Journal of the Senate

SECOND REGULAR SESSION

SEVENTIETH DAY—MONDAY, MAY 14, 2018

The Senate met pursuant to adjournment.

President Parson in the Chair.

Reverend Carl Gauck offered the following prayer:

"His compassion fails not. They are new every morning." (Lamentations 3:22-23)

Gracious God, we are glad to be in Your presence, having arrived safely and ready to engage this final week together. We know by Your grace You count each here as Your child, children of the promise; so we ask that we may fully embrace these days remembering Your graciousness to us so that we might be gracious to those we encounter this day in gratitude to You for all you provide us. In Your Holy Name we pray. Amen.

The Pledge of Allegiance to the Flag was recited.

A quorum being established, the Senate proceeded with its business.

The Journal for Friday, May 11, 2018 was read and approved.

Senator Kehoe announced photographers from KOMU-TV were given permission to take pictures in the Senate Chamber.

The following Senators were present during the day's proceedings:

Present—Senators

Brown	Chappelle-Nadal	Cierpiot	Crawford	Cunningham	Curls	Dixon
Eigel	Emery	Hegeman	Hoskins	Hummel	Kehoe	Koenig
Munzlinger	Nasheed	Onder	Richard	Riddle	Rizzo	Romine
Rowden	Sater	Schaaf	Schatz	Schupp	Sifton	Wallingford
Walsh	Wasson	Wieland—31				

Absent—Senators—None

Absent with leave—Senators

Holsman	Libla—2

Vacancies—1

The Lieutenant Governor was present.

RESOLUTIONS

Senator Onder offered Senate Resolution No. 2084, regarding Robert Edward "Bob" Shanahan, O'Fallon, which was adopted.

Senator Kehoe offered Senate Resolution No. 2085, regarding David Steinmeyer, Jefferson City, which was adopted.

Senators Kehoe and Riddle offered Senate Resolution No. 2086, regarding the One Hundredth Anniversary of the Jefferson City Rotary Club, which was adopted.

Senator Hegeman offered Senate Resolution No. 2087, regarding Mary Ritko, which was adopted.

Senator Hegeman offered Senate Resolution No. 2088, regarding Leisa Bryson, King City, which was adopted.

Senator Hegeman offered Senate Resolution No. 2089, regarding Molly Livingston, which was adopted.

Senator Hegeman offered Senate Resolution No. 2090, regarding Cindy Whitney, which was adopted.

Senator Hegeman offered Senate Resolution No. 2091, regarding Virginia Neff, which was adopted.

Senator Hegeman offered Senate Resolution No. 2092, regarding Terri Clement, which was adopted.

Senator Hegeman offered Senate Resolution No. 2093, regarding Darbi Bauman, which was adopted.

Senator Hegeman offered Senate Resolution No. 2094, regarding Jodie Kurtz, which was adopted.

Senator Hegeman offered Senate Resolution No. 2095, regarding Brenda Ricks, which was adopted.

Senator Hegeman offered Senate Resolution No. 2096, regarding Wanda Bloom, which was adopted.

Senator Hegeman offered Senate Resolution No. 2097, regarding Cole Bird, which was adopted.

Senator Hegeman offered Senate Resolution No. 2098, regarding the Sixty-seventh Wedding Anniversary of Eugene and JoAnn Cooper, Stanberry, which was adopted.

Senator Hegeman offered Senate Resolution No. 2099, regarding the Fiftieth Wedding Anniversary of Don and Dorothy Clements, Hopkins, which was adopted.

On behalf of Senator Holsman, Senator Walsh offered Senate Resolution No. 2100, regarding Kansas City Chorus, which was adopted.

Senator Wasson offered Senate Resolution No. 2101, regarding Eagle Scout Spencer Davis, Nixa, which was adopted.

REFERRALS

President Pro Tem Richard referred **HCS** for **HCR 86** to the Committee on Rules, Joint Rules, Resolutions and Ethics.

CONFERENCE COMMITTEE APPOINTMENTS

President Pro Tem Richard appointed the following conference committee to act with a like committee from the House on **HCS** for **SCS** for **SB 718**, as amended: Senators Eigel, Onder, Sater, Holsman and Nasheed.

PRIVILEGED MOTIONS

Senator Hegeman moved that **SS No. 2** for **SCS** for **SB 590**, with **HA 1**, be taken up for 3rd reading and final passage, which motion prevailed.

HA 1 was taken up.

Senator Hegeman moved that the above amendment be adopted.

President Pro Tem Richard assumed the Chair.

At the request of Senator Hegeman, the above motion was withdrawn.

Senator Hegeman moved that the Senate refuse to concur in **HA 1** to **SS No. 2** for **SCS** for **SB 590** and request the House to recede from its position or, failing to do so, grant the Senate a conference thereon, which motion prevailed.

President Parson assumed the Chair.

Senator Nasheed and Senator Chappelle-Nadal were engaged in debate.

Senator Dixon raised a point of order that calling the motives of members into question is out of order, pursuant to U.S. Senate Rule 19.2, the usage of which is provided for in Senate Rule 97. The point of order was referred to the President Pro Tem who took it under advisement, which placed **SS No. 2** for **SCS** for **SB 590**, with **HA 1** and the point of order (pending), back on the Calendar.

HOUSE BILLS ON THIRD READING

At the request of Senator Dixon, **HCS** for **HB 2042**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Riddle, **HCS** for **HB 1868**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Riddle, **HCS** for **HB 2249**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Eigel, **HCS** for **HB 2540**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Koenig, **HB 1446**, with **SCS** was placed on the Informal Calendar.

HCS for **HBs 2337** and **2272**, with **SCS** was placed on the Informal Calendar.

HCS for **HBs 2277** and **1983**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Hoskins, **HCS** for **HB 2031** was placed on the Informal Calendar.

At the request of Senator Wallingford, **HCS** for **HB 1667**, with **SCS** was placed on the Informal Calendar.

HCS for **HB 1713**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Dixon, **HB 1249**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Riddle, **HB 1832**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Wallingford, **HB 2347**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Dixon, **HB 2562**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Cierpiot, **HB 1892** was placed on the Informal Calendar.

At the request of Senator Eigel, **HB 2208**, with **SCS** was placed on the Informal Calendar.

At the request of Senator Cunningham, **HB 2039** was placed on the Informal Calendar.

HCS for **HB 2540**, with **SCS**, entitled:

An Act to repeal sections 32.087, 32.200, 34.040, 34.042, 34.044, 34.047, 34.353, 66.601, 66.620, 67.395, 67.525, 67.571, 67.576, 67.578, 67.581, 67.582, 67.583, 67.584, 67.712, 67.713, 67.729, 67.737, 67.738, 67.745, 67.782, 67.799, 67.997, 67.1300, 67.1303, 67.1305, 67.1545, 67.1712, 67.1713, 67.1775, 67.1959, 67.1971, 67.2000, 67.2030, 67.2525, 67.2530, 94.578, 94.605, 94.660, 94.705, 100.286, 100.297, 135.025, 135.030, 135.110, 135.305, 135.313, 137.010, 143.011, 143.021, 143.022, 143.071, 143.151, 143.161, 143.171, 143.225, 143.261, 143.451, 143.461, 144.008, 144.010, 144.014, 144.030, 144.032, 144.043, 144.049, 144.060, 144.069, 144.070, 144.080, 144.083, 144.100, 144.121, 144.140, 144.210, 144.285, 144.517, 144.526, 144.600, 144.605, 144.635, 144.655, 144.710, 144.759, 144.761, 144.1000, 144.1003, 144.1006, 144.1009, 144.1012, 144.1015, 148.030, 148.140, 148.620, 184.845, 208.431, 208.432, 208.433, 208.434, 208.435, 208.436, 208.437, 208.1050, 221.407, 238.235, 238.410, 254.075, 254.150, 254.160, 254.170, 254.180, 254.210, 301.025, 301.032, 301.041, 301.050, 301.055, 301.057, 301.058, 301.059, 301.061, 301.062, 301.063, 301.064, 301.065, 301.066, 301.067, 301.069, 301.114, 301.131, 301.134, 301.136, 301.140, 301.142, 301.144, 301.175, 301.190, 301.191, 301.192, 301.219, 301.227, 301.265, 301.266, 301.267, 301.300, 301.370, 301.380, 301.449, 301.457, 301.458, 301.459, 301.462, 301.463, 301.468, 301.469, 301.471, 301.472, 301.473, 301.474, 301.477, 301.481, 301.560, 301.562, 301.566, 301.580, 301.711, 301.3032, 301.3040, 301.3043, 301.3045, 301.3047, 301.3049, 301.3050, 301.3051, 301.3052, 301.3053, 301.3054, 301.3055, 301.3060, 301.3061, 301.3062, 301.3065, 301.3074, 301.3075, 301.3076, 301.3077, 301.3078, 301.3079, 301.3080, 301.3082, 301.3084, 301.3086, 301.3087, 301.3088, 301.3089, 301.3092, 301.3093, 301.3094, 301.3095, 301.3096, 301.3097, 301.3098, 301.3099, 301.3101, 301.3102, 301.3103, 301.3105, 301.3106, 301.3107, 301.3109, 301.3115, 301.3117, 301.3118, 301.3119, 301.3122, 301.3123, 301.3124, 301.3125, 301.3126, 301.3128, 301.3129, 301.3130, 301.3131, 301.3132, 301.3133, 301.3137, 301.3139, 301.3141, 301.3143, 301.3144, 301.3145, 301.3146, 301.3147, 301.3150, 301.3154, 301.3161, 301.3162, 301.3163, 301.3165, 301.3166, 301.3167, 301.3168, 301.3169, 301.3170, 301.3172, 301.3173, 301.4000, 302.140, 302.177, 302.178, 302.181, 302.185, 302.286, 302.304, 302.312, 302.420, 302.541, 302.720, 302.735, 306.015, 306.016, 306.030, 306.031, 306.060, 306.127, 306.435, 306.535, 306.550, 313.826, 313.905, 313.935, 320.093, 479.368, and 644.032, RSMo, and to enact in lieu thereof two hundred eighty-five new sections relating to state revenues, with a contingent effective date for certain sections, a delayed effective date for certain sections, and penalty provisions.

Was called from the Informal Calendar and taken up by Senator Eigel.

SCS for **HCS** for **HB 2540**, entitled:

SENATE COMMITTEE SUBSTITUTE FOR
HOUSE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 2540

An Act to repeal sections 143.011, 143.022, 143.151, 143.161, and 143.171, RSMo, and to enact in lieu thereof six new sections relating to individual income taxes, with an effective date for certain sections and a contingent effective date for a certain section.

Was taken up.

President Pro Tem Richard assumed the Chair.

Senator Eigel moved that **SCS** for **HCS** for **HB 2540** be adopted.

Senator Schatz offered **SS** for **SCS** for **HCS** for **HB 2540**, entitled:

SENATE SUBSTITUTE FOR
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 2540

An Act to repeal sections 142.803, 143.011, 143.022, 143.151, 143.161, and 143.171, RSMo, and to enact in lieu thereof seven new sections relating to taxation, with a referendum clause.

Senator Schatz moved that **SS** for **SCS** for **HCS** for **HB 2540** be adopted.

