5335S.09S

CONFERENCE COMMITTEE SUBSTITUTE NO. 2

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

SENATE COMMITTEE SUBSTITUTE

FOR

SENATE BILL NO. 716

AN ACT

To repeal sections 174.335, 195.070, 334.035, 334.735, 338.010, 376.1363, and 630.167, RSMo, and to enact in lieu thereof sixteen new sections relating to public health.

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

Section A. Sections 174.335, 195.070, 334.035, 334.735, 338.010, 376.1363, and 630.167, RSMo, are repealed and sixteen new sections enacted in lieu thereof, to be known as sections 174.335, 191.761, 191.990, 191.1140, 195.070, 197.168, 208.662, 334.035, 334.036, 334.037, 334.735, 338.010, 376.1363, 630.167, 1, and 2, to read as follows:

174.335. 1. Beginning with the 2004-2005 school year and for each school year thereafter, every public institution of higher education in this state shall require all students who reside in on-campus housing to **[**sign a written waiver stating that the institution of higher education has provided the student, or if the student is a minor, the student's parents or guardian, with detailed written information on the risks

associated with meningococcal disease and the availability and effectiveness of**]** have received the meningococcal vaccine unless a signed statement of medical or religious exemption is on file with the institution's administration. A student shall be exempted from the immunization requirement of this section upon signed certification by a physician licensed under chapter 334, indicating that the immunization would seriously endanger the student's health or life or the student has documentation of the disease or laboratory evidence of immunity to the disease. A student shall be exempted from the immunization requirement of this section if he or she objects in writing to the institution's administration that immunization violates his or her religious beliefs.

2. **[**Any student who elects to receive the meningococcal vaccine shall not be required to sign a waiver referenced in subsection 1 of this section and shall present a record of said vaccination to the institution of higher education.

3.**]** Each public university or college in this state shall maintain records on the meningococcal vaccination status of every student residing in on-campus housing at the university or college**[**, including any written waivers executed pursuant to subsection 1 of this section**]**.

[4.**]** 3. Nothing in this section shall be construed as requiring any institution of higher education to provide or pay for vaccinations against meningococcal disease.

191.761. 1. Beginning July 1, 2015, the department of health and senior services shall provide a courier service to transport collected, donated umbilical cord blood samples to a

nonprofit umbilical cord blood bank located in a city not within a county in existence as of the effective date of this section. The collection sites shall only be those facilities designated and trained by the blood bank in the collection and handling of umbilical cord blood specimens.

2. The department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly 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.

191.990. 1. The MO HealthNet division and the department of health and senior services shall collaborate to coordinate goals and benchmarks in each agency's plans to reduce the incidence of diabetes in Missouri, improve diabetes care, and control complications associated with diabetes.

2. The MO HealthNet division and the department of health and senior services shall submit a report to the general assembly by January first of each odd-numbered year on the following:

(1) The prevalence and financial impact of diabetes of all types on the state of Missouri. Items in this assessment shall include an estimate of the number of people with diagnosed and

undiagnosed diabetes, the number of individuals with diabetes impacted or covered by the agency programs addressing diabetes, the financial impact of diabetes, and its complications on Missouri based on the most recently published cost estimates for diabetes;

(2) An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease;

(3) A description of the level of coordination existing between the agencies, their contracted partners, and other stakeholders on activities, programs, and messaging on managing, treating, or preventing all forms of diabetes and its complications;

(4) The development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the general assembly. The plans shall identify proposed action steps to reduce the impact of diabetes, prediabetes, and related diabetes complications. The plan also shall identify expected outcomes of the action steps proposed in the following biennium while also establishing benchmarks for controlling and preventing diabetes; and

(5) The development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan identified in subdivision (4) of this subsection. This blueprint shall include a budget range for all options presented in the plan identified in subdivision (4) of this subsection for consideration by the general assembly.

3. The requirements of subsections 1 and 2 of this section

shall be limited to diabetes information, data, initiatives, and programs within each agency prior to the effective date of this section, unless there is unobligated funding for diabetes in each agency that may be used for new research, data collection, reporting, or other requirements of subsections 1 and 2 of this section.

