

**Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND
PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 2—Licensing of Physicians and Surgeons**

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.045, 334.046, 334.090 and 334.125, RSMo 2000 and 334.100, RSMo Supp. 2006, the board rescinds a rule as follows:

20 CSR 2150-2.001 Definitions is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on August 1, 2016 (41 MoReg 963). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.045 and 334.046, RSMo 2000, sections 334.090 and 334.100, RSMo Supp. 2013 and sections 334.036, 334.038, and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.001 Definitions is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 963-964). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received three (3) comments on the proposed rule.

COMMENT #1: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating that section (2)(D) indicates that an assistant physician applicant must submit proof of graduation from an “approved medical school,” a term that is defined under 20 CSR 2150-2.100, as: “a medical school accredited by the Liaison Committee on Medical Education of the American Medical Association, the American Osteopathic Association’s Commission on Osteopathic College Accreditation, or that appears in the World Directory of Medical Schools or its successor.” However, the statute creating the assistant physician licensure is not crafted this broadly. Section 334.036, RSMo, defines “medical school graduate,” for purposes of assistant physician licensure, as “any person who has graduated from a medical college or osteopathic medical college described in section 334.031.” Section 334.031, RSMo, in turn, clarifies that “Any medical college approved and accredited as reputable by the American Medical Association or the Liaison Committee on Medical Education and any osteopathic college approved and accredited as reputable by the American Osteopathic Association is deemed to have complied with the requirements of this subsection.” This section makes no mention of the World Directory; the only accrediting bodies mentioned are the American Medical Association (AMA), Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA). By opening assistant physician licensure to graduates from schools listed on the World Directory, a student from any international school of medicine could obtain licensure as an assistant physician. Given its responsibility for assuring that assistant physician licensees have some common standard or background in medical education, the Board should be aware that the World Directory is not an accrediting body. Its mission statement reads: It is the mission of the *World Directory of Medical Schools (World Directory)* to list all of the medical schools in the world...*The listing of a medical school in the World Directory of Medical Schools does not denote recognition, accreditation, or endorsement by the World Directory of*

Medical Schools *or its partner organizations...*” Being listed on the World Directory does not represent any measure or standard of competency by a given school. The rule should remove this reference to the World Directory and be consistent with the statute which states that accreditation by the AMA, AOA or LCME meet the specified standard of medical education.

RESPONSE AND EXPLANATION OF CHANGE: The Board appreciates the comments and amends the language as suggested to incorporate the standard for medical schools as outline in section 334.031.1, RSMo.

COMMENT #2: A comment was received from the Missouri Academy of Family Physicians (MAFP) suggesting section (9) be amended to change the “Accreditation Counsel (should be “Council”) on Graduate Medical Education (ACGME)” is not part of the American Medical Association (since 2000, per ACGME website: <http://www.acgme.org/About-Us/Overview/ACGME-History>); and the “Education Committee” of the American Osteopathic Association has been changed to “Program and Trainee Review Council”.

RESPONSE AND EXPLANATION OF CHANGE: The Board appreciates the comments and amends the language as suggested.

COMMENT #3: A comment was received from the Missouri Academy of Family Physicians (MAFP) suggesting section (15) be amended to change “family practice medicine” to “family medicine” to reflect the specialty of integrated care for all patients in the delivery of acute, chronic, and preventive medical care services.

RESPONSE AND EXPLANATION OF CHANGE: The Board appreciates the comments and amends the language as suggested.

20 CSR 2150-2.001 Definitions

- (3) Approved medical school—a medical school accredited by the Liaison Commission on Medical Education of the American Medical Association or the American Osteopathic Association’s Commission on Osteopathic College Accreditation, or other medical school program that enforces requirements of four terms of thirty-two weeks for actual instruction in each term, including, in addition to class work, such experience in operative and hospital work during the last two years of instruction as is required by the American Medical Association and the American Osteopathic Association.
- (9) Hospitals approved by the board—all hospitals who are part of a residency training program approved and accredited to teach graduate medical education by the Accreditation Council on Graduate Medical Education (ACGME) of the American Medical Association or the Program and Trainee Review Council of the American Osteopathic Association.
- (15) Primary care—physician services in family medicine, general practice, internal medicine, pediatrics, obstetrics, or gynecology. This shall not include surgery other than minor office based procedures.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.045 Name and Address Changes is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 964-966). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.090.2 and 334.125, RSMo 2000, the board withdraws a rescission as follows:

20 CSR 2150-2.080 Fees is withdrawn.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on August 1, 2016 (41 MoReg 967). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: The board received one (1) staff comment on this proposed rule.