Senator Schaaf offered **SA 1**, which was read:

SENATE AMENDMENT NO. 1

Amend Senate Substitute for Senate Committee Substitute for House Committee Substitute for House Bill No. 2540, Page 1, In the Title, Line 4, by inserting after the word "taxation" the following:

"**of Missouri's hard-working citizens**"

Senator Schaaf moved that the above amendment be adopted.

At the request of Senator Schatz, **SS** for **SCS** for **HCS** for **HB 2540** was withdrawn, rendering **SA 1** moot.

Senator Schupp offered **SA 1**:

SENATE AMENDMENT NO. 1

Amend Senate Committee Substitute for House Committee Substitute for House Bill No. 2540, Page 1, In the Title, Lines 4-5 of the title, by striking said lines and inserting in lieu thereof the following: "an effective date."; and

Further amend said bill, Page 2, Section 143.011, Lines 47-49, by striking said lines; and

Further amend said bill and section, Page 3, Lines 50-69, by striking said lines; and further amend said section by renumbering the subsections accordingly; and

Further amend said bill, Page 9, Section B, Lines 1-2, by striking "The repeal and reenactment of sections 143.011, 143.022, 143.151, 143.161, and 143.171" and inserting in lieu thereof the following: "Section A"; and

Further amend said bill and page, Section C, by striking all of said section from the bill; and

Further amend the title and enacting clause accordingly.

Senator Schupp moved that the above amendment be adopted.

President Parson assumed the Chair.

Senator Eigel offered **SSA 1** for **SA 1**:

SENATE SUBSTITUTE AMENDMENT NO. 1 FOR
SENATE AMENDMENT NO. 1

Amend Senate Committee Substitute for House Committee Substitute for House Bill No. 2540, Page 1,

In the Title, Lines 4-5 of the title, by striking said lines and inserting in lieu thereof the following: "an effective date."; and

Further amend said bill, page 2, section 143.011, lines 47-49, by striking said lines; and

Further amend said bill and section, Page 3, Lines 50-69, by striking said lines; and further amend said section by renumbering the remaining subsections accordingly; and

Further amend said bill, pages 7-9, section 143.177, by striking all of said section from the bill; and

Further amend said bill, page 9, Section B, Lines 1-2, by striking "The repeal and reenactment of sections 143.011, 143.022, 143.151, 143.161, and 143.171" and inserting in lieu thereof the following: "Section A"; and

Further amend said bill and page, Section C, by striking all of said section from the bill; and

Further amend the title and enacting clause accordingly.

Senator Eigel moved that the above substitute amendment be adopted, which motion prevailed.

President Pro Tem Richard assumed the Chair.

At the request of Senator Eigel, **HCS** for **HB 2540**, with **SCS** (pending), was placed on the Informal Calendar.

MESSAGES FROM THE HOUSE

The following messages were received from the House of Representatives through its Chief Clerk:

Mr. President: I am instructed by the House of Representatives to inform the Senate that the House has taken up and passed **HCS** for **SB 951**, entitled:

An Act to repeal sections 191.227, 197.052, 197.305, 210.070, 536.031, and 577.029, RSMo, and to enact in lieu thereof six new sections relating to health care.

With House Amendment Nos. 1, 2, House Amendment No. 1 to House Amendment No. 3, House Amendment No. 3, as amended, House Amendment Nos. 4, 5 and 6.

HOUSE AMENDMENT NO. 1

Amend House Committee Substitute for Senate Bill No. 951, Page 1, Section 191.227, Line 6, by deleting the phrase "**For the purposes of this subsection,**" and

Further amend said bill and section, Page 2, Line 27, by inserting at the end of said line a hard return and the following:

"**Such fee shall be the fee in effect on February 1, 2018, increased or decreased annually under this section.**"; and

Further amend said bill, Section 197.305, Pages 4 and 5, Lines 44 to 51, by deleting said lines and inserting in lieu thereof the following:

"(e) Any change in licensed bed capacity of a health care facility **licensed under chapter 198** which increases the total number of beds by more than ten or more than ten percent of total bed capacity,

whichever is less, over a two-year period**, provided that any such health care facility seeking an increase in total beds or total bed capacity in an amount less than described in this paragraph shall be eligible for such increase only if the facility has had no patient care class I deficiencies within the last eighteen months and has maintained at least an eighty-five percent average occupancy rate for the previous six quarters**;"; and

Further amend said bill, Page 6, Section 577.029, Line 1, by deleting the numeral "**1.**"; and

Further amend said bill, page, and section, Line 3, by deleting the words, "[shall] **may**" and inserting in lieu thereof the word, "shall"; and

Further amend said section, Pages 6 and 7, Lines 5 and 6, by deleting all of said lines and inserting in lieu thereof the following:

"the blood, unless such medical personnel, in his or her good faith medical judgment, believes such procedure would endanger the life or health of the person in custody. Blood may be"; and

Further amend said section, Page 7, Lines 13-16, by deleting all of said lines from the bill; and

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

HOUSE AMENDMENT NO. 2

Amend House Committee Substitute for Senate Bill No. 951, Page 1, Section A, Line 3, by inserting immediately after said line the following:

"**9.158. The month of November shall be known and designated as "Diabetes Awareness Month". The citizens of the state of Missouri are encouraged to participate in appropriate activities and events to increase awareness of diabetes. Diabetes is a group of metabolic diseases in which the body has elevated blood sugar levels over a prolonged period of time and affects Missourians of all ages.**"; and

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

HOUSE AMENDMENT NO. 1 TO
HOUSE AMENDMENT NO. 3

Amend House Amendment No. 3 to House Committee Substitute for Senate Bill No. 951, Page 10, Line 28, by inserting after all of said line the following:

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

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

HOUSE AMENDMENT NO. 3

Amend House Committee Substitute for Senate Bill No. 951, Page , Section , Line ,

Amend House Committee Substitute for Senate Bill No. 951, Page 1, Section A, Line 3, by inserting after all of said section and line the following:

"**9.192. The years of 2018 to 2028 shall hereby be designated as the "Show-Me Freedom from Opioid Addiction Decade".**"; and

Further amend said bill, Page 3, Section 191.227, Line 72, by inserting after all of said section and line the following:

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

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

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

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

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

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

(6) "Telehealth" or "telemedicine", the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology.

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

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

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

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

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

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

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

laws of this state.

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

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

208.670. 1. As used in this section, these terms shall have the following meaning:

(1) **"Consultation", a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association;**

(2) "Distant site", the same meaning as such term is defined in section 191.1145;

(3) "Originating site", the same meaning as such term is defined in section 191.1145;

(4) "Provider", **[**any provider of medical services and mental health services, including all other medical disciplines**] the same meaning as the term "health care provider" is defined in section 191.1145, and such provider meets all other MO HealthNet eligibility requirements**;

[(2)**] (5)** "Telehealth", the same meaning as such term is defined in section 191.1145.

2. **[**Reimbursement for the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program shall be allowed for orthopedics, dermatology, ophthalmology and optometry, in cases of diabetic retinopathy, burn and wound care, dental services which require a diagnosis, and maternal-fetal medicine ultrasounds.

3. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the practice of telehealth in the MO HealthNet program. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth, certification of agencies offering telehealth, and payment for services by providers. Telehealth providers shall be required to obtain participant consent before telehealth services are initiated and to ensure confidentiality of medical information.

4. Telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. Reimbursement for such services shall be made in the same way as reimbursement for in-person contacts.

5. The provisions of section 208.671 shall apply to the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program**] The department of social services shall reimburse providers for services provided through telehealth if such providers can ensure services are rendered meeting the standard of care that would otherwise be expected should such services be provided in person. The department shall not restrict the originating site through rule or payment so long as the provider can ensure services are rendered meeting the standard of care that**

would otherwise be expected should such services be provided in person. Payment for services rendered via telehealth shall not depend on any minimum distance requirement between the originating and distant site. Reimbursement for telehealth services shall be made in the same way as reimbursement for in-person contact; however, consideration shall also be made for reimbursement to the originating site. Reimbursement for asynchronous store-and-forward may be capped at the reimbursement rate had the service been provided in person.

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

2. An advanced practice registered nurse, as defined in section 335.016, but not a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016, who holds a certificate of controlled substance prescriptive authority from the board of nursing under section 335.019 and who is delegated the authority to prescribe controlled substances under a collaborative practice arrangement under section 334.104 may prescribe any controlled substances listed in Schedules III, IV, and V of section 195.017, and may have restricted authority in Schedule II. Prescriptions for Schedule II medications prescribed by an advanced practice registered nurse who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone. However, no such certified advanced practice registered nurse shall prescribe controlled substance for his or her own self or family. Schedule III narcotic controlled substance and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill.

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

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

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

195.265. 1. Unused controlled substances may be accepted from ultimate users, from hospice or home health care providers 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 options that render a product safe from misuse, or any other methods that comply with state and federal laws and regulations, may reduce the availability of unused controlled substances, and may minimize the potential environmental impact of drug disposal;

(b) Provides a list of drug disposal take back sites, which may be sorted and searched by name or location and is updated every six months by the department;

(c) Provides a list of take back events and mail back events in the state, including the date, time, and location information for each event and is updated every six months by the department; and

(d) Provides information for authorized collectors regarding state and federal requirements to comply with the provisions of subsection 1 of this section; and

(2) Promotional activities designed to ensure consumer awareness of proper storage and disposal of prescription drugs, including controlled substances."; and

Further amend said bill, Page 5, Section 197.305, Line 68, by inserting after all of said line the following:

"208.677. **[**1. For purposes of the provision of telehealth services in the MO HealthNet program, the term "originating site" shall mean a telehealth site where the MO HealthNet participant receiving the telehealth service is located for the encounter. The standard of care in the practice of telehealth shall be the same as the standard of care for services provided in person. An originating site shall be one of the following locations:

(1) An office of a physician or health care provider;

(2) A hospital;

(3) A critical access hospital;

(4) A rural health clinic;

(5) A federally qualified health center;

(6) A long-term care facility licensed under chapter 198;

(7) A dialysis center;

(8) A Missouri state habilitation center or regional office;

(9) A community mental health center;

(10) A Missouri state mental health facility;

(11) A Missouri state facility;

(12) A Missouri residential treatment facility licensed by and under contract with the children's division. Facilities shall have multiple campuses and have the ability to adhere to technology requirements. Only Missouri licensed psychiatrists, licensed psychologists, or provisionally licensed psychologists, and advanced practice registered nurses who are MO HealthNet providers shall be consulting providers at these locations;

(13) A comprehensive substance treatment and rehabilitation (CSTAR) program;

(14) A school;

(15) The MO HealthNet recipient's home;

(16) A clinical designated area in a pharmacy; or

(17) A child assessment center as described in section 210.001.

2. If the originating site is a school, the school shall obtain permission from the parent or guardian of any student receiving telehealth services prior to each provision of service.**] Prior to the provision of telehealth services in a school, the parent or guardian of the child shall provide authorization for the provision of such service. Such authorization shall include the ability for the parent or guardian to authorize services via telehealth in the school for the remainder of the school year.**"; and

Further amend said bill, Page 5, Section 210.070, Line 8, by inserting after all of said section and line the following:

"217.364. 1. The department of corrections shall establish by regulation the "Offenders Under Treatment Program". The program shall include institutional placement of certain offenders, as outlined in subsection 3 of this section, under the supervision and control of the department of corrections. The department shall establish rules determining how, when and where an offender shall be admitted into or removed from the program.