191.1140. 1. Subject to appropriations, the University of Missouri shall manage the "Show-Me Extension for Community Health Care Outcomes (ECHO) Program". The department of health and senior services shall collaborate with the University of Missouri in utilizing the program to expand the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved areas of the state and to monitor outcomes of such treatment.

2. The program is designed to utilize current telehealth technology to disseminate knowledge of best practices for the treatment of chronic, common, and complex diseases from a multidisciplinary team of medical experts to local primary care providers who will deliver the treatment protocol to patients, which will alleviate the need of many patients to travel to see specialists and will allow patients to receive treatment more quickly.

3. The program shall utilize local community health care workers with knowledge of local social determinants as a force multiplier to obtain better patient compliance and improved health outcomes.

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. 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 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.

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

197.168. Each year between October first and March first and in accordance with the latest recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, each hospital licensed under this chapter shall offer, prior to discharge and with the approval of the attending physician or other practitioner authorized to order vaccinations or as authorized by physician-approved hospital policies or protocols for influenza vaccinations pursuant to state hospital regulations, immunizations against influenza virus to all inpatients sixty-five years of age and older unless contraindicated for such patient and contingent upon the availability of the vaccine.

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

2. For an unborn child to be enrolled in the show-me healthy babies program, his or her mother shall not be eligible for coverage under Title XIX of the federal Social Security Act, the Medicaid program, as it is administered by the state, and shall not have access to affordable employer-subsidized health

care insurance or other affordable health care coverage that includes coverage for the unborn child. In addition, the unborn child shall be in a family with income eligibility of no more than three hundred percent of the federal poverty level, or the equivalent modified adjusted gross income, unless the income eligibility is set lower by the general assembly through appropriations. In calculating family size as it relates to income eligibility, the family shall include, in addition to other family members, the unborn child, or in the case of a mother with a multiple pregnancy, all unborn children.

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

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

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

otherwise limited by the general assembly through appropriations.

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

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

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

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

10. At least annually, the department shall prepare and

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

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

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

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

(4) The change in healthy behaviors by pregnant women, such as the cessation of the use of tobacco, alcohol, illicit drugs, or other harmful practices, and any resulting or projected short-term and long-term decrease in birth defects; poor motor skills;

vision, speech, and hearing problems; breathing and respiratory problems; feeding and digestive problems; and other physical, mental, educational, and behavioral problems; and

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

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

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

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

334.035. Except as otherwise provided in section 334.036, every applicant for a permanent license as a physician and surgeon shall provide the board with satisfactory evidence of having successfully completed such postgraduate training in hospitals or medical or osteopathic colleges as the board may prescribe by rule.

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

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

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

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

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

(d) Has proficiency in the English language;

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

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

2. (1) An assistant physician collaborative practice arrangement shall limit the assistant physician to providing only

primary care services and only in medically underserved rural or urban areas of this state or in any pilot project areas established in which assistant physicians may practice.

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

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

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

3. (1) For purposes of this section, the licensure of assistant physicians shall take place within processes established by rules of the state board of registration for the healing arts. The board of healing arts is authorized to establish rules under chapter 536 establishing licensure and renewal procedures, supervision, collaborative practice arrangements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensure may be denied or the licensure of an assistant physician may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule.

(2) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if

applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly under chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

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

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

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

334.037. 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. 95-210, 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 shall not enter into a collaborative practice arrangement with more than three full-time equivalent assistant physicians. 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.

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. 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 when delegated the authority to prescribe controlled substances in a collaborative practice arrangement. 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 shall be limited to a five-day supply without refill. 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.

(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.