COMMENT: Based on the board's five- (5-) year projections, the board filed an emergency rescission and rule to reduce fees established by 20 CSR 2150-2.080 in order to maintain board's fund at a level that is authorized by section 334.090, RSMo.

RESPONSE: As a result, the board is withdrawing this proposed rescission because of the emergency rescission and rule that became effective September 11, 2016.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under section 334.090.2, RSMo Supp. 2013, and sections 334.036, and 334.125, RSMo Supp. 2014, the board withdraws a rule as follows:

20 CSR 2150-2.080 Fees is withdrawn.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 967-970). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: The board received one (1) staff comment on this proposed rule.

COMMENT: Based on the board's five- (5-) year projections, the board filed an emergency rule to reduce fees established by 20 CSR 2150-2.080 in order to maintain board's fund at a level that is authorized by section 334.090, RSMo.

RESPONSE: As a result, the board is withdrawing this proposed rule because of the emergency rule that became effective September 11, 2016.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.200 Assistant Physician - Application for Licensure is adopted.

A notice of proposed rulemaking containing the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 971-975). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received two (2) comments on the proposed rule and eleven (11) general comments regarding the licensure of assistant physicians.

COMMENT #1: A comment was received from the Missouri Academy of Family Physicians (MAFP) suggesting subsection (2)(D) - The “Accreditation Counsel (should be “Council”) on Graduate Medical Education (ACGME)” is not part of the American Medical Association (since 2000, per ACGME website: <http://www.acgme.org/About-Us/Overview/ACGME-History>); and the “Education Committee” of the American Osteopathic Association has been changed to “Program and Trainee Review Council”.

RESPONSE AND EXPLANATION OF CHANGE: The board appreciates the comments and amends the language in subsection (2)(D) of 20 CSR 2150-2.200 as suggested.

COMMENT #2: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating their comments submitted in July 2015 during the pre-filing review, encouraged the board to seek records from hospitals with which the AP applicant had previously trained, specifically faculty evaluations. We recognize that the proposed rule under (4)(F) requires the applicant to disclose if, “the applicant has ever had any adverse action taken against his or her privileges at any hospital...” While this standard is weaker, and relies on self-disclosure by the candidate, we recognize it represents a step toward determining if the applicant has encountered prior difficulties in their medical training. We support the required disclosure in the proposed rule, but continue to encourage the board to go farther and request a summary of faculty evaluations from the applicant’s former hospital or residency program.

RESPONSE: Paragraph (2)(E)(6) of this rule requires applicants for licensure to submit proof of hospital affiliation from each hospital where the applicant has held admitting privileges in the last ten (10) years or to submit a letter from the hospital to include the dates the applicant had admitting privileges and where there was ever any adverse action taken against those privileges,

including, but not limited to, revocation, suspension, or limitation of privileges or if the applicant ever resigned privileges while under investigation. Therefore, the board makes no changes.

COMMENT #3: Comments were received from Tim deVries, and Joseph Irvin supporting assistant physician licensure stating that law will be beneficial and allow Missouri to be a trend setter.

RESPONSE: No action was taken by the board.

COMMENT #4: A comment was received from Irene Scott generally summarizing the assistant physician law. No comment of support or opposition was included.

RESPONSE: No action was taken by the board.

COMMENT #5: A comment was received from Faiza Shekhani supporting the rules and stating issues of criticism of the assistant physician could be addressed by preferring United States of America (US) nationals with more experience in patient care (whether in the US or overseas) and US nationals with USMLE step 3 exam, passed within past 2 years.

RESPONSE: No action was taken by the board as this change would require legislative action by the Missouri General Assembly.

COMMENT #6: Comments were received from fourteen (14) individuals, Chris Strupp, Melissa Kovcas, Falin Larson, Danniell Lewis, Whitney James, Young Kim, Faisal Ishfaq, Ulziibat Person, Maimoona Arshee, Subpal Gill, Maira Beasely, Adil Iqbal, and Sabahath Shaikh requesting a change or abolishment of section 334.036 (1)(b), RSMo as it relates to successful completion of Step 1 and Step 2 of the United State Medical Licensing Examination (UMSLE) within a two- (2-) year period immediately preceding the application for licensure as a assistant physician. Commenters stated this language as written would prohibit them from being granted licensure as an assistant physician.

RESPONSE: No action was taken by the board as this change would require legislative action by the Missouri General Assembly.

COMMENT #7: Comments were received from William Blanchard and Kemberly Briggs requesting an amendment to the language as written in section 334.036 (1)(b), RSMo, or a waiver be granted as it relates to no more than three (3) years after graduation from medical college or osteopathic medical college be changes. The commenters stated that the language as written would prohibit them from being granted licensure as an assistant physician.