2. As used in this section, the term "offenders under treatment program" means a one-hundred-eighty-day institutional correctional program for the monitoring, control and treatment of certain substance abuse offenders and certain nonviolent offenders followed by placement on parole with continued supervision. **As used in this section, the term "medication-assisted treatment" means the use of pharmacological medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.**

3. The following offenders may participate in the program as determined by the department:

(1) Any nonviolent offender who has not previously been remanded to the department and who has been found guilty of violating the provisions of chapter 195 or 579 or whose substance abuse was a precipitating or contributing factor in the commission of his offense; or

(2) Any nonviolent offender who has pled guilty or been found guilty of a crime which did not involve the use of a weapon, and who has not previously been remanded to the department.

4. This program shall be used as an intermediate sanction by the department. The program may include education, treatment and rehabilitation programs. If an offender successfully completes the institutional phase of the program, the department shall notify the board of probation and parole within thirty days of completion. Upon notification from the department that the offender has successfully completed the program, the board of probation and parole may at its discretion release the offender on parole as authorized in subsection 1 of section 217.690.

5. The availability of space in the institutional program shall be determined by the department of corrections.

6. If the offender fails to complete the program, the offender shall be taken out of the program and shall serve the remainder of his sentence with the department.

7. Time spent in the program shall count as time served on the sentence.

8. If an offender requires treatment for opioid or other substance misuse or dependence, the department shall not prohibit such offender from participating in and receiving medication-assisted treatment under the care of a physician licensed in this state to practice medicine. An offender shall not be required to refrain from using medication-assisted treatment as a term or condition of his or her sentence.

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 between August 28, 2014, and August 28, 2017, may apply for licensure and shall be deemed in compliance with the provisions of this subdivision;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Maintain geographic proximity; except, the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar year for rural health clinics as defined by **[**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 documentation that it is consistent with each professional's education, knowledge, skill, and competence;

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

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

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

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

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

(1) Geographic areas to be covered;

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

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

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

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

4. The state board of registration for the healing arts shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to an assistant

physician provided the provisions of this section and the rules promulgated thereunder are satisfied.

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

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

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

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

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

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

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

assistant physicians.

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

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

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

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

2. Collaborative practice arrangements, which shall be in writing, may delegate to a registered professional nurse the authority to administer, dispense or prescribe drugs and provide treatment if the registered professional nurse is an advanced practice registered nurse as defined in subdivision (2) of section 335.016. Collaborative practice arrangements may delegate to an advanced practice registered nurse, as defined in section 335.016, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017, and Schedule II - hydrocodone; except that, the collaborative practice arrangement shall not delegate the authority to administer any controlled substances listed in Schedules III, IV, and V of section 195.017, or Schedule II - hydrocodone for the purpose of inducing sedation or general anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic

controlled substance and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill. Such collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols or standing orders for the delivery of health care services. **An advanced practice registered nurse may prescribe buprenorphine for up to a thirty-day supply without refill for 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;

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

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

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

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

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

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

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

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

practice registered nurse;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

of the physician assistant activity by the supervising physician and the physician assistant.

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

(8) Assisting in surgery;

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

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

4. Physician assistants shall not prescribe any drug, medicine, device or therapy unless pursuant to a physician supervision agreement in accordance with the law, nor prescribe lenses, prisms or contact lenses for the aid, relief or correction of vision or the measurement of visual power or visual efficiency of the human eye, nor administer or monitor general or regional block anesthesia during diagnostic tests, surgery or obstetric procedures. Prescribing of drugs, medications, devices or therapies by a physician assistant shall be pursuant to a physician assistant supervision agreement which is specific to the clinical conditions treated by the supervising physician and the physician assistant shall be subject to the following:

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

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

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

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

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

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

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

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

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

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

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

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

how the supervising physician and the physician assistant shall:

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

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

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

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

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

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

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

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

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

13. No physician shall be designated to serve as supervising physician **or collaborating physician** for more than **[**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 prescribed for up to a thirty-day supply without refill for patients receiving medication assisted treatment for substance use disorders under the direction of the supervising physician**. Physician assistants who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

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

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

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

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

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

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

337.025. 1. The provisions of this section shall govern the education and experience requirements for

initial licensure as a psychologist for the following persons:

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

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

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

3. A doctoral degree in psychology is defined as:

(1) A program accredited, or provisionally accredited, by the American Psychological Association **[**or**] (APA),** the Canadian Psychological Association**, or the Psychological Clinical Science Accreditation System (PCSAS) provided that such program include 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;

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

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

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

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

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

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

(i) Require the completion by the applicant of a core program in psychology which shall be met by the completion and award of at least one three-semester-hour graduate credit course or a combination of graduate credit courses totaling three semester hours or five quarter hours in each of the following areas:

a. The biological bases of behavior such as courses in: physiological psychology, comparative

psychology, neuropsychology, sensation and perception, psychopharmacology;

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

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

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

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

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

(1) A minimum of fifteen hundred hours of experience in a successfully completed internship to be completed in not less than twelve nor more than twenty-four months; and

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

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

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

(c) Postdoctoral professional experience obtained in no more than twenty-four consecutive calendar months. In no case shall this experience be accumulated at a rate of 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-to-face individual supervision. Clinical supervision may be delegated by the primary supervisor to one or more secondary supervisors who are qualified psychologists. The secondary supervisors shall retain order, control, and full professional responsibility for the applicant's clinical work under their supervision and shall meet with the applicant a minimum of one hour per week in face-to-face individual supervision. If the primary supervisor is also the clinical supervisor, meetings shall be a minimum of one hour per week. Group supervision shall not be acceptable for supervised professional experience. The primary supervisor shall certify to the committee that the applicant has complied with these requirements and that the applicant has demonstrated ethical and competent practice of psychology. The changing by an agency of the primary supervisor during the course of the supervised experience shall not invalidate the supervised experience.

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

337.029. 1. A psychologist licensed in another jurisdiction who has had no violations and no suspensions and no revocation of a license to practice psychology in any jurisdiction may receive a license in Missouri, provided the psychologist passes a written examination on Missouri laws and regulations governing the practice of psychology and meets one of the following criteria:

(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 receive certification from the committee as a health service provider if the psychologist meets one or more of the following criteria:

(1) Is a diplomate of the American Board of Professional Psychology in one or more of the specialties recognized by the American Board of Professional Psychology as pertaining to health service delivery;

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

(3) Has completed or obtained through education, training, or experience the requisite knowledge comparable to that which is required pursuant to section 337.033.

337.033. 1. A licensed psychologist shall limit his or her practice to demonstrated areas of competence as documented by relevant professional education, training, and experience. A psychologist trained in one area shall not practice in another area without obtaining additional relevant professional education, training, and experience through an acceptable program of respecialization.

2. A psychologist may not represent or hold himself or herself out as a state certified or registered psychological health service provider unless the psychologist has first received the psychologist health service provider certification from the committee; provided, however, nothing in this section shall be construed to limit or prevent a licensed, whether temporary, provisional or permanent, psychologist who does not hold a health service provider certificate from providing psychological services so long as such services are consistent with subsection 1 of this section.

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

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

(1) A doctoral degree or completion of a recognized respecialization program in one or more of the American Psychological Association designated health service provider delivery areas which is accredited, or provisionally accredited, **either** by the American Psychological Association **or the Psychological Clinical Science Accreditation System**; or

(2) A clinical or counseling psychology doctoral degree program or respecialization program designated, or provisionally approved, 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 doctoral degree or completion of a respecialization program in one or more of the American Psychological Association designated health service provider delivery areas that meets the following criteria:

(a) The program, wherever it may be administratively housed, shall be clearly identified and labeled as being in one or more of the American Psychological Association designated health service provider delivery areas;

(b) Such a program shall specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists in one or more of the American Psychological Association designated health service provider delivery areas.

5. A person who is lawfully licensed as a psychologist pursuant to the provisions of this chapter on August 28, 1989, or who has been approved to sit for examination prior to August 28, 1989, and who subsequently passes the examination shall be deemed to have met all requirements for health service provider certification; provided, however, that such person shall be governed by the provisions of subsection 1 of this section with respect to limitation of practice.

6. Any person who is lawfully licensed as a psychologist in this state and who meets one or more of the following criteria shall automatically, upon payment of the requisite fee, be entitled to receive a health service provider certification from the committee:

(1) Is a diplomate of the American Board of Professional Psychology in one or more of the specialties recognized by the American Board of Professional Psychology as pertaining to health service delivery; or

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

374.426. 1. Any entity in the business of delivering or financing health care shall provide data regarding quality of patient care and patient satisfaction to the director of the department of insurance, financial institutions and professional registration. Failure to provide such data as required by the director of the department of insurance, financial institutions and professional registration shall constitute grounds for violation of the unfair trade practices act, sections 375.930 to 375.948.

2. In defining data standards for quality of care and patient satisfaction, the director of the department of insurance, financial institutions and professional registration shall:

(1) Use as the initial data set the HMO Employer Data and Information Set developed by the National Committee for Quality Assurance;

(2) Consult with nationally recognized accreditation organizations, including but not limited to the National Committee for Quality Assurance and the Joint Committee on Accreditation of Health Care Organizations; and

(3) Consult with a state committee of a national committee convened to develop standards regarding uniform billing of health care claims.

3. In defining data standards for quality of care and patient satisfaction, the director of the department of insurance, financial institutions and professional registration shall not require patient scoring of pain control.

4. Beginning August 28, 2018, the director of the department of insurance, financial institutions and professional registration shall discontinue the use of patient satisfaction scores and shall not make them available to the public to the extent allowed by federal law.

376.811. 1. Every insurance company and health services corporation doing business in this state shall offer in all health insurance policies benefits or coverage for chemical dependency meeting the following minimum standards:

(1) Coverage for outpatient treatment through a nonresidential treatment program, or through partial-

or full-day program services, of not less than twenty-six days per policy benefit period;

(2) Coverage for residential treatment program of not less than twenty-one days per policy benefit period;

(3) Coverage for medical or social setting detoxification of not less than six days per policy benefit period;

(4) **Coverage for medication-assisted treatment for substance use disorders, using any drug approved for sale by the Food and Drug Administration for use in treating such patient's condition, including opioid-use and heroin-use disorders. No prior authorization, step therapy, or fail-first therapy shall be required for medication-assisted treatment;**

[(4)**] (5)** The coverages set forth in this subsection may be subject to a separate lifetime frequency cap of not less than ten episodes of treatment, except that such separate lifetime frequency cap shall not apply to medical detoxification in a life-threatening situation as determined by the treating physician and subsequently documented within forty-eight hours of treatment to the reasonable satisfaction of the insurance company or health services corporation; and

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

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

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

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

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

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

(2) Coverage for residential treatment programs for the therapeutic care and treatment of a recognized mental illness when prescribed by a licensed professional and rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals to the same extent as any other illness;

(3) Coverage for inpatient hospital treatment for a recognized mental illness to the same extent as for any other illness, not to exceed ninety days per year;

(4) The coverages set forth in this subsection shall be subject to the same coinsurance, co-payment, deductible, annual maximum and lifetime maximum factors as apply to physical illness; and

(5) The coverages set forth in this subsection may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

3. The offer required by sections 376.810 to 376.814 may be accepted or rejected by the group or individual policyholder or contract holder and, if accepted, shall fully and completely satisfy and substitute for the coverage under section 376.779. Nothing in sections 376.810 to 376.814 shall prohibit an insurance company, health services corporation or health maintenance organization from including all or part of the coverages set forth in sections 376.810 to 376.814 as standard coverage in their policies or contracts issued in this state.