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

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

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

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

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

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

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

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

(8) "Supervision", control exercised over a physician assistant working with a supervising physician and oversight of the activities of and accepting responsibility for the physician assistant's delivery of care. The physician assistant shall only practice at a location where the physician routinely provides patient care, except existing patients of the supervising physician in the patient's home and correctional facilities. The supervising physician must be immediately available in person or via telecommunication during the time the physician assistant is providing patient care. Prior to commencing practice, the supervising physician and physician assistant shall attest on a form provided by the board that the physician shall provide

supervision appropriate to the physician assistant's training and that the physician assistant shall not practice beyond the physician assistant's training and experience. Appropriate supervision shall require the supervising physician to be working within the same facility as the physician assistant for at least four hours within one calendar day for every fourteen days on which the physician assistant provides patient care as described in subsection 3 of this section. Only days in which the physician assistant provides patient care as described in subsection 3 of this section shall be counted toward the fourteen-day period. The requirement of appropriate supervision shall be applied so that no more than thirteen calendar days in which a physician assistant provides patient care shall pass between the physician's four hours working within the same facility. The board shall promulgate rules pursuant to chapter 536 for documentation of joint review of the physician assistant activity by the supervising physician and the physician assistant.

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

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

requirements in addition to the minimum federal law shall be required.

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

(1) Taking patient histories;

(2) Performing physical examinations of a patient;

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

(4) Performing routine therapeutic procedures;

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

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

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

(8) Assisting in surgery;

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

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

4. Physician assistants shall not prescribe nor dispense any drug, medicine, device or therapy unless pursuant to a

physician supervision agreement in accordance with the law, nor prescribe lenses, prisms or contact lenses for the aid, relief or correction of vision or the measurement of visual power or visual efficiency of the human eye, nor administer or monitor general or regional block anesthesia during diagnostic tests, surgery or obstetric procedures. Prescribing and dispensing of drugs, medications, devices or therapies by a physician assistant shall be pursuant to a physician assistant supervision agreement which is specific to the clinical conditions treated by the supervising physician and the physician assistant shall be subject to the following:

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

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

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

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

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

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

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

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

may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule or regulation. Persons licensed pursuant to the provisions of chapter 335 shall not be required to be licensed as physician assistants. All applicants for physician assistant licensure who complete a physician assistant training program after January 1, 2008, shall have a master's degree from a physician assistant program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

338.010. 1. The "practice of pharmacy" means the interpretation, implementation, and evaluation of medical prescription orders, including any legend drugs under 21 U.S.C.

Section 353; receipt, transmission, or handling of such orders or facilitating the dispensing of such orders; the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by the prescription order so long as the prescription order is specific to each patient for care by a pharmacist; the compounding, dispensing, labeling, and administration of drugs and devices pursuant to medical prescription orders and administration of viral influenza, pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, and meningitis vaccines by written protocol authorized by a physician for persons twelve years of age or older as authorized by rule or the administration of pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, and meningitis vaccines by written protocol authorized by a physician for a specific patient as authorized by rule; the participation in drug selection according to state law and participation in drug utilization reviews; the proper and safe storage of drugs and devices and the maintenance of proper records thereof; consultation with patients and other health care practitioners, and veterinarians and their clients about legend drugs, about the safe and effective use of drugs and devices; and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management and control of a pharmacy. No person shall engage in the practice of pharmacy unless he is licensed under the provisions of this chapter. This chapter shall not be construed to prohibit the use of auxiliary personnel under the direct supervision of a pharmacist from assisting the pharmacist in any of his or her

duties. This assistance in no way is intended to relieve the pharmacist from his or her responsibilities for compliance with this chapter and he or she will be responsible for the actions of the auxiliary personnel acting in his or her assistance. This chapter shall also not be construed to prohibit or interfere with any legally registered practitioner of medicine, dentistry, or podiatry, or veterinary medicine only for use in animals, or the practice of optometry in accordance with and as provided in sections 195.070 and 336.220 in the compounding, administering, prescribing, or dispensing of his or her own prescriptions.

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

3. Nothing in this section shall be construed as to prevent any person, firm or corporation from owning a pharmacy regulated by sections 338.210 to 338.315, provided that a licensed pharmacist is in charge of such pharmacy.

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

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

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

7. The state board of registration for the healing arts, under section 334.125, and the state board of pharmacy, under section 338.140, shall jointly promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Such rules shall require protocols to include provisions allowing for timely communication between the pharmacist and the referring physician, and any other patient protection provisions deemed appropriate by both boards. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither board shall separately promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are

subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

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

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

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

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

Veterinary Medical Association (AVMA).