RESPONSE: No action was taken by the board as this change would require legislative action by the Missouri General Assembly.

COMMENT #8: A comment was received from Malkiat Singh asking the board to consider proof of proficiency of an applicant if they are disqualified by the requirements of section 334.036 (1)(b), RSMo.

RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

COMMENT #9: A comment was received from Hasfa Hassan stating that many international medical graduates have more clinical exposure than an American medical graduate because they have more clinical exposure during their medical education or have completed a post graduate training program in another country. The commenter suggested the board take into consideration the applicant's clinical exposure during medical school and the international graduate's post graduate training.

RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

COMMENT #10: Three (3) comments from Esteban Ivanoff-Tzvetcoff, Muhammed Saad, Aruna Sana were received stating they believe it is ridiculous that physician assistants and nurse practitioners have less training and having to pass easier exams are allowed to practice medicine, while medical students who did not match because there are not enough residency programs. One (1) commenter stated that this was plainly discriminatory and not democratic. Two (2) of the comments suggested assistant physicians should have three (3) months of direct supervision by a licensed physician before starting an independent job; assistant physicians should be allowed to take the Missouri State Medical Board exam after twenty-four (24) months of work experience under the supervision of a licensed physician; and assistant physicians should be allowed to practice independently after passing the State Medical Board exam (within 3 years).

RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

COMMENT #11: A comment was received from Tricia Degres for future rule considerations and/or additions so as not to delay the current timeline of the assistant physician being finalized this December. These considerations include rural residency credit; converting the assistant physician license to a full physician's license following a three (3) year rural residency; allowing the assistant physician to collaborate with a nurse practitioner; and expanding the area of critical shortage to include, but not be limited to, emergency rooms and veteran administration (VA) hospitals

RESPONSE: The board encourages the commenter to contact a member of the Missouri General Assembly.

COMMENT #12: A comment from Brian Sweeney was received regarding the denial of a license failure to meet any requirements of (a) Chapter 334, RSMo, or 20 CSR 2150-2.200 through 20 CSR 2150-2.270; (b) Failure to demonstrate good moral character; or (c) Any cause listed in section 334.100, RSMo. Chapter 334,040, RSMo states "The board shall not issue a permanent license as a physician and surgeon or allow the Missouri state board examination to be administered to any applicant who has failed to achieve a passing score within three (3) attempts on licensing examinations administered in one (1) or more states or territories of the United States, the District of Columbia or Canada." Many applicants who have passed the examination in more than three (3) attempts will not be qualified for an assistant physician

license. The commenter requested the Board remove this requirement and stated that the current licensure requirements in many states are being reviewed to reduce barriers to entry as a response to the Supreme Court ruling "North Carolina State Board of Dental Examiners v FTC".

RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

COMMENT #13: A comment was received from the American Association of Physician Assistants (AAPA) stating assistant physician-related rules must be created in its own chapter of the administrative code because assistant physicians do not meet the standard definitions of physicians and do not meet the Missouri criteria for physician licensure. Similarly, AAPA opposes adding the assistant physician regulations to the Physician Assistant chapter of the administrative code.

RESPONSE: Chapter 2 of 20 CSR 2150 contains rules and regulations of several categories of physician licensure. The board felt Chapter 2 was the appropriate chapter of the 20 CSR 2150 to place the assistant physician rules.

20 CSR 2150-2.200 Assistant Physician - Application for Licensure

(2) Applicants applying for licensure shall submit the following:

(D) Proof that the applicant has passed step 2 or level 2 of a board approved medical licensing examination within the two (2) year period immediately preceding application for licensure as an assistant physician, but in no event more than three (3) years after graduation from medical college or osteopathic medical college. However, if the applicant was serving as a resident physician in a residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME) of the American Medical Association or the Program and Trainee Review Council of the American Osteopathic Association in the United States within thirty (30) days of filing his or her application for an assistant physician license, the two- (2-) year time period shall not apply;

Coalition for Patients First

Protecting Patient Care & Preserving Health Equity

Overview

Students, interns, residents, and fully trained physicians all have a role in caring for the nation's patient populations. Licensed health care professionals should also have a clearly defined role in patient care that is consistent with their education, training and competencies.

The evolving health care system may require new types of professionals to play a patient-oriented role in health care. "Assistant Physicians" (AP) appear to be developing from medical school graduates who have been unable to enter a graduate medical education (GME) program, and not from a patient-driven need from the health care system. While there are apparently medical school graduates unable to pursue GME training, it is our opinion that this does not create a need for a new profession of partially trained and inadequately assessed graduate physicians.

The system that trains physicians gradually and cautiously introduces new physicians to the workforce after observed and direct assessment of their abilities in a health care environment, and testing in high stakes examinations. Those medical graduates who have not succeeded in this process should not be given a scope of practice similar to fully-licensed physicians who have completed all necessary and required training.