4. Every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies mental health benefits or coverage as part of the policy or as a supplement to the policy. Such mental health benefits or coverage shall include at least two sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, licensed clinical social worker, or, subject to contractual provisions, a licensed marital and family therapist, acting within the scope of such license and under the following minimum standards:

(1) Coverage and benefits in this subsection shall be for the purpose of diagnosis or assessment, but not dependent upon findings; and

(2) Coverage and benefits in this subsection shall not be subject to any conditions of preapproval, and shall be deemed reimbursable as long as the provisions of this subsection are satisfied; and

(3) Coverage and benefits in this subsection shall be subject to the same coinsurance, co-payment and deductible factors as apply to regular office visits under coverages and benefits for physical illness.

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.

376.1550. 1. Notwithstanding any other provision of law to the contrary, each health carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a mental health condition, as defined in this section, and shall comply with the following provisions:

(1) A health benefit plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required by a health carrier or health benefit plan shall be comprehensive

for coverage of all health conditions, whether mental or physical;

(2) The coverages set forth is this subsection:

(a) May be administered pursuant to a managed care program established by the health carrier; and

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

(3) A health benefit plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health conditions may provide coverage for treatment of mental health conditions through a managed care organization; provided that the managed care organization is in compliance with rules adopted by the department of insurance, financial institutions and professional registration that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the director shall assure that:

(a) Timely and appropriate access to care is available;

(b) The quantity, location, and specialty distribution of health care providers is adequate; and

(c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured;

(4) Coverage for treatment for chemical dependency shall comply with sections 376.779, 376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term "health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to 376.836, the term "health insurance policy" shall include group coverage.

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

(1) "Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both;

(2) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(3) "Health carrier", the same meaning as such term is defined in section 376.1350;

(4) "Mental health condition", any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders **[**except for chemical dependency**]**;

(5) "Managed care organization", any financing mechanism or system that manages care delivery for its members or subscribers, including health maintenance organizations and any other similar health care delivery system or organization;

(6) "Rate, term, or condition", any lifetime or annual payment limits, deductibles, co-payments, coinsurance, and other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of a health benefit plan that affects the insured.

3. This section shall not apply to a health plan or policy that is individually underwritten or provides such coverage for specific individuals and members of their families pursuant to section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836, 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 policies 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.

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

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

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

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

(3) Care that is custodial in nature;

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

(5) Treatments that are considered experimental.

6. The director shall grant a policyholder a waiver from the provisions of this section if the policyholder demonstrates to the director by actual experience over any consecutive twenty-four-month period that compliance with this section has increased the cost of the health insurance policy by an amount that results in a two percent increase in premium costs to the policyholder. The director shall promulgate rules establishing a procedure and appropriate standards for making such a demonstration. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void."; and

Further amend said bill, Page 7, Section 577.029, Line 16, by inserting after all of said section and line the following:

"**630.875. 1. This section shall be known and may be cited as the "Improved Access to Treatment for Opioid Addictions Act" or "IATOA Act".**

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

(1) "Department", the department of mental health;

(2) "IATOA program", the improved access to treatment for opioid addictions program created under subsection 3 of this section.

3. Subject to appropriations, the department shall create and oversee an "Improved Access to Treatment for Opioid Addictions Program", which is hereby created and whose purpose is to disseminate information and best practices regarding opioid addiction and to facilitate collaborations to better treat and prevent opioid addiction in this state. The IATOA program shall facilitate partnerships between assistant physicians, physician assistants, and advanced practice registered nurses practicing in federally qualified health centers, rural health clinics, and other health care facilities and physicians practicing at remote facilities located in this state. The IATOA program shall provide resources that grant patients and their treating assistant physicians, physician assistants, advanced practice registered nurses, or physicians access to knowledge and expertise through means such as telemedicine and Extension for Community Healthcare Outcomes (ECHO) programs established under section 191.1140.

4. Assistant physicians, physician assistants, and advanced practice registered nurses who participate in the IATOA program shall complete the necessary requirements to prescribe buprenorphine within at least thirty days of joining the IATOA program.

5. For the purposes of the IATOA program, a remote collaborating or supervising physician working with an on-site assistant physician, physician assistant, or advanced practice registered nurse shall be considered to be on-site. An assistant physician, physician assistant, or advanced practice registered nurse collaborating with a remote physician shall comply with all laws and requirements applicable to assistant physicians, physician assistants, or advanced practice registered nurses with on-site supervision before providing treatment to a patient.

6. An assistant physician, physician assistant, or advanced practice registered nurse collaborating with a physician who is waiver-certified for the use of buprenorphine, may participate in the IATOA program in any area of the state and provide all services and functions of an assistant physician, physician assistant, or advanced practice registered nurse.

7. The department may develop curriculum and benchmark examinations on the subject of opioid addiction and treatment. The department may collaborate with specialists, institutions of higher education, and medical schools for such development. Completion of such a curriculum and passing of such an examination by an assistant physician, physician assistant, advanced practice registered nurse, or physician shall result in a certificate awarded by the department or sponsoring institution, if any.

8. An assistant physician, physician assistant, or advanced practice registered nurse participating in the IATOA program may also:

(1) Engage in community education;

(2) Engage in professional education outreach programs with local treatment providers;

(3) Serve as a liaison to courts;

(4) Serve as a liaison to addiction support organizations;

(5) Provide educational outreach to schools;

(6) Treat physical ailments of patients in an addiction treatment program or considering entering such a program;

(7) Refer patients to treatment centers;

(8) Assist patients with court and social service obligations;

(9) Perform other functions as authorized by the department; and

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

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

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

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

11. The department shall promulgate rules to implement the provisions of the improved access to treatment for opioid addictions act as soon as reasonably possible. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void.

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 services of the department of mental health;

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

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

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

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

(9) "Licensed professional counselor", a person licensed as a professional counselor under 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;

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

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

(b) A substantial risk that serious physical harm to a person will result or is occurring because of an impairment in his capacity to make decisions with respect to his hospitalization and need for treatment as evidenced by his current mental disorder or mental illness which results in an inability to provide for his own basic necessities of food, clothing, shelter, safety or medical care or his inability to provide for his own mental health care which may result in a substantial risk of serious physical harm. Evidence of that substantial risk may also include information about patterns of behavior that historically have resulted in serious harm to the person previously taking place because of a mental disorder or mental illness which resulted in his inability to provide for his basic necessities of food, clothing, shelter, safety or medical or mental health care; or

(c) A substantial risk that serious physical harm will be inflicted by a person upon another as evidenced by recent overt acts, behavior or threats, including verbal threats, which have caused such harm or which would place a reasonable person in reasonable fear of sustaining such harm. Evidence of that substantial risk may also include information about patterns of behavior that historically have resulted in physical harm previously being inflicted by a person upon another person;

(11) "Mental health coordinator", a mental health professional who has knowledge of the laws relating to hospital admissions and civil commitment and who is authorized by the 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 either by the court or by the mental health facility where the respondent is detained;

(16) "Peace officer", a sheriff, deputy sheriff, county or municipal police officer or highway patrolman;

(17) **"Psychiatric advanced practice registered nurse", a registered nurse who is currently recognized by the board of nursing as an advanced practice registered nurse, who has at least two years of experience in providing psychiatric treatment to individuals suffering from mental disorders;**

(18) "Psychiatric assistant physician", a licensed assistant physician under chapter 334 and who has had at least two years of experience as an assistant physician in providing psychiatric treatment to individuals suffering from mental health disorders;

(19) "Psychiatric nurse", a registered professional nurse who is licensed under chapter 335 and who has had at least two years of experience as a registered professional nurse in providing psychiatric nursing treatment to individuals suffering from mental disorders;

(20) "Psychiatric physician assistant", a licensed physician assistant under chapter 334 and who has had at least two years of experience as a physician assistant in providing psychiatric treatment to individuals suffering from mental health disorders or a graduate of a postgraduate residency or fellowship for physician assistants in psychiatry;

[(18)**] (21)** "Psychiatric social worker", a person with a master's or further advanced degree from an accredited school of 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.

[208.671. 1. As used in this section and section 208.673, the following terms shall mean:

(1) "Asynchronous store-and-forward", the transfer of a participant's clinically important digital samples, such as still images, videos, audio, text files, and relevant data from an originating site through the use of a camera or similar recording device that stores digital samples that are forwarded via telecommunication to a distant site for consultation by a consulting provider without requiring the simultaneous presence of the participant and the participant's treating provider;

(2) "Asynchronous store-and-forward technology", cameras or other recording devices that store images which may be forwarded via telecommunication devices at a later time;

(3) "Consultation", a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association;

(4) "Consulting provider", a provider who, upon referral by the treating provider, evaluates a participant and appropriate medical data or images delivered through asynchronous store-and-forward technology. If a consulting provider is unable to render an opinion due to insufficient information, the consulting provider may request additional information to facilitate the rendering of an opinion or decline to render an opinion;

(5) "Distant site", the site where a consulting provider is located at the time the consultation service is provided;

(6) "Originating site", the site where a MO HealthNet participant receiving services and such participant's treating provider are both physically located;

(7) "Provider", any provider of medical, mental health, optometric, or dental health services, including all other medical disciplines, licensed and providing MO HealthNet services who has the authority to refer participants for medical, mental health, optometric, dental, or other health care services within the scope of practice and licensure of the provider;

(8) "Telehealth", as that term is defined in section 191.1145;

(9) "Treating provider", a provider who:

(a) Evaluates a participant;

(b) Determines the need for a consultation;

(c) Arranges the services of a consulting provider for the purpose of diagnosis and treatment; and

(d) Provides or supplements the participant's history and provides pertinent physical examination findings and medical information to the consulting provider.

2. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program. Such rules shall include, but not be limited to:

(1) Appropriate standards for the use of asynchronous store-and-forward technology in the practice of telehealth;

(2) Certification of agencies offering asynchronous store-and-forward technology in the practice of telehealth;

(3) Timelines for completion and communication of a consulting provider's consultation or opinion, or if the consulting provider is unable to render an opinion, timelines for communicating a request for additional information or that the consulting provider declines to render an opinion;

(4) Length of time digital files of such asynchronous store-and-forward services are to be maintained;

(5) Security and privacy of such digital files;

(6) Participant consent for asynchronous store-and-forward services; and

(7) Payment for services by providers; except that, consulting providers who decline to render an opinion shall not receive payment under this section unless and until an opinion is rendered.

Telehealth providers using asynchronous store-and-forward technology shall be required to obtain participant consent before asynchronous store-and-forward services are initiated and to ensure confidentiality of medical information.

3. Asynchronous store-and-forward technology in the practice of telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. The total payment for both the treating provider and the consulting provider shall not exceed the payment for a face-to-face consultation of the same level.

4. The standard of care for the use of asynchronous store-and-forward technology in the practice of telehealth shall be the same as the standard of care for services provided in person.**]**

[208.673. 1. There is hereby established the "Telehealth Services Advisory Committee" to advise the department of social services and propose rules regarding the coverage of telehealth services in the MO HealthNet program utilizing asynchronous store-and-forward technology.

