by the
28 director of the department, or his designee, to serve a

designated geographic area or mental health facility and who has the powers, duties and responsibilities provided in this chapter;

(12) "Mental health facility", any residential facility, public or private, or any public or private hospital, which can provide evaluation, treatment and, inpatient care to persons suffering from a mental disorder or mental illness and which is recognized as such by the department or any outpatient treatment program certified by the department of mental health. No correctional institution or facility, jail, regional center or developmental disability facility shall be a mental health facility within the meaning of this chapter;

(13) "Mental health professional", a psychiatrist, resident in psychiatry, psychiatric physician assistant, psychiatric assistant physician, psychiatric advanced practice registered nurse, psychologist, psychiatric nurse, licensed professional counselor, or psychiatric social worker;

(14) "Mental health program", any public or private residential facility, public or private hospital, public or private specialized service or public or private day program that can provide care, treatment, rehabilitation or services, either through its own staff or through contracted providers, in an inpatient or outpatient setting to persons with a mental disorder or mental illness or with a diagnosis of alcohol abuse or drug abuse which is recognized as such by the department. No correctional institution or facility or jail may be a mental health program within the meaning of this chapter;

(15) "Ninety-six hours" shall be construed and computed to exclude Saturdays, Sundays and legal holidays which are observed

1 either by the court or by the mental health facility where the
2 respondent is detained;
3 (16) "Peace officer", a sheriff, deputy sheriff, county or
4 municipal police officer or highway patrolman;
5 (17) "Psychiatric advanced practice registered nurse", a
6 registered nurse who is currently recognized by the board of
7 nursing as an advanced practice registered nurse, who has at
8 least two years of experience in providing psychiatric treatment
9 to individuals suffering from mental disorders;
10 (18) "Psychiatric assistant physician", a licensed
11 assistant physician under chapter 334 and who has had at least
12 two years of experience as an assistant physician in providing
13 psychiatric treatment to individuals suffering from mental health
14 disorders;
15 (19) "Psychiatric nurse", a registered professional nurse
16 who is licensed under chapter 335 and who has had at least two
17 years of experience as a registered professional nurse in
18 providing psychiatric nursing treatment to individuals suffering
19 from mental disorders;
20 (20) "Psychiatric physician assistant", a licensed
21 physician assistant under chapter 334 and who has had at least
22 two years of experience as a physician assistant in providing
23 psychiatric treatment to individuals suffering from mental health
24 disorders or a graduate of a postgraduate residency or fellowship
25 for physician assistants in psychiatry;
26 **[**(18)**]** (21) "Psychiatric social worker", a person with a
27 master's or further advanced degree from an accredited school of
28 social work, practicing pursuant to chapter 337, and with a

minimum of one year training or experience in providing psychiatric care, treatment or services in a psychiatric setting to individuals suffering from a mental disorder;

[(19)**]** (22) "Psychiatrist", a licensed physician who in addition has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program certified as equivalent by the department;

[(20)**]** (23) "Psychologist", a person licensed to practice psychology under chapter 337 with a minimum of one year training or experience in providing treatment or services to mentally disordered or mentally ill individuals;

[(21)**]** (24) "Resident in psychiatry", a licensed physician who is in a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program certified as equivalent by the department;

[(22)**]** (25) "Respondent", an individual against whom involuntary civil detention proceedings are instituted pursuant to this chapter;

[(23)**]** (26) "Treatment", any effort to accomplish a significant change in the mental or emotional conditions or the behavior of the patient consistent with generally recognized principles or standards in the mental health professions.

Section B. Because immediate action is necessary to save the lives of Missouri citizens who are suffering from the opioid crisis, the repeal and reenactment of sections 195.070, 217.364, 334.036, and 374.426 and the enactment of sections 9.192,

195.265, and 630.875 of this act are deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and are hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of sections 195.070, 217.364, 334.036, and 374.426 and the enactment of sections 9.192, 195.265, and 630.875 of this act shall be in full force and effect upon their passage and approval.

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Bill Eigel Shawn Rhoades