Position Statement

Standardized Licensure Requirements: Patient Safety, Transparency and Equity

The Coalition supports team-based care, which utilizes the expertise of a fully-trained and licensed physician, and is proven in its ability to deliver high-quality care to patients in need. In addition to passing a licensing examination series, which demonstrates competency, every state requires completion of at least one year of postgraduate residency training in order to be licensed as a physician. The Coalition believes that residency training provides medical school graduates with the necessary skills needed to deliver independent patient care and care delivered through the health care team.

Health care providers within the team should be utilized to the greatest extent of their education, training and competencies. Additionally, the Coalition believes that licensure eligibility should be standardized by profession and scope of practice. This is the only way that states can assure patient protection and transparency, and create an equitable system for licensing health care professionals.

Assistant/Associate Physicians: Incomplete Training, Limited Patient Protection

In 2014, Missouri enacted a law that created a new type of health care provider, the Assistant Physician. The Missouri law allows APs to provide primary care services to individuals in rural and/or underserved areas under the supervision of a licensed physician. While the law was enacted in 2014, the Missouri Board for the Healing Arts has not yet adopted final rules for the licensure of APs, and therefore none are currently in practice. The Board sent draft rules to the Governor's Office for review and approval, and Governor Jay Nixon approved the proposal. The final rules have now been published for a 30-day open comment period, ending August 31, 2016.

During the 2015 legislative session, Kansas and Arkansas proposed similar bills. These bills were amended to limit renewals, require continuous direct supervision and ensure patient safety. During the 2016 state legislation cycle, bills were introduced in Washington State and Virginia. These bills are very similar to the Missouri law, and would create an "Associate Physician" license, allowing individuals who lack complete medical training to provide this care to patients under limited supervision. Though the terminology varies by state, the "Assistant" and "Associate" Physician positions are similar in concept.

The Coalition remains concerned with the Missouri law and similar proposals in other states. Allowing medical school graduates without complete medical training to provide independent patient care under limited supervision may jeopardize patient safety. States must also understand that this is a dangerous precedent that establishes an inappropriate standard for the delivery of health care to patients in rural and/or underserved areas.

Additionally, promoting primary care as a fallback or an alternative to a student's desired specialty is inappropriate. This devalues the important and necessary care that primary care physicians provide to patients as a first line defense in protecting patient well-being and advancing population health. Individuals who fail to match into their desired medical specialty will not necessarily make a good primary care physician, which is another example of why these proposals will prevent states from meeting their overall goal of increasing the delivery of high quality primary care to patients in rural and underserved areas.

Key Concerns and Talking Points

1. Medical school graduates are not prepared or trained to provide independent care to patients. Medical schools strive to graduate students who are prepared to enter the next phase of their professional career pathway, residency training. They require continuous direct supervision, as provided through the postgraduate residency training experience. Their role in delivering care expands, as they continue to develop the skills, knowledge and competencies required to deliver high-quality, comprehensive patient care.
 - a. Medical school provides exposure and fully supervised experiences, ensuring the safety of patients and that patient care is not delivered without appropriate and safety-driven oversight. The assessment of independent practice is not part of clinical clerkships in the 3rd and 4th years of training.
2. Residency training is critical and required to become a licensed physician to practice independently. These proposals, while well meaning, disregard the decades of evidence and experience behind established GME programs in the US.
 - a. Accredited residency programs are highly structured to provide a well-rounded and rigorous clinical and educational experience for medical school graduates.
 - b. Traditional residency programs are based in environments that have clinical education as a core mission, with residents providing care under the supervision of physician educators. Residents are evaluated based on standardized approaches that examine the residents' knowledge base, clinical skills and professionalism, while also identifying those in need of more training. Based on these assessments, residents are afforded progressively greater autonomy.
 - c. Diagnostic analytic thought patterns are developed by a physician and individual practice patterns are established during this phase of the medical education experience. This is the aspect of training that provides a professional with the competency for independent thought and practice.
 - d. In the midst of training, it is inappropriate to confer a title implying training is complete. Physicians are trained for independent practice and any legislative intervention that subverts the end product of medical training is harmful to both patients and to the larger health care system.
3. These proposals create a two-tiered physician system whereby some patients have access to fully-trained and licensed DOs/MDs whose abilities do not require supervision, and others would receive care from those who complete medical school, but lack patient care knowledge and skills because they have not completed residency training. Patients in rural and underserved areas, who are already at a geographic and often economic disadvantage, deserve the same quality of care as those who live in prosperous areas of the state.