2. The committee shall be comprised of the following members:

(1) The director of the MO HealthNet division, or the director's designee;

(2) The medical director of the MO HealthNet division;

(3) A representative from a Missouri institution of higher education with expertise in telehealth;

(4) A representative from the Missouri office of primary care and rural health;

(5) Two board-certified specialists licensed to practice medicine in this state;

(6) A representative from a hospital located in this state that utilizes telehealth;

(7) A primary care physician from a federally qualified health center (FQHC) or rural health clinic;

(8) A primary care physician from a rural setting other than from an FQHC or rural health clinic;

(9) A dentist licensed to practice in this state; and

(10) A psychologist, or a physician who specializes in psychiatry, licensed to practice in this state.

3. Members of the committee listed in subdivisions (3) to (10) of subsection 2 of this section shall be appointed by the governor with the advice and consent of the senate. The first appointments to the committee shall consist of three members to serve three-year terms, three members to serve two-year terms, and three members to serve a one-year term as designated by the governor. Each member of the committee shall serve for a term of three years thereafter.

4. Members of the committee shall not receive any compensation for their services but shall be reimbursed for any actual and necessary expenses incurred in the performance of their duties.

5. Any member appointed by the governor may be removed from office by the governor without cause. If there is a vacancy for any cause, the governor shall make an appointment to become effective immediately for the

unexpired term.

6. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2016, shall be invalid and void.**]**

[208.675. For purposes of the provision of telehealth services in the MO HealthNet program, the following individuals, licensed in Missouri, shall be considered eligible health care providers:

(1) Physicians, assistant physicians, and physician assistants;

(2) Advanced practice registered nurses;

(3) Dentists, oral surgeons, and dental hygienists under the supervision of a currently registered and licensed dentist;

(4) Psychologists and provisional licensees;

(5) Pharmacists;

(6) Speech, occupational, or physical therapists;

(7) Clinical social workers;

(8) Podiatrists;

(9) Optometrists;

(10) Licensed professional counselors; and

(11) Eligible health care providers under subdivisions (1) to (10) of this section practicing in a rural health clinic, federally qualified health center, or community mental health center.**]**"; and

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

HOUSE AMENDMENT NO. 4

Amend House Committee Substitute for Senate Bill No. 951, Page 5, Section 197.305, Line 68, by inserting immediately after said section and line the following:

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

(1) "Data match", a method of comparing the department's information with that of another entity and identifying those records which appear in both files. This process is accomplished by a computerized comparison by which both the department and the entity utilize a computer readable electronic media format;

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

(3) "Entity":

(a) Any insurance company as defined in chapter 375 or any public organization or agency transacting or doing the business of insurance; or

(b) Any health service corporation or health maintenance organization as defined in chapter 354 or any other provider of health services as defined in chapter 354;

(c) Any self-insured organization or business providing health services as defined in chapter 354; or

(d) Any third-party administrator (TPA), administrative services organization (ASO), or pharmacy benefit manager (PBM) transacting or doing business in Missouri or administering or processing claims or benefits, or both, for residents of Missouri;

(4) "Individual", any applicant or present or former participant receiving public assistance benefits under sections 208.151 to 208.159 **or a person receiving department of mental health services for the purposes of subsection 9 of this section**;

(5) "Insurance", any agreement, contract, policy plan or writing entered into voluntarily or by court or administrative order providing for the payment of medical services or for the provision of medical care to or on behalf of an individual;

(6) "Request", any inquiry by the MO HealthNet division for the purpose of determining the existence of insurance where the department may have expended MO HealthNet benefits.

2. The department may enter into a contract with any entity, and the entity shall, upon request of the department of social services, inform the department of any records or information pertaining to the insurance of any individual.

3. The information which is required to be provided by the entity regarding an individual is limited to those insurance benefits that could have been claimed and paid by an insurance policy agreement or plan with respect to medical services or items which are otherwise covered under the MO HealthNet program.

4. A request for a data match made by the department pursuant to this section shall include sufficient information to identify each person named in the request in a form that is compatible with the record-keeping methods of the entity. Requests for information shall pertain to any individual or the person legally responsible for such individual and may be requested at a minimum of twice a year.

5. The department shall reimburse the entity which is requested to supply information as provided by this section for actual direct costs, based upon industry standards, incurred in furnishing the requested information and as set out in the contract. The department shall specify the time and manner in which information is to be delivered by the entity to the department. No reimbursement will be provided for information requested by the department other than by means of a data match.

6. Any entity which has received a request from the department pursuant to this section shall provide the requested information in compliance with HIPPAA required transactions within sixty days of receipt of the request. Willful failure of an entity to provide the requested information within such period shall result in liability to the state for civil penalties of up to ten dollars for each day thereafter. The attorney general shall, upon request of the department, bring an action in a circuit court of competent jurisdiction to

recover the civil penalty. The court shall determine the amount of the civil penalty to be assessed. A health insurance carrier, including instances where it acts in the capacity of an administrator of an ASO account, and a TPA acting in the capacity of an administrator for a fully insured or self-funded employer, is required to accept and respond to the HIPPAA ANSI standard transaction for the purpose of validating eligibility.

7. The director of the department shall establish guidelines to assure that the information furnished to any entity or obtained from any entity does not violate the laws pertaining to the confidentiality and privacy of an applicant or participant receiving MO HealthNet benefits. Any person disclosing confidential information for purposes other than set forth in this section shall be guilty of a class A misdemeanor.

8. The application for or the receipt of benefits under sections 208.151 to 208.159 shall be deemed consent by the individual to allow the department to request information from any entity regarding insurance coverage of said person.

9. The provisions of this section that apply to the department of social services shall also apply to the department of mental health when contracting with any entity to supply information as provided for in this section regarding an individual receiving department of mental health services."; and

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

HOUSE AMENDMENT NO. 5

Amend House Committee Substitute for Senate Bill No. 951, Page 1, Section A, Line 3, by inserting immediately after said line the following:

"58.451. 1. When any person, in any county in which a coroner is required by section 58.010, dies and there is reasonable ground to believe that such person died as a result of:

(1) Violence by homicide, suicide, or accident;

(2) Criminal abortions, including those self-induced;

(3) Some unforeseen sudden occurrence and the deceased had not been attended by a physician during the thirty-six-hour period preceding the death;

(4) In any unusual or suspicious manner;

(5) Any injury or illness while in the custody of the law or while an inmate in a public institution[;]

the police, sheriff, law enforcement officer or official, or any person having knowledge of such a death shall immediately notify the coroner of the known facts concerning the time, place, manner and circumstances of the death. Immediately upon receipt of notification, the coroner or deputy coroner shall take charge of the dead body and fully investigate the essential facts concerning the medical causes of death, including whether by the act of man, and the manner of death. The coroner or deputy coroner may take the names and addresses of witnesses to the death and shall file this information in the coroner's office. The coroner or deputy coroner shall take possession of all property of value found on the body, making exact inventory of such property on the report and shall direct the return of such property to the person entitled to its custody or possession. The coroner or deputy coroner shall take possession of any object or article which, in the coroner's or the deputy coroner's opinion, may be useful in establishing the cause of death, and deliver it to the prosecuting attorney of the county.

2. When a death occurs outside a licensed health care facility, the first licensed medical professional or law enforcement official learning of such death shall immediately contact the county coroner. Immediately upon receipt of such notification, the coroner or the coroner's deputy shall make the determination if further investigation is necessary, based on information provided by the individual contacting the coroner, and immediately advise such individual of the coroner's intentions.

3. Notwithstanding the provisions of subsection 2 of this section, when a death occurs under the care of a hospice, no investigation shall be required if the death is certified by the treating physician of the deceased or the medical director of the hospice. The hospice shall provide written notice to the coroner within twenty-four hours of the death.

[3.] **4.** Upon taking charge of the dead body and before moving the body the coroner shall notify the police department of any city in which the dead body is found, or if the dead body is found in the unincorporated area of a county governed by the provisions of sections 58.451 to 58.457, the coroner shall notify the county sheriff or the highway patrol and cause the body to remain unmoved until the police department, sheriff or the highway patrol has inspected the body and the surrounding circumstances and carefully noted the appearance, the condition and position of the body and recorded every fact and circumstance tending to show the cause and manner of death, with the names and addresses of all known witnesses, and shall subscribe the same and make such record a part of the coroner's report.

[4.] **5.** In any case of sudden, violent or suspicious death after which the body was buried without any investigation or autopsy, the coroner, upon being advised of such facts, may at the coroner's own discretion request that the prosecuting attorney apply for a court order requiring the body to be exhumed.

[5.] **6.** The coroner may certify the cause of death in any case where death occurred without medical attendance or where an attending physician refuses to sign a certificate of death or when a physician is unavailable to sign a certificate of death.

[6.] **7.** When the cause of death is established by the coroner, the coroner shall file a copy of the findings in the coroner's office within thirty days.

[7.] **8.** If on view of the dead body and after personal inquiry into the cause and manner of death, the coroner determines that a further examination is necessary in the public interest, the coroner on the coroner's own authority may make or cause to be made an autopsy on the body. The coroner may on the coroner's own authority employ the services of a pathologist, chemist, or other expert to aid in the examination of the body or of substances supposed to have caused or contributed to death, and if the pathologist, chemist, or other expert is not already employed by the city or county for the discharge of such services, the pathologist, chemist, or other expert shall, upon written authorization of the coroner, be allowed reasonable compensation, payable by the city or county, in the manner provided in section 58.530. The coroner shall, at the time of the autopsy, record or cause to be recorded each fact and circumstance tending to show the condition of the body and the cause and manner of death.

[8.] **9.** If on view of the dead body and after personal inquiry into the cause and manner of death, the coroner considers a further inquiry and examination necessary in the public interest, the coroner shall make out the coroner's warrant directed to the sheriff of the city or county requiring the sheriff forthwith to summon six good and lawful citizens of the county to appear before the coroner, at the time and place expressed in the warrant, and to inquire how and by whom the deceased died.

[9.] **10.** (1) When a person is being transferred from one county to another county for medical treatment and such person dies while being transferred, or dies while being treated in the emergency room of the receiving facility**,** the place which the person is determined to be dead shall be considered the place of death and the county coroner or medical examiner of the county from which the person was originally being transferred shall be responsible for determining the cause and manner of death for the Missouri certificate of death.

(2) The coroner or medical examiner in the county in which the person is determined to be dead may with authorization of the coroner or medical examiner from the original transferring county, investigate and conduct postmortem examinations at the expense of the coroner or medical examiner from the original transferring county. The coroner or medical examiner from the original transferring county shall be responsible for investigating the circumstances of such and completing the Missouri certificate of death. The certificate of death shall be filed in the county where the deceased was pronounced dead.

(3) Such coroner or medical examiner of the county where a person is determined to be dead shall immediately notify the coroner or medical examiner of the county from which the person was originally being transferred of the death of such person, and shall make available information and records obtained for investigation of the death.

(4) If a person does not die while being transferred and is institutionalized as a regularly admitted patient after such transfer and subsequently dies while in such institution, the coroner or medical examiner of the county in which the person is determined to be dead shall immediately notify the coroner or medical examiner of the county from which such person was originally transferred of the death of such person. In such cases, the county in which the deceased was institutionalized shall be considered the place of death. If the manner of death is by homicide, suicide, accident, criminal abortion including those that are self-induced, child fatality, or any unusual or suspicious manner, the investigation of the cause and manner of death shall revert to the county of origin, and this coroner or medical examiner shall be responsible for the Missouri certificate of death. The certificate of death shall be filed in the county where the deceased was pronounced dead.