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

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

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

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

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

(1) The identity of the patient;

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

(3) The route of administration;

(4) The anatomic site of the administration;

(5) The dose administered; and

(6) The date of administration.

376.1363. 1. A health carrier shall maintain written procedures for making utilization review decisions and for

notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

2. For initial determinations, a health carrier shall make the determination within **[**two working days**]** thirty-six hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

(1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the initial certification, and provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within two working days of making the initial certification;

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within one working day of making the adverse determination.

3. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information:

(1) In the case of a determination to certify an extended

stay or additional services, the carrier shall notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the enrollee and the provider within one working day after telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

(2) In the case of an adverse determination, the carrier shall notify by telephone or electronically the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the enrollee and the provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the enrollee until the enrollee has been notified of the determination.

4. For retrospective review determinations, a health carrier shall make the determination within thirty working days of receiving all necessary information. A carrier shall provide notice in writing of the carrier's determination to an enrollee within ten working days of making the determination.

5. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. A health carrier

shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information.

6. A health carrier shall have written procedures to address the failure or inability of a provider or an enrollee to provide all necessary information for review. In cases where the provider or an enrollee will not release necessary information, the health carrier may deny certification of an admission, procedure or service.

630.167. 1. Upon receipt of a report the department or the department of health and senior services, if such facility or program is licensed pursuant to chapter 197, shall initiate an investigation within twenty-four hours. The department of mental health shall complete all investigations within sixty days, unless good cause for the failure to complete the investigation is documented.

2. If the investigation indicates possible abuse or neglect of a patient, resident or client, the investigator shall refer the complaint together with the investigator's report to the department director for appropriate action. If, during the investigation or at its completion, the department has reasonable cause to believe that immediate removal from a facility not operated or funded by the department is necessary to protect the residents from abuse or neglect, the department or the local prosecuting attorney may, or the attorney general upon request of the department shall, file a petition for temporary care and protection of the residents in a circuit court of competent

jurisdiction. The circuit court in which the petition is filed shall have equitable jurisdiction to issue an ex parte order granting the department authority for the temporary care and protection of the resident for a period not to exceed thirty days.

3. (1) Except as otherwise provided in this section, reports referred to in section 630.165 and the investigative reports referred to in this section shall be confidential, shall not be deemed a public record, and shall not be subject to the provisions of section 109.180 or chapter 610. Investigative reports pertaining to abuse and neglect shall remain confidential until a final report is complete, subject to the conditions contained in this section. Final reports of substantiated abuse or neglect issued on or after August 28, 2007, are open and shall be available for release in accordance with chapter 610. The names and all other identifying information in such final substantiated reports, including diagnosis and treatment information about the patient, resident, or client who is the subject of such report, shall be confidential and may only be released to the patient, resident, or client who has not been adjudged incapacitated under chapter 475, the custodial parent or guardian parent, or other guardian of the patient, resident or client. The names and other descriptive information of the complainant, witnesses, or other persons for whom findings are not made against in the final substantiated report shall be confidential and not deemed a public record. Final reports of unsubstantiated allegations of abuse and neglect shall remain closed records and shall only be released to the parents or other

guardian of the patient, resident, or client who is the subject of such report, patient, resident, or client and the department vendor, provider, agent, or facility where the patient, resident, or client was receiving department services at the time of the unsubstantiated allegations of abuse and neglect, but the names and any other descriptive information of the complainant or any other person mentioned in the reports shall not be disclosed unless such complainant or person specifically consents to such disclosure. Requests for final reports of substantiated or unsubstantiated abuse or neglect from a patient, resident or client who has not been adjudged incapacitated under chapter 475 may be denied or withheld if the director of the department or his or her designee determines that such release would jeopardize the person's therapeutic care, treatment, habilitation, or rehabilitation, or the safety of others and provided that the reasons for such denial or withholding are submitted in writing to the patient, resident or client who has not been adjudged incapacitated under chapter 475. All reports referred to in this section shall be admissible in any judicial proceedings or hearing in accordance with section 621.075 or any administrative hearing before the director of the department of mental health, or the director's designee. All such reports may be disclosed by the department of mental health to law enforcement officers and public health officers, but only to the extent necessary to carry out the responsibilities of their offices, and to the department of social services, and the department of health and senior services, and to boards appointed pursuant to sections 205.968 to 205.990 that are providing services to the patient, resident or

client as necessary to report or have investigated abuse, neglect, or rights violations of patients, residents or clients provided that all such law enforcement officers, public health officers, department of social services' officers, department of health and senior services' officers, and boards shall be obligated to keep such information confidential.