- a. This includes receiving care from licensed health professionals who have completed the necessary education and training.
 - b. Health care consumers also deserve transparency from the health professionals who are providing their care. The AP title has the potential to confuse patients, health systems, payers and other providers.
4. These attempts run counter to efforts to raise the bar for health care providers, by maintaining/increasing standards for licensure and supporting competency demonstration requirements that adequately protect patients. Lowering the bar for who can provide care to patients degrades these ongoing efforts and creates inequity in the licensing requirements for health care providers licensed to provide the same health care services. In doing so, states will erode the trust of the patient and the public, a critical factor in the successful delivery of services in the patient-centered model of care.
5. Last year, over 95% of US medical students secured a residency training position. The numbers of unmatched medical school graduates from LCME or AOA accredited colleges are too small to make noticeable progress toward addressing workforce shortages.
 - a. These proposals fail to take into account that certain individuals fail to match into a training program because of their specialty choice.
 - b. Primary care residency slots remain available for qualified medical school graduates with an interest in practicing in these specialties.
6. If the goal is to address primary care workforce shortages, while ensuring access to optimal patient care, states would be wise to take a different approach. States should instead focus on increasing residency funding to create new and expand existing primary care training programs. States should also provide support for programs that encourage medical school graduates to pursue primary care specialties, particularly in rural and underserved areas. Programs like health provider loan repayment/forgiveness and Medicaid payment parity for primary care services are examples of proven strategies. States should consider optimizing state statutes and rules to ensure that all health professionals are practicing to the top of their education and experience.
 - a. This is the best way to create fully-trained and licensed physicians equipped to handle the complex primary care needs of patients, and address workforce shortages across all health care provider types in rural and underserved areas.
 - b. New models of care delivery like telemedicine, Accountable Care Coalition and Patient Centered Medical Homes are also effective ways to maximize the impact of the existing health care workforce. States should focus on providing appropriate payment for team-based care provided in these delivery models.

Member Coalition

American Academy of PAs
American Academy of Pediatrics
American Association of Colleges of Osteopathic Medicine
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
Association of American Medical Colleges
American Medical Association American Osteopathic Association

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.210 Assistant Physician License Renewal is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 976-980). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received two (2) comments on the proposed rule.

COMMENT #1: A comment was received from the American Association of Physician Assistants (AAPA) stating that in keeping with the legislative intent of offering an avenue for clinical experience for medical graduates who will enter residency programs, the rules must limit renewals to not more than three years.

RESPONSE: Section 334.036, RSMo does not limit the number of renewals for assistant physician licensure. It is the board's understanding that limiting the time an individual can hold an assistant physician license was removed during the final passage of Senate Bill 735 (2014) as it was the intent of the bill sponsor that this be a permanent licensure/position for those who seek it. Therefore, the board believes any changes to the licensure requirements or the length of time an individual be licensed as an assistant physician would require legislative action be taken by the Missouri General Assembly. With regard to an Attorney General's Opinion, the Board plans to implement the law passed by the Missouri General Assembly. No changes have been made to the rule as a result of this comment.

COMMENT #2: A comment was received from Coalition for Patients First (Coalition), which includes the following Coalition: American Academy of PAs, American Academy of Pediatrics, American Association of Colleges of Osteopathic Medicine, American College of Osteopathic Family Physicians, American College of Osteopathic Internists, Association of American Medical Colleges, American Medical Association and American Osteopathic Association. The Coalition stated they would like the board to restrict licensure renewals to a finite number and strongly believe it was not the intent of the legislature to use assistant physicians as an alternative to full and unlimited physician licensure. They further believe that moving forward with allowing individuals who lack complete medical training to provide direct patient care under limited supervision places Missouri patients at an increased risk and threatens public health, safety and welfare. The Coalition request the board limit the number of renewals to two (2) in the

final rule. Assistant physician practice should provide medical school graduates who failed to match into a postgraduate residency program with a pathway toward full medical licensure and practice. This opportunity can offer assistant physician's time to develop their skills and medical knowledge as they seek a residency position. Limiting renewals to two (2) years would also align with the law's requirement for an assistant physician to pass the final portion of the licensure examination series after the second year. Upon the successful passage of the complete licensure examination series, followed by a minimum of one (1) year of postgraduate training, assistant physicians would be eligible for full medical licensure in the State of Missouri. The Coalition believe the board does have the authority to impose this limitation when reading this in the context of the entire law, where the General Assembly did provide specific limitations on the specialty and location of assistant physician's practice and prescribing of controlled substances, it should be inferred that the General Assembly did not intend for the board to be restricted in its authority to limit licensure renewal. The Coalition suggested that the Director of the Department of Insurance, Financial Institutions and Professional Registration seek a formal opinion from the Attorney General on this issue. They believe it is imperative that the board understand its full rights and responsibilities regarding its authority to regulate assistant physicians before moving forward to finalize the proposed rule. The Coalition requests that the Attorney General review the content of Section 334.036.3(1) and that the board delay finalizing the proposed rule until a formal opinion is made on the board's authority to limit licensure renewal under this section. The commenters also submitted a position statement, which is attached.