[10.] **11.** There shall not be any statute of limitations or time limits on the cause of death when death is the final result or determined to be caused by homicide, suicide, accident, child fatality, criminal abortion including those self-induced, or any unusual or suspicious manner. The place of death shall be the place in which the person is determined to be dead. The final investigation of death in determining the cause and matter of death shall revert to the county of origin, and the coroner or medical examiner of such county shall be responsible for the Missouri certificate of death. The certificate of death shall be filed in the county where the deceased was pronounced dead.

[11.] **12.** Except as provided in subsection [9] **10** of this section, if a person dies in one county and the body is subsequently transferred to another county, for burial or other reasons, the county coroner or medical examiner where the death occurred shall be responsible for the certificate of death and for investigating the cause and manner of the death.

[12.] **13.** In performing the duties, the coroner or medical examiner shall comply with sections 58.775 to 58.785 with respect to organ donation.

58.720. 1. When any person dies within a county having a medical examiner as a result of:

(1) Violence by homicide, suicide, or accident;

(2) Thermal, chemical, electrical, or radiation injury;

(3) Criminal abortions, including those self-induced;

(4) Disease thought to be of a hazardous and contagious nature or which might constitute a threat to public health; or when any person dies:

(a) Suddenly when in apparent good health;

(b) When unattended by a physician, chiropractor, or an accredited Christian Science practitioner, during the period of thirty-six hours immediately preceding his death;

(c) While in the custody of the law, or while an inmate in a public institution;

(d) In any unusual or suspicious manner[;]

the police, sheriff, law enforcement officer or official, or any person having knowledge of such a death shall immediately notify the office of the medical examiner of the known facts concerning the time, place, manner and circumstances of the death. Immediately upon receipt of notification, the medical examiner or his designated assistant shall take charge of the dead body and fully investigate the essential facts concerning the medical causes of death. He may take the names and addresses of witnesses to the death and shall file this information in his office. The medical examiner or his designated assistant shall take possession of all property of value found on the body, making exact inventory thereof on his report and shall direct the return of such property to the person entitled to its custody or possession. The medical examiner or his designated assistant examiner shall take possession of any object or article which, in his opinion, may be useful in establishing the cause of death, and deliver it to the prosecuting attorney of the county.

2. When a death occurs outside a licensed health care facility, the first licensed medical professional or law enforcement official learning of such death shall contact the county medical examiner. Immediately upon receipt of such notification, the medical examiner or the medical examiner's deputy shall make a determination if further investigation is necessary, based on information provided by the individual contacting the medical examiner, and immediately advise such individual of the medical examiner's intentions.

3. Notwithstanding the provisions of subsection 2 of this section, when a death occurs under the care of a hospice, no investigation shall be required if the death is certified by the treating physician of the deceased or the medical director of the hospice. The hospice shall provide written notice to the medical examiner within twenty-four hours of the death.

[3.] **4.** In any case of sudden, violent or suspicious death after which the body was buried without any investigation or autopsy, the medical examiner, upon being advised of such facts, may at his own discretion request that the prosecuting attorney apply for a court order requiring the body to be exhumed.

[4.] **5.** The medical examiner shall certify the cause of death in any case where death occurred without medical attendance or where an attending physician refuses to sign a certificate of death, and may sign a certificate of death in the case of any death.

[5.] **6.** When the cause of death is established by the medical examiner, he shall file a copy of his findings in his office within thirty days after notification of the death.

[6.] **7.** (1) When a person is being transferred from one county to another county for medical treatment and such person dies while being transferred, or dies while being treated in the emergency room of the receiving facility, the place which the person is determined to be dead shall be considered the place of death and the county coroner or the medical examiner of the county from which the person was originally being transferred shall be responsible for determining the cause and manner of death for the Missouri certificate of death.

(2) The coroner or medical examiner in the county in which the person is determined to be dead may, with authorization of the coroner or medical examiner from the transferring county, investigate and conduct postmortem examinations at the expense of the coroner or medical examiner from the transferring county. The coroner or medical examiner from the transferring county shall be responsible for investigating the circumstances of such and completing the Missouri certificate of death. The certificate of death shall be filed in the county where the deceased was pronounced dead.

(3) Such coroner or medical examiner, or the county where a person is determined to be dead, shall immediately notify the coroner or medical examiner of the county from which the person was originally being transferred of the death of such person and shall make available information and records obtained for investigation of death.

(4) If a person does not die while being transferred and is institutionalized as a regularly admitted patient after such transfer and subsequently dies while in such institution, the coroner or medical examiner of the county in which the person is determined to be dead shall immediately notify the coroner or medical examiner of the county from which such person was originally transferred of the death of such person. In such cases, the county in which the deceased was institutionalized shall be considered the place of death. If the manner of death is by homicide, suicide, accident, criminal abortion including those that are self-induced, child fatality, or any unusual or suspicious manner, the investigation of the cause and manner of death shall revert to the county of origin, and this coroner or medical examiner shall be responsible for the Missouri certificate of death. The certificate of death shall be filed in the county where the deceased was pronounced dead.

[7.] **8.** There shall not be any statute of limitations or time limits on cause of death when death is the final result or determined to be caused by homicide, suicide, accident, criminal abortion including those self-induced, child fatality, or any unusual or suspicious manner. The place of death shall be the place in which the person is determined to be dead, but the final investigation of death determining the cause and manner of death shall revert to the county of origin, and this coroner or medical examiner shall be responsible for the Missouri certificate of death. The certificate of death shall be filed in the county where the deceased was pronounced dead.

[8.] **9.** Except as provided in subsection [6] **7** of this section, if a person dies in one county and the body is subsequently transferred to another county, for burial or other reasons, the county coroner or medical examiner where the death occurred shall be responsible for the certificate of death and for investigating the cause and manner of the death.

[9.] **10.** In performing the duties, the coroner or medical examiner shall comply with sections 58.775 to 58.785 with respect to organ donation."; and

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

HOUSE AMENDMENT NO. 6

Amend House Committee Substitute for Senate Bill No. 951, Page 5, Section 210.070, Line 8, by inserting immediately after said line the following:

"**334.1000. As used in sections 334.1000 to 334.1030, the following terms shall mean:**

(1) "Advisory committee", the Missouri radiologic imaging and radiation therapy advisory committee;

(2) "Board", the state board of registration for the healing arts;

(3) "Certification organization", a certification organization that specializes in the certification and registration of radiologic imaging or radiation therapy technical personnel that is accredited by the National Commission for Certifying Agencies, American National Standards Institute, or other accreditation organization recognized by the board;

(4) "Ionizing radiation", radiation that may consist of alpha particles, beta particles, gamma rays, x-rays, neutrons, high-speed electrons, high-speed protons, or other particles capable of producing ions. Ionizing radiation does not include non-ionizing radiation, such as radiofrequency or microwaves, visible infrared or ultraviolet light, or ultrasound;

(5) "Licensed practitioner", a person licensed to practice medicine, chiropractic medicine, podiatry, dentistry, or a certified registered nurse anesthetist in this state with education and specialist training in the medical or dental use of radiation who is deemed competent to independently perform or supervise radiologic imaging or radiation therapy procedures by their respective state licensure board;

(6) "Limited x-ray machine operator", a person who is licensed to perform only x-ray or bone densitometry procedures not involving the administration or utilization of contrast media on selected specific parts of human anatomy under the supervision of a licensed practitioner;

(7) "Nuclear medicine technologist", a person who is licensed to perform a variety of nuclear medicine and molecular imaging procedures using sealed and unsealed radiation sources, ionizing radiation, adjunctive medicine and pharmaceuticals associated with nuclear medicine procedures, and therapeutic procedures using unsealed radioactive sources;

(8) "Radiation therapist", a person who is licensed to administer ionizing radiation to human beings for therapeutic purposes;

(9) "Radiation therapy", the use of ionizing radiation for the purpose of treating disease;

(10) "Radiographer", a person who is licensed to perform a comprehensive set of diagnostic radiographic procedures using external ionizing radiation to produce radiographic, fluoroscopic, or digital images;

(11) "Radiologic imaging", any procedure or article intended for use in the diagnosis or visualization of disease or other medical conditions in human beings, including, but not limited to computed tomography, fluoroscopy, nuclear medicine, radiography, and other procedures using ionizing radiation;

(12) "Radiologist", a physician licensed in this state and certified by or board-eligible to be certified by the American Board of Radiology, the American Osteopathic Board of Radiology, the British Royal College of Radiology, or the Canadian College of Physicians and Surgeons in that medical specialty;

(13) "Radiologist assistant", a person who is licensed to perform a variety of activities under the supervision of a radiologist in the areas of patient care, patient management, radiologic imaging, or interventional procedures guided by radiologic imaging, and who does not interpret images, render diagnoses or prescribe medications or therapies.

334.1005. 1. Except as provided in this section, after January 1, 2020, only a person licensed under the provisions of sections 334.1000 to 334.1030 or a licensed practitioner may perform radiologic imaging or radiation therapy procedures on humans for diagnostic or therapeutic purposes.

2. The board shall issue licenses to persons certified by a certification organization to perform nuclear medicine technology, radiation therapy, radiography, and radiologist assistant procedures and to limited x-ray machine operators meeting licensure standards established by the board.

3. No person, corporation, or facility shall knowingly employ a person who does not hold a license or who is not exempt from the provisions of sections 334.1000 to 334.1030 to perform radiologic imaging or radiation therapy procedures for more than one hundred eighty days.

4. Nothing in this section relating to radiologic imaging or radiation therapy shall limit or enlarge the practice of a licensed practitioner.

5. The provisions of section 334.1000 to 334.1030 shall not apply to the following:

(1) A dental hygienist or dental assistant licensed by this state;

(2) A resident physician enrolled in and attending a school or college of medicine, chiropractic, podiatry, dentistry, radiologic imaging, or radiation therapy who performs radiologic imaging or radiation therapy procedures on humans;

(3) A student enrolled in and attending a school or college of medicine, chiropractic, podiatry, dentistry, radiologic imaging, or radiation therapy who performs radiologic imaging or radiation therapy procedures on humans while under the supervision of a licensed practitioner or a person holding a nuclear medicine technologist, radiation therapist, radiographer, or radiologist assistant license;

(4) A person who is employed by the United States government when performing radiologic imaging or radiation therapy associated with that employment; or

(5) A person performing radiologic imaging procedures on nonhuman subjects or cadavers.

334.1010. 1. There is hereby created the "Missouri Radiologic Imaging and Radiation Therapy Advisory Committee". The board shall provide administrative support to the advisory committee. The advisory committee shall guide, advise, and make recommendations to the board, and shall consist of five members appointed by the director of the division of professional registration, a majority of whom shall be licensed practitioners, individuals certified or registered by a certification organization, or individuals licensed under sections 334.1000 to 334.1030.