(2) Except as otherwise provided in this section, the proceedings, findings, deliberations, reports and minutes of committees of health care professionals as defined in section 537.035 or mental health professionals as defined in section 632.005 who have the responsibility to evaluate, maintain, or monitor the quality and utilization of mental health services are privileged and shall not be subject to the discovery, subpoena or other means of legal compulsion for their release to any person or entity or be admissible into evidence into any judicial or administrative action for failure to provide adequate or appropriate care. Such committees may exist, either within department facilities or its agents, contractors, or vendors, as applicable. Except as otherwise provided in this section, no person who was in attendance at any investigation or committee proceeding shall be permitted or required to disclose any information acquired in connection with or in the course of such proceeding or to disclose any opinion, recommendation or evaluation of the committee or board or any member thereof; provided, however, that information otherwise discoverable or admissible from original sources is not to be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before any committee or in the

course of any investigation, nor is any member, employee or agent of such committee or other person appearing before it to be prevented from testifying as to matters within their personal knowledge and in accordance with the other provisions of this section, but such witness cannot be questioned about the testimony or other proceedings before any investigation or before any committee.

(3) Nothing in this section shall limit authority otherwise provided by law of a health care licensing board of the state of Missouri to obtain information by subpoena or other authorized process from investigation committees or to require disclosure of otherwise confidential information relating to matters and investigations within the jurisdiction of such health care licensing boards; provided, however, that such information, once obtained by such board and associated persons, shall be governed in accordance with the provisions of this subsection.

(4) Nothing in this section shall limit authority otherwise provided by law in subdivisions (5) and (6) of subsection 2 of section 630.140 concerning access to records by the entity or agency authorized to implement a system to protect and advocate the rights of persons with developmental disabilities under the provisions of 42 U.S.C. Sections 15042 to 15044 and the entity or agency authorized to implement a system to protect and advocate the rights of persons with mental illness under the provisions of 42 U.S.C. 10801. In addition, nothing in this section shall serve to negate assurances that have been given by the governor of Missouri to the U.S. Administration on Developmental Disabilities, Office of Human Development Services, Department of

Health and Human Services concerning access to records by the agency designated as the protection and advocacy system for the state of Missouri. However, such information, once obtained by such entity or agency, shall be governed in accordance with the provisions of this subsection.

4. **[**Anyone**]** Any person who makes a report pursuant to this section or who testifies in any administrative or judicial proceeding arising from the report shall be immune from any civil liability for making such a report or for testifying unless such person acted in bad faith or with malicious purpose.

5. (1) Within five working days after a report required to be made pursuant to this section is received, the person making the report shall be notified in writing of its receipt and of the initiation of the investigation.

(2) For investigations alleging neglect of a patient, resident, or client, the guardian of such patient, resident, or client shall be notified of:

(a) The investigation and given an opportunity to provide information to the investigators;

(b) The results of the investigation within five working days of the completion of the investigation and decision of the department of mental health of the results of the investigation.

6. The department of mental health shall obtain two independent reviews of all patient, resident, or client deaths that it investigates.

7. No person who directs or exercises any authority in a residential facility, day program or specialized service shall evict, harass, dismiss or retaliate against a patient, resident

or client or employee because he or she or any member of his or her family has made a report of any violation or suspected violation of laws, ordinances or regulations applying to the facility which he or she has reasonable cause to believe has been committed or has occurred.