RESPONSE: Section 334.036, RSMo does not limit the number of renewals for assistant physician licensure. It is the board's understanding that limiting the time an individual can hold an assistant physician license was removed during the final passage of Senate Bill 735 (2014) as it was the intent of the bill sponsor that this be a permanent licensure/position for those who seek it. Therefore, the board believes any changes to the licensure requirements or the length of time an individual be licensed as an assistant physician would require legislative action be taken by the Missouri General Assembly. With regard to an Attorney General's Opinion, the board has not requested one and plans to implement the law passed by the Missouri General Assembly. No changes have been made to the rule as a result of this comment.

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By the authority vested in the State Board of Registration for the Healing Arts under section 324.039, RSMo Supp. 2013, sections 334.036 and 334.125, RSMo. Supp. 2014, and section 334.045, RSMo 2000, the board adopts a rule as follows:

20 CSR 2150-2.220 Assistant Physician Inactive Status is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 981-983). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment on the proposed rule.

COMMENT: A comment was received from the American Association of Physician Assistants (AAPA) stating an inactive status should not be included in the rule.

RESPONSE: Section 334.002, RSMo, authorizes any person licensed by Chapter 334, RSMo to apply to the board for an inactive status. Therefore, no change was made to the rule based on this comment.

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Chapter 2—Licensing of Physicians and Surgeons**

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.230 Assistant Physician—Continuing Education is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 984-986). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received two (2) comments on the proposed rule.

COMMENT #1: A comment was received from the Missouri Academy of Family Physicians (MAFP) stating section (2) - The “Accreditation Counsel (should be “Council”) on Graduate Medical Education (ACGME)” is not part of the American Medical Association (since 2000, per ACGME website: <http://www.acgme.org/About-Us/Overview/ACGME-History>); and the “Education Committee” of the American Osteopathic Association has been changed to “Program and Trainee Review Council”.

RESPONSE AND EXPLANATION OF CHANGE: The board appreciates the comments and amends the language as suggested.

COMMENT #2: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating the proposed rule requires the applicant attest to completing at least one hundred (100) hours of continuing medical education (CME) over a two (2) year timeframe. We believe this is an appropriate CME standard and support its inclusion in the rule. However, CME should not be confused with or substituted for training or direct experience in treating patients. WUSTL is concerned that the board has not required a sufficient amount of hands-on training for assistant physicians before they are allowed to practice without direct supervision.

DRAFT RESPONSE: The board appreciates the comment. However, requiring hands-on training exceeds the board’s scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly. No changes have been made to the rule as a result of this comment.

20 CSR 2150-2.230 Assistant Physician—Continuing Education

- (2) In order to count toward the required one hundred (100) hours, the continuing education shall be accredited by the American Medical Association (AMA) as Category 1; or by the American Academy of Family Physicians (AAFP) or the American Osteopathic Association (AOA) as Category 1-A or 2-A; or offered by a residency program or hospital-approved by Accreditation Council on Graduate Medical Education (ACGME) of the American Medical Association or the Program and Trainee Review Council of the American Osteopathic Association.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, and section 334.037, RSMo Supp. 2015, the board adopts a rule as follows:

20 CSR 2150-2.240 Assistant Physician Collaborative Practice Agreements is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 987-990). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received four (4) comments on the proposed rule and seven (7) general comments.

COMMENT #1: A comment was received from the Missouri Academy of Family Physicians (MAFP) suggesting subsection (2)(D) be amended to state - The methods of treatment, including any authority to administer, dispense, or prescribe drugs, delegated in a collaborative practice arrangement between a collaborating physician and a collaborating assistant physician, shall be delivered only pursuant to a written agreement, jointly agreed-upon protocols, or standing orders that are specific to the clinical conditions treated by the collaborating physician and “collaborating” assistant physician.

RESPONSE AND EXPLANATION OF CHANGE: The board appreciates the comments and amends the language as suggested.