2. The board, based on recommendations, guidance, and advice from the advisory committee, shall:

(1) Establish scopes of practice for limited x-ray machine operators, nuclear medicine technologists, radiation therapists, radiographers, and radiologist assistants;

(2) Promulgate rules for issuance of licenses;

(3) Establish minimum requirements for the issuance of licenses and recognition of licenses issued by other states;

(4) Establish minimum requirements for continuing education;

(5) Determine fees and requirements for the issuance of new licenses and renewal of licenses;

(6) Contract to use a competency based examination that shall provide for a virtually administered option for the determination of limited x-ray machine operator qualifications for licensure;

(7) Promulgate rules for acceptance of certification and registration by a certification organization recognized by the board as qualification for licensure;

(8) Promulgate rules for issuance of licenses to retired military personnel and spouses of active-duty military personnel;

(9) Establish ethical, moral, and practice standards; and

(10) Promulgate rules and procedures for the denial or refusal to renew a license, and the suspension, revocation, or other discipline of active licensees.

3. The board shall create alternative licensure requirements for individuals working in rural health clinics as defined in P.L. 95-210 and for areas of this state that the board deems too remote to contain a sufficient number of qualified persons licensed under sections 334.1000 to 334.1030 to perform radiologic imaging or radiation therapy procedures.

4. All fees payable pursuant to the provisions of sections 334.1000 to 334.1030 shall be collected by the division of professional registration, which shall transmit such funds to the department of revenue for deposit in the state treasury to the credit of the board of registration for the healing arts fund. The division of professional registration and the board of registration for the healing arts may use these funds as necessary for the administration of sections 334.1000 to 334.1030.

5. The fee charged for a limited x-ray machine operator examination shall not exceed the actual cost to administer the examination.

334.1015. 1. To be eligible for licensure by the board, at the time of application an applicant shall be at least eighteen years of age.

2. The board shall accept nuclear medicine technology, radiation therapy, radiography, or radiologist assistant certification and registration by a certification organization recognized by the board as a qualification for licensure.

3. The board may issue limited x-ray machine operator licenses in the following areas:

(1) Chest radiography: radiography of the thorax, heart, and lungs;

(2) Extremity radiography: radiography of the upper and lower extremities, including the pectoral girdle;

(3) Spine radiography: radiography of the vertebral column;

(4) Skull/sinus radiography: radiography of the skull and facial structures;

(5) Podiatric radiography: radiography of the foot, ankle, and lower leg below the knee;

(6) Bone densitometry: performance and analysis of bone density scans; or

(7) Other areas the board deems necessary to ensure necessary services throughout the state.

4. The board may require a limited x-ray machine operator to verify training in x-ray procedures at their place of employment, including a minimum of one hundred hours of supervised experience performing x-ray procedures.

(1) The hours shall be sufficient for individuals to be licensed in any limited machine operator area for which they pass an examination;

(2) The hours shall be documented by the licensee and verified by the licensee's supervisor.

5. Individuals shall be licensed in any limited machine operator area for which they successfully pass an examination as defined by the board.

6. The board shall not require, but may recommend, any advance class work, either remote or in person, prior to a limited x-ray machine operator candidate taking such examination.

7. No additional testing requirements or other stipulations shall be imposed after the initial examination for limited x-ray machine operator licensure provided the licensee maintain required continuing education and is not disciplined under rules promulgated pursuant to subdivision (10) of subsection 2 of section 334.1010.

8. The board shall require limited x-ray machine operators to complete a minimum of twelve hours biannually of continuing education that may be fulfilled by approved continuing education activities at the licensee's place of employment.

9. The board may accept certification from the American Chiropractic Registry of Radiologic Technologists for persons applying for a limited x-ray machine operator license in spine radiography.

10. The board may accept certification from the American Society of Podiatric Medical Assistants for persons applying for a limited x-ray machine operator license in podiatric radiography.

11. The board may accept certification from the International Society of Clinical Densitometry for persons applying for a limited x-ray machine operator license in bone densitometry.

334.1020. 1. A licensee who violates any provision of sections 334.1000 to 334.1030 shall be guilty of a class A misdemeanor. Each act of such unlawful practice shall constitute a distinct and separate offense.

2. The board may assess a civil penalty not in excess of two hundred dollars for each violation of sections 334.1000 to 334.1030 or any rules adopted by the board. The clear proceeds of any civil penalty assessed under this section shall be remitted to the credit of the public school fund of the state.

334.1025. A person who has been engaged in the practice of radiologic imaging and radiation therapy, other than a radiologist assistant, and who does not hold a current certification and registration by a certification organization recognized by the board may continue to practice in the radiologic imaging or radiation therapy modality in which they are currently employed, provided that such person:

(1) Registers with the board on or before January 1, 2020;

(2) Does not change the scope of their current practice or current place of employment;

(3) Completes all continuing education requirements for their modality biennially as prescribed by the board;

(4) Practices only under the supervision of a licensed practitioner; and

(5) Meets all licensure requirements of sections 334.1000 to 334.1030 and the rules adopted by the board and obtains a license from the board on or before October 1, 2023.

334.1030. 1. The board may promulgate rules to implement the provisions of sections 334.1000 to 334.1030. 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.

2. Any authority granted to the board or the advisory committee to adopt or promulgate rules or to establish the scope of practice for the licensure issued by the board shall not include the authority to define, regulate, or interpret the scope of practice of any profession not licensed by the board."; and

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

In which the concurrence of the Senate is respectfully requested.

Also,

Mr. President: I am instructed by the House of Representatives to inform the Senate that the House has taken up and passed **HCS** for **SB 581**, entitled:

An Act to repeal sections 512.180, 535.030, 535.110, 535.170, 535.200, 535.210, and 535.300, RSMo, and to enact in lieu thereof seven new sections relating to landlord tenant actions.

In which the concurrence of the Senate is respectfully requested.

Also,

Mr. President: I am instructed by the House of Representatives to inform the Senate that the House has taken up and passed **HCS** for **SB 871**, entitled:

An Act to repeal sections 478.375, 478.600, 478.625, and 488.2250, RSMo, and to enact in lieu thereof three new sections relating to court administration.

With House Amendment Nos. 1 and 2.

HOUSE AMENDMENT NO. 1

Amend House Committee Substitute for Senate Bill No. 871, Page 1, Section A, Line 3, by inserting after all of said section and line the following:

"455.513. 1. **The court may immediately issue an ex parte order of protection** upon the filing of a verified petition under sections 455.500 to 455.538, for good cause shown in the petition, and upon finding that**:**

(1) No prior order regarding custody **involving the respondent and the child** is pending or has been made**;** or [that]

(2) The respondent is less than seventeen years of age[, the court may immediately issue an ex parte order of protection].

An immediate and present danger of domestic violence, stalking, or sexual assault to a child shall constitute good cause for purposes of this section. An ex parte order of protection entered by the court shall be in effect until the time of the hearing. The court shall deny the ex parte order and dismiss the petition if the petitioner is not authorized to seek relief pursuant to section 455.505.

2. Upon the entry of the ex parte order of protection, the court shall enter its order appointing a guardian ad litem or court-appointed special advocate to represent the child victim.

3. If the allegations in the petition would give rise to jurisdiction under section 211.031, the court may direct the children's division to conduct an investigation and to provide appropriate services. The division shall submit a written investigative report to the court and to the juvenile officer within thirty days of being ordered to do so. The report shall be made available to the parties and the guardian ad litem or court-appointed special advocate.

4. If the allegations in the petition would give rise to jurisdiction under section 211.031 because the respondent is less than seventeen years of age, the court may issue an ex parte order and shall transfer the case to juvenile court for a hearing on a full order of protection. Service of process shall be made pursuant to section 455.035."; and

Further amend said bill, Page 2, Section 478.625, Line 7, by inserting immediately after said section and line the following:

"483.075. 1. Every clerk shall record the judgments, rules, orders and other proceedings of the court; issue and attest all process when required by law and affix the seal of his office thereto, or if none be provided, then his private seal; keep a perfect account of all moneys coming into his hands on account of costs or otherwise, and punctually pay over the same.

2. Provided, that where the clerk of the circuit court is a party, plaintiff or defendant, whether singly or jointly with others, to a suit or action, the writ of summons and all other process shall be issued by the clerk of the county commission, the reason therefor being noted on said process, and said latter named clerk shall, on the trial of said cause, act as temporary clerk of the circuit court and otherwise perform in said cause all the duties of the circuit court clerk. **This subsection shall not apply where the clerk of the circuit court is named as a party under sections 610.130 to 610.145 or other sections relating to the expungement**

of criminal records."; and

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

HOUSE AMENDMENT NO. 2

Amend House Committee Substitute for Senate Bill No. 871, Page 3, Section 488.2250, Line 19, by inserting after all of said section and line the following:

"516.105. **1.** All actions against physicians, hospitals, dentists, registered or licensed practical nurses, optometrists, podiatrists, pharmacists, chiropractors, professional physical therapists, mental health professionals licensed under chapter 337, and any other entity providing health care services and all employees of any of the foregoing acting in the course and scope of their employment, for damages for malpractice, negligence, error or mistake related to health care shall be brought within two years from the date of occurrence of the act of neglect complained of, except that:

(1) In cases in which the act of neglect complained of is introducing and negligently permitting any foreign object to remain within the body of a living person, the action shall be brought within two years from the date of the discovery of such alleged negligence, or from the date on which the patient in the exercise of ordinary care should have discovered such alleged negligence, whichever date first occurs; and

(2) In cases in which the act of neglect complained of is the negligent failure to inform the patient of the results of medical tests, the action for failure to inform shall be brought within two years from the date of the discovery of such alleged negligent failure to inform, or from the date on which the patient in the exercise of ordinary care should have discovered such alleged negligent failure to inform, whichever date first occurs; except that, no such action shall be brought for any negligent failure to inform about the results of medical tests performed more than two years before August 28, 1999. For purposes of this subdivision, the act of neglect based on the negligent failure to inform the patient of the results of medical tests shall not include the act of informing the patient of the results of negligently performed medical tests or the act of informing the patient of erroneous test results; and

(3) In cases in which the person bringing the action is a minor less than eighteen years of age, such minor shall have until his or her twentieth birthday to bring such action.

In no event shall any action for damages for malpractice, error, or mistake be commenced after the expiration of ten years from the date of the act of neglect complained of or for two years from a minor's eighteenth birthday, whichever is later.

2. Any service on a defendant by a plaintiff after the statute of limitations set forth in subsection 1 of this section has expired or after the expiration of any extension of the time provided to commence an action pursuant to law shall be made within one hundred eighty days of the filing of the petition. If such service is not made on a defendant within one hundred eighty days of the filing of the petition, the court shall dismiss the action against the defendant. The dismissal shall be without prejudice unless the plaintiff has previously taken or suffered a nonsuit, in which case the dismissal shall be with prejudice.

537.100. **1.** Every action instituted under section 537.080 shall be commenced within three years after the cause of action shall accrue; provided, that if any defendant, whether a resident or nonresident of the

state at the time any such cause of action accrues, shall then or thereafter be absent or depart from the state, so that personal service cannot be had upon such defendant in the state in any such action heretofore or hereafter accruing, the time during which such defendant is so absent from the state shall not be deemed or taken as any part of the time limited for the commencement of such action against him; and provided, that if any such action shall have been commenced within the time prescribed in this section, and the plaintiff therein take or suffer a nonsuit, or after a verdict for him the judgment be arrested, or after a judgment for him the same be reversed on appeal or error, such plaintiff may commence a new action from time to time within one year after such nonsuit suffered or such judgment arrested or reversed; and in determining whether such new action has been begun within the period so limited, the time during which such nonresident or absent defendant is so absent from the state shall not be deemed or taken as any part of such period of limitation.