[7.**]** 8. Any person who is discharged as a result of an administrative substantiation of allegations contained in a report of abuse or neglect may, after exhausting administrative remedies as provided in chapter 36, appeal such decision to the circuit court of the county in which such person resides within ninety days of such final administrative decision. The court may accept an appeal up to twenty-four months after the party filing the appeal received notice of the department's determination, upon a showing that:

(1) Good cause exists for the untimely commencement of the request for the review;

(2) If the opportunity to appeal is not granted it will adversely affect the party's opportunity for employment; and

(3) There is no other adequate remedy at law.

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

(1) "Assistant physician", a person licensed to practice under section 334.036 in a collaborative practice arrangement under section 334.037;

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

(3) "Medically underserved area":

(a) An area in this state with a medically underserved

population;

(b) An area in this state designated by the United States secretary of health and human services as an area with a shortage of personal health services;

(c) A population group designated by the United States secretary of health and human services as having a shortage of personal health services;

(d) An area designated under state or federal law as a medically underserved community; or

(e) An area that the department considers to be medically underserved based on relevant demographic, geographic, and environmental factors;

(4) "Primary care", physician services in family practice, general practice, internal medicine, pediatrics, obstetrics, or gynecology;

(5) "Start-up money", a payment made by a county or municipality in this state which includes a medically underserved area for reasonable costs incurred for the establishment of a medical clinic, ancillary facilities for diagnosing and treating patients, and payment of physicians, assistant physicians, and any support staff.

2. (1) The department shall establish and administer a program under this section to increase the number of medical clinics in medically underserved areas. A county or municipality in this state that includes a medically underserved area may establish a medical clinic in the medically underserved area by contributing start-up money for the medical clinic and having such contribution matched wholly or partly by grant moneys from

the medical clinics in medically underserved areas fund established in subsection 3 of this section. The department shall seek all available moneys from any source whatsoever, including, but not limited to, healthcare foundations to assist in funding the program.

(2) A participating county or municipality that includes a medically underserved area may provide start-up money for a medical clinic over a two-year period. The department shall not provide more than one hundred thousand dollars to such county or municipality in a fiscal year unless the department makes a specific finding of need in the medically underserved area.

(3) The department shall establish priorities so that the counties or municipalities which include the neediest medically underserved areas eligible for assistance under this section are assured the receipt of a grant.

3. (1) There is hereby created in the state treasury the "Medical Clinics in Medically Underserved Areas Fund", which shall consist of any state moneys appropriated, gifts, grants, donations, or any other contribution from any source for such purpose. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and, upon appropriation, money in the fund shall be used solely for the administration of this section.

(2) Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund.

(3) The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

4. To be eligible to receive a matching grant from the department, a county or municipality that includes a medically underserved area shall:

(1) Apply for the matching grant; and

(2) Provide evidence satisfactory to the department that it has entered into an agreement or combination of agreements with a collaborating physician or physicians for the collaborating physician or physicians and assistant physician or assistant physicians in accordance with a collaborative practice arrangement under section 334.037 to provide primary care in the medically underserved area for at least two years.

5. The department shall promulgate rules necessary for the implementation of this section, including rules addressing:

(1) Eligibility criteria for a medically underserved area;

(2) A requirement that a medical clinic utilize an assistant physician in a collaborative practice arrangement under section 334.037;

(3) Minimum and maximum county or municipality contributions to the start-up money for a medical clinic to be matched with grant moneys from the state;

(4) Conditions under which grant moneys shall be repaid by a county or municipality for failure to comply with the requirements for receipt of such grant moneys;

(5) Procedures for disbursement of grant moneys by the department;

(6) The form and manner in which a county or municipality shall make its contribution to the start-up money; and

(7) Requirements for the county or municipality to retain interest in any property, equipment, or durable goods for seven years including, but not limited to, the criteria for a county or municipality to be excused from such retention requirement.

Section 2. 1. The department of mental health shall develop guidelines for the screening and assessment of persons receiving services from the department that address the interaction between physical and mental health to ensure that all potential causes of changes in behavior or mental status caused by or associated with a medical condition are assessed.

2. The provisions of this section shall only apply to state owned or operated facilities and not to long-term care facilities licensed under chapter 198, hospitals licensed under chapter 197, or hospitals as defined in section 197.020.

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

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Dan Brown	Dwight Scharnhorst