COMMENT #2: A comment was received from Employee Retirement Income Security Act (ERISA) Industry Committee (ERIC) supporting rules that recognize the potential benefits of telehealth as they relate to assistant physician collaborative practice agreements. ERIC represents large employers and welcomes the opportunity to share our support for leveraging telehealth to increase access to health care. ERIC thanks the board for thoughtfully developing regulations to maximize the benefits of telehealth and to express large employer’s interest on the issues. ERIC encourages the board, to the extent permitted by law to:

- Adopt technology-neutral requirements, permitting use of different types of technology platforms that are designed for telehealth;
- Adopt licensing policies that facilitate inter-state practice so providers, located in or out of the state, who deliver high-quality care, can serve patients located in Missouri;
- Avoid restrictions that require patients to visit specific location (e.g., “originating sites”) in order to access telehealth services;

- Avoid imposing additional requirements on providers that offer telehealth service that are not imposed on in-person visits; and
- Consider the needs of patients to have better access to care that can be provided via telehealth, either through a telehealth visit or remote monitoring of health conditions.

RESPONSE: The board appreciates the comments and makes no changes to the rule.

COMMENT #3: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating the model of the assistant physicians relies exclusively on the collaborating physician taking responsibility for the supervision and training of the assistant physician. WUSTL is deeply concerned that the proposed rule does not provide adequate standards for supervision and training, especially for the recent medical graduate. The proposed rule under subsection (1)(B) allows an assistant physician to practice at a location fifty (50) miles away from the collaborating physician if not utilizing telehealth; if utilizing telehealth, there is no mileage restriction. Thus, an assistant physician could conceivably be providing health care services in Sikeston while the collaborating physician is in St. Joseph. Whereas these mileage standards might be appropriate for a well-trained medical professional, the only training required in the proposed rule – before the assistant physician can practice away from the collaborating physician—is a one- (1-) month period where the collaborating physician is continuously present. Aside from the above-mentioned biennial continuing medical education (CME) requirement, there is no other mention in the proposed rule regarding actual training for an assistant physician beyond this one-month apprenticeship. An earlier draft of the proposed rule, which was the basis of their July 14, 2015, comment letter, would have required the first six (6) months of licensure to involve one hundred percent (100%) supervision by the collaborating physician, followed by another six (6) months of at least two (2) half-days of supervision per week. This standard was recommended by a group of medical school representatives who determined this was an appropriate, albeit minimal, amount of supervision and training for individuals who will be given the ability to prescribe medical treatment. These requirements are essential to ensure both the development of the assistant physician’s ability to diagnose disease and recommend treatment, but also to ensure the safety of the patients they see. Moreover, the statute under 334.037(3) states that any patient being seen by an assistant physician retains the “right to see the collaborating physician.” A reasonable interpretation of this section could lead one (1) to conclude this right is to see the physician “in person,” and not via telehealth or via phone. It is unclear how the patient being seen by the assistant physician in Sikeston can exercise her or his right if the collaborating physician is in St. Joseph. WUSTL strongly urge the board to include more rigorous training and supervision standards in the final rule. At a minimum, the first six (6) months of collaborative practice should involve one hundred percent (100%) supervision of the assistant physician, followed by a graduated process of independence.

RESPONSE: Mileage restrictions and the use of telehealth are established by rule to be consistent with other collaborative practice agreements. The board acted cautiously not to place greater restrictions than what is required by statute. The board believes this change would require legislative action by the Missouri General Assembly. No changes have been made to the rule as a result of this comment.

COMMENT #4: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating there are several components in the sections dealing with the prescription of controlled substances that are confusing. Paragraph (2)(E)8. provides for the ability of the collaborating physician to delegate to an assistant physician the ability to prescribe controlled substances listed in Schedules II (hydrocodone), III, IV and V. Section (2)(E)8 further specifies that Schedule III substances are limited to a one hundred twenty (120) hour supply. If Schedule III drugs are limited to a one hundred twenty (120) hour supply, WUSTL believe this limit should apply to Schedule II controlled substance prescriptions as well. Moreover, paragraph (2)(E)10 goes on to state that an assistant physician may only dispense “starter doses of medication to cover a period of time for seventy-two (72) hours.” Given the high potential for abuse of scheduled drugs, WUSTL recommends the seventy-two (72) hour standard be applied to drugs both dispensed and prescribed that are on the Schedule. A consistent standard would be clearer for the assistant physician, the collaborating physician, and the patient.

RESPONSE: The board appreciates the comment. The board makes no change as this change would require legislative action by the Missouri General Assembly.

COMMENT #5: One (1) comment was received from the American Association of Physician Assistants (AAPA) suggesting another way to expand access to care would be to optimize Missouri’s physician assistant (PAs) statutes and rules to ensure that PAs are practicing to the top of their education and experience. PAs could be optimized by allowing chart review to determine the practice level. PAs are healthcare providers who are nationally certified and state licensed to practice medicine and prescribe medication in every medical and surgical specialty and setting. PAs practice and prescribe in all fifty (50) states, the District of Columbia and all U.S. territories with the exception of Puerto Rico. PAs are educated at the graduate level, with most PAs receiving a Master’s degree. In order to maintain national certification, PAs are required to recertify as medical generalists every ten (10) years and complete one hundred (100) hours of continuing medical education every two (2) years.