2. Any service on a defendant by a plaintiff after the statute of limitations set forth in subsection 1 of this section has expired or after the expiration of any extension of the time provided to commence an action pursuant to law shall be made within one hundred eighty days of the filing of the petition. If such service is not made on a defendant within one hundred eighty days of the filing of the petition, the court shall dismiss the action against the defendant. The dismissal shall be without prejudice unless the plaintiff has previously taken or suffered a nonsuit, in which case the dismissal shall be with prejudice."; and

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

In which the concurrence of the Senate is respectfully requested.

MESSAGES FROM THE GOVERNOR

Senator Kehoe inquired of the President as to whether Messages from the Governor had been received by the Secretary of the Senate; and if messages were received, that the reading be waived and they be printed in the Journal.

Senator Romine rose to object to the acceptance and printing of the message and further moved that the message from the Governor received by the Secretary of the Senate's office on May 11, 2018, regarding appointments to the State Board of Education be rejected, not be printed in the Journal, and be returned to the Governor, which motion prevailed.

RESOLUTIONS

Senator Nasheed offered Senate Resolution No. 2102, regarding Wanda Leach, which was adopted.

Senator Nasheed offered Senate Resolution No. 2103, regarding Herbert Michael Ford Sr., St. Louis, which was adopted.

Senator Nasheed offered Senate Resolution No. 2104, regarding Mila SSekasozi, which was adopted.

Senator Nasheed offered Senate Resolution No. 2105, regarding Lena Ann Jones, which was adopted.

Senator Hummel offered Senate Resolution No. 2106, regarding Dave Lalumondier, Crystal City, which was adopted.

Senator Hummel offered Senate Resolution No. 2107, regarding John Patrick "Jack" Wells, Saint Louis, which was adopted.

Senator Walsh offered Senate Resolution No. 2108, regarding Lambert E. Behlmann, Florissant, which was adopted.

Senator Walsh offered Senate Resolution No. 2109, regarding William L. "Bill" Spurgeon, Florissant, which was adopted.

On motion of Senator Kehoe, the Senate adjourned under the rules.

SENATE CALENDAR

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SEVENTY-FIRST DAY–TUESDAY, MAY 15, 2018

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FORMAL CALENDAR

HOUSE BILLS ON SECOND READING

HB 2644-Rowland

HCS for HJR 100

THIRD READING OF SENATE BILLS

SS for SB 579-Libla (In Fiscal Oversight)

SS for SB 699-Sifton (In Fiscal Oversight)

SENATE BILLS FOR PERFECTION

1. SJR 36-Schatz, with SCS
2. SB 678-Eigel
3. SB 1102-Kehoe, with SCS
4. SB 1015-Wieland, with SCS
5. SB 709-Schatz, with SCS
6. SB 640-Sater
7. SB 963-Wieland, with SCS
8. SB 952-Rowden
9. SB 864-Hoskins
10. SB 998-Schatz, with SCS
11. SB 703-Hegeman
12. SB 915-Crawford
13. SB 934-Hegeman
14. SB 988-Rowden, with SCS
15. SB 790-Cierpiot, with SCS
16. SB 734-Schatz, with SCS

HOUSE BILLS ON THIRD READING

HCS for HBs 2280, 2120, 1468 & 1616, with SCS (Sater) (In Fiscal Oversight)

INFORMAL CALENDAR

THIRD READING OF SENATE BILLS

SS#2 for SCS for SBs 617, 611 & 667-Eigel (In Fiscal Oversight)

SENATE BILLS FOR PERFECTION

SB 546-Munzlinger, with SS#4 (pending)
SB 550-Wasson, with SCS
SBs 555 & 609-Brown, with SCS
SB 556-Brown, with SA 1 (pending)
SB 561-Sater, with SA 1 (pending)
SB 567-Cunningham, with SCS, SS for SCS, SA 1 & SA 1 to SA 1 (pending)
SB 578-Romine
SB 591-Hegeman, with SCS
SB 596-Riddle, with SCS
SB 599-Schatz
SB 602-Onder, with SCS
SB 612-Koenig, with SCS, SS#2 for SCS, SA 2, SSA 1 for SA 2 & SA 1 to SSA 1 for SA 2 (pending)
SB 663-Schatz, with SCS, SS for SCS & SA 1 (pending)
SB 730-Wallingford, with SCS & SA 1 (pending)
SB 751-Schatz
SB 767-Hoskins, with SCS, SS for SCS & SA 2 (pending)
SB 774-Munzlinger
SB 813-Riddle, with SCS & SA 1 (pending)
SB 822-Hegeman, with SCS & SS for SCS (pending)
SB 832-Rowden, with SCS, SS#2 for SCS & point of order (pending)
SB 837-Rowden
SB 848-Riddle
SB 849-Kehoe and Schupp, with SCS, SA 1 & SA 1 to SA 1 (pending)
SB 859-Koenig, with SCS & SS for SCS (pending)
SB 860-Koenig, with SCS, SS for SCS & SA 1 (pending)
SB 861-Hegeman, with SCS
SB 865-Kehoe
SB 893-Sater, with SCS, SS for SCS & SA 1 (pending)
SB 912-Rowden, with SCS & SS#3 for SCS (pending)
SB 920-Riddle, with SS & SA 2 (pending)
SB 928-Onder, with SCS
SB 1003-Wasson, with SS & SA 1 (pending)
SB 1021-Dixon and Wallingford, with SCS

HOUSE BILLS ON THIRD READING

HB 1247-Pike (Onder)
HB 1249-Plocher, with SCS (Dixon)
HB 1250-Plocher, with SCS (Dixon)
HCS for HB 1251, with SCS (Crawford)
HCS for HB 1264 (Hegeman)
HB 1267-Lichtenegger (Munzlinger)
SS#2 for SCS for HCS for HBs 1288, 1377 & 2050 (Dixon)
HB 1303-Alferman, with SCS (Rowden)
HB 1329-Remole, with SCS, SS for SCS & SA 5 (pending) (Munzlinger)
HCS for HB 1388, with SCS (Riddle)
HB 1389-Fitzpatrick, with SCS (Schatz)
HB 1409-Fitzpatrick (Kehoe)
HB 1413-Taylor, with SCS, SS for SCS & SA 1 (pending) (Onder)

SS for HB 1415-Lauer (Wasson)
HB 1442-Alferman, with SCS, SS for SCS & SA 1 (pending) (Schatz)
HCS for HB 1443, with SCS (Sater)
HB 1446-Eggleston, with SCS (Koenig)
HCS for HB 1456, with SCS (Wallingford)
HB 1578-Kolkmeyer (Munzlinger)
HCS for HB 1597, with SCS (Dixon)
HCS for HB 1605, with SCS (Kehoe)
HCS for HB 1611 (Riddle)
HCS for HB 1614 (Hegeman)
HCS for HB 1617, with SCS, SS#2 for SCS & SA 1 (pending) (Onder)
HB 1630-Evans (Rowden)
HCS for HB 1645 (Rowden)
HCS for HB 1667, with SCS (Wallingford)
HB 1691-Miller, with SCS & SS for SCS (pending) (Emery)
HCS for HB 1710, with SCS (Eigel)
HCS for HB 1713, with SCS (Sater)
HB 1719-Grier, with SCS (Riddle)
HCS for HBs 1729, 1621 & 1436 (Brown)
HCS for HB 1796, with SS (pending) (Rowden)
HB 1809-Tate (Schatz)
HB 1831-Ruth, with SA 1 & SA 1 to SA 1 (pending) (Wieland)
HB 1832-Cornejo, with SCS (Riddle)
HCS for HB 1868, with SCS (Riddle)
HCS for HB 1872 (Hegeman)
HB 1892-Wilson (Cierpiot)
HB 1968-Grier (Schatz)
HB 1998-Bondon, with SCS (Emery)
HB 2026-Wilson, with SCS (Rowden)
HCS for HB 2031 (Hoskins)
HB 2039-Fraker (Cunningham)
HCS for HB 2042, with SCS (Dixon)
HB 2043-Tate (Wasson)
HB 2044-Taylor, with SCS (pending) (Dixon)
HCS for HB 2079, with SCS (Crawford)
HCS for HB 2119 (Rowden)
HB 2122-Engler, with SCS (Schatz)
HCS for HB 2129, with SS (pending) (Romine)
HB 2179-Richardson (Kehoe)
HB 2208-Curtman, with SCS (Eigel)
HCS for HB 2216, with SCS (Emery)
HCS for HB 2249, with SCS (Riddle)
HCS for HBs 2277 & 1983, with SCS (Schatz)
HCS for HBs 2337 & 2272, with SCS (Wieland)
HB 2347-Davis, with SCS (Wallingford)
HCS for HB 2540, with SCS (pending) (Eigel)
HB 2562-Austin, with SCS (Dixon)

SENATE BILLS WITH HOUSE AMENDMENTS

SS for SCS for SB 549-Wasson, with HA 1, HA 3, HA 4, HA 5, as amended, HA 6, HA 7, HA 8, HA 9 & HA 10
SB 581-Libla, with HCS
SS#2 for SCS for SB 590-Hegeman, with HA 1 & point of order (pending)
SS for SB 597-Riddle, with HCS, as amended
SCS for SB 769-Cunningham, with HCS
SCS for SBs 807 & 577-Wasson, with HCS, as amended
SB 871-Romine, with HCS, as amended
SB 951-Crawford, with HCS, as amended

BILLS IN CONFERENCE AND BILLS CARRYING REQUEST MESSAGES

In Conference

SB 569-Cunningham, with HCS, as amended (Senate adopted CCR and passed CCS)
SS for SB 608-Hoskins, with HCS
SB 660-Riddle, with HCS, as amended
SB 687-Sater, with HCS, as amended
SCS for SB 718-Eigel, with HCS, as amended

SB 743-Sater, with HCS, as amended
SS for SCS for SB 775-Brown, with HCS, as amended (Senate adopted CCR and passed CCS)
SB 806-Crawford, with HCS, as amended
SS for SCS for SB 826-Sater, with HCS, as amended
SS for SB 870-Hegeman, with HCS, as amended
(Senate adopted CCR and passed CCS)

Requests to Recede or Grant Conference

SS for SCS for SBs 603, 576 & 898-Onder, with HCS, as amended
(Senate requests House recede or grant conference)
HB 1350-Smith (163), with SS for SCS, as amended (Rowden)
(House requests Senate recede or grant conference)

RESOLUTIONS

SR 1137-Walsh, with SS (pending)
SR 1487-Schaaf
SR 2020-Schaaf
SR 2052-Schaaf
SR 2053-Schaaf
SR 2054-Schaaf
SR 2055-Schaaf
SR 2056-Schaaf
SR 2057-Schaaf
SR 2058-Schaaf
SR 2059-Schaaf
SR 2060-Schaaf
SR 2061-Schaaf
SR 2062-Schaaf
SR 2063-Schaaf
SR 2064-Schaaf
SR 2065-Schaaf
SR 2066-Schaaf

Reported from Committee

SCR 30-Wallingford, with SA 1 (pending)
SCR 50-Hegeman
SCR 53-Munzlinger
HCR 63-Haefner (Wieland)
HCR 69-Davis (Hoskins)
HCR 96-Conway (Eigel)

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