RESPONSE: No action was taken by the board as this change would require legislative action by the Missouri General Assembly.

COMMENT #6: A comment was received from the American Association of Physician Assistants (AAPA) stating the rules should specify that assistant physicians may only serve in certain federal or state designated healthcare shortage area.

RESPONSE: Section 334.038, RSMo, defines the assistant physician’s practice location; therefore, the rules do not need to restate statute. The board made no changes to the rule based on this comment.

COMMENT #7: Three (3) comments were received from Esteban Ivanoff-Tzvetcoff, Muhammad Saad, and Aruna Sana stating they believe it is ridiculous that physician assistants and nurse practitioners have less training and having to pass easier exams are allowed to practice medicine, while medical students who did not match because there are not enough residency programs. One (1) commenter stated that this was plainly discriminatory and not democratic. Two (2) of the comments suggested assistant physicians should have three (3) months of direct supervision by a licensed physician before starting an independent job; assistant physicians

should be allowed to take Missouri State Medical Board exam after twenty-four (24) months of work experience under the supervision of a licensed physician; and assistant physicians should be allowed to practice independently after passing the State Medical Board exam (within 3 years).

RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

COMMENT #8: A comment was received from Washington University in St. Louis School of Medicine (WUSTL) stating many organizations such as the American Association of Medical Colleges (AAMC), American Osteopathic Association (AOA) and American Medical Association, have raised concerns about the assistant physician concept. WUSTL shares these concerns. Central to those objections is the fear of putting untrained individuals into situations where they are dealing with vulnerable patients in underserved areas without an adequate support system in place. Just because patients live in an underserved area does not mean they should be subject to a different standard of care than other individuals. The board must take care to ensure that assistant physicians are providing evidence-based medical care. It is important for the board to think about ways it can track the experience of assistant physicians and their patients to understand better what is working well and what may need further refinement or improvement in the future. WUSTL stated they would be willing to assist the board in thinking through how to track such outcomes.

RESPONSE: The board appreciates the comment.

COMMENT #9: A comment was received from Washington University in St. Louis School of Medicine (WUSTL). The comment builds upon and reinforces comments provided by Dr. Rebecca McAlister, the school's Associate Dean for Graduate Medical Education, on May 12, 2015, and by Dr. Larry Shapiro, former Executive Vice Chancellor for Medical Affairs and Dean, dated July 10, 2015. WUSTL states that unfortunately, the regulations as proposed, in many ways, represent a step backwards compared to earlier drafts of the rule shared last year. WUSTL, as an organization dedicated to preparing medical professionals for the rigors of practicing medicine, state they are deeply concerned that the proposed rules do not provide adequate supervision of, or training for, assistant physicians before they are allowed to prescribe medical treatments. A medical degree itself is not sufficient to ensure an individual can appropriately diagnose and treat a patient presenting with disease. The national model currently used to ensure physicians are capable of competently delivering health care involves completion of the Board of Registration for the M.D. degree followed by a period of residency training which can range from three (3) years to seven (7) years, depending on the physician's specialty. Some specialists will seek even further subspecialty training through fellowships. Any licensed physician will tell you how critical these training experiences are in becoming an experienced and proficient doctor. The assistant physician pathway, by design, lacks a credible period of training. This absence is why it is essential that the board uphold its obligation to protect public health and safety by ensuring that assistant physicians are adequately supervised and exposed to meaningful training opportunities.

RESPONSE: No action was taken by the board as this change exceeds the board's scope and rulemaking authority. This change would require legislative action by the Missouri General Assembly.

20 CSR 2150-2.240 Assistant Physician Collaborative Practice Agreements

(2) Methods of treatment.

(D) The methods of treatment, including any authority to administer, dispense, or prescribe drugs, delegated in a collaborative practice arrangement between a collaborating physician and a collaborating assistant physician, shall be delivered only pursuant to a written agreement, jointly agreed-upon protocols, or standing orders that are specific to the clinical conditions treated by the collaborating physician and collaborating assistant physician.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, the board adopts a rule as follows:

20 CSR 2150-2.250 Assistant Physician Supervision Change Requirements **is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 991-993). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.036 and 334.125, RSMo Supp. 2014, and section 334.037, RSMo Supp. 2015, the board adopts a rule as follows:

20 CSR 2150-2.260 Assistant Physician Certificate of Prescriptive Authority **is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 1, 2016 (41 MoReg 994-996). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.