

Missouri Rewrote the Rules:

Five New Health Laws Every Provider Must Know

Missouri's 103rd General Assembly recently handed new authority to telehealth providers, more accountability to providers competing for Certificates of Need (CON), increased flexibility to behavioral health providers, urgency for hospital's price transparency, and protections for 340b entities.

Five new laws passed during the 2026 Missouri legislative session fundamentally change healthcare in:

- (1) how telehealth care is delivered;
- (2) how CON applications are contested;
- (3) how psychiatric emergency holds are obtained;
- (4) when PBMs and health insurers are prohibited from discriminating against 340B covered entities; and,
- (5) when a hospital is prohibited from pursuing any collection action against a patient.¹

1. Telehealth's Flexible Physical Exam Requirement and Expanded Prescribing Authority

I. What Changed

Missouri law already allows a patient-provider relationship to be established via telemedicine under Mo. Rev. Stat. § 191.1146, but the existing framework imposed a significant practical barrier. The statute required that telehealth technology be "sufficient to establish an informed diagnosis as though the medical interview and physical examination *had been performed in person.*" That language effectively required every telehealth encounter to replicate the equivalent of a physical exam, creating ambiguity about when providers could prescribe, particularly controlled substances, without an in-person component.

¹Missouri Governor Kehoe has until July 15, 2026, to act on bills from the 2026 Regular Session, including House Bill 2372. Absent a different specified effective date or an emergency clause, enacted provisions become effective August 28, 2026.

HB 2372 makes a critical change. It inserts the phrase “*if required to meet the standard of care*” before the physical examination requirement in both § 191.1146 and § 334.108. This means a physical exam is no longer a blanket prerequisite for establishing the relationship or prescribing through telemedicine. Instead, a physical exam is required only when the standard of care for the specific condition demands one. For many conditions, including mental health, medication-assisted treatment for substance use disorders, and chronic disease management, the standard of care often does not require a physical exam, which significantly expands the scope of what providers can do through telehealth alone.

The bill also makes several additional changes:

- It replaces the term “interview” with “evaluation” throughout § 191.1146;
- It modernizes the treatment of patient questionnaires by allowing them if reviewed by a treating health care professional and if they contain information sufficient to replicate a medical evaluation;
- The bill replaces the blanket prohibition on prescribing based on “an internet request or internet questionnaire” with a more flexible standard prohibiting prescribing “in the absence of a proper provider-patient relationship”;
- It adds a new HIPAA-compliance requirement for medical records of telemedicine prescriptions; and,
- The bill also requires that any provider using a questionnaire to establish the relationship be employed or contracted with a business entity licensed to provide health care in Missouri.

II. Why This Matters

While Missouri already allowed telehealth-initiated patient relationships, the practical requirement that every encounter replicate a physical exam chilled adoption, particularly for controlled substances prescribing in psychiatry, pain management, and addiction treatment. By making the physical exam conditional on the standard of care, HB 2372 removes that barrier and creates immediate opportunities:

- Physician groups and telemedicine platforms can now prescribe controlled substances through telehealth encounters without uncertainty about whether a physical exam was required for the specific condition being treated. This flexibility opens new service lines in psychiatry, MAT, and chronic pain management.

- Rural and underserved patients gain faster access to psychiatric care, pain management, and addiction treatment without traveling hours for an in-person visit.
- Pharmacies filling telehealth prescriptions for controlled substances now have a clear statutory framework.

If you have been cautious about telehealth prescribing because of ambiguity around the physical exam requirement, that ambiguity is now resolved. The new statute, however, still requires a properly established provider-patient relationship, and comes with guardrails including clinical protocols, consent language, PDMP checks, identity verification, and documentation requirements. Providers who incorporate these updated requirements into their compliance systems first will be best positioned in this expanded market.

III. Act Now

Update telehealth policies and train providers on the changes to Mo. Rev. Stat. § 191.1146 and § 334.108. Evaluate which of your telehealth services involve conditions where the standard of care does not require a physical exam. Those are the areas where the new law creates the most immediate opportunity. Build documentation templates for establishing the patient-provider relationship and each controlled substances prescribing decision. Establish procedures for PDMP queries, identity verification, and modality compliance. Confirm alignment with DEA and federal requirements.

2. Certificate of Need Committee Must Rescind CON If Material Fact Was Withheld or Misrepresented

I. What Changed

HB 2372 amends Mo. Rev. Stat. § 197.315 to create a new post-approval accountability mechanism for Certificates of Need (CON). Under the new provision, if the Missouri Health Facilities Review Committee (MHFRC) obtains evidence within 30 days of the applicant's receipt of a CON *that a material fact was withheld from or misrepresented* to the Committee during the original hearing, the Committee shall, at its next regularly scheduled meeting, vote to rescind the granted CON.

Upon rescission, the applicant is required to file a new application that corrects any omissions or misstatements. This is not a private right of appeal for competitors. It is a mandatory duty imposed on the Committee itself. Any party, however, with evidence of misrepresentation can presumably bring that evidence to the Committee's attention within the 30-day window.

II. Why This Matters

This provision changes the calculus for both applicants and their competitors:

- If you are a competitor and you have evidence that a CON applicant withheld or misrepresented material facts during the hearing, you now have a defined 30-day window to present that evidence to the MHFRC. If the Committee finds the evidence sufficient, it is required to rescind the CON.
- If you are an applicant, every material representation you make to the MHFRC during the hearing is now subject to a 30-day post-approval window during which the Committee can be presented with contradicting evidence. An inflated utilization projection, an omitted conflict of interest, or a misrepresented community-need figure could result in mandatory rescission of your CON and sending you back to square one with a new application.

This new law emphasizes the importance of meticulous CON filings and calculations.

III. Act Now

CON applicants should implement rigorous internal fact-checking and require executive review of every material representation before the hearing. Assume that competitors will scrutinize your filing and present any discrepancies to the MHFRC within 30 days of your receipt of the CON. Competitors who believe a CON was granted based on misrepresented or withheld facts, gather your evidence immediately and present it to the Committee within the 30-day window following the applicant's receipt of the certificate. The statute imposes a mandatory duty on the Committee to act — but only if the evidence reaches the Committee in time.

3. Behavioral Health Providers No Longer Required to Obtain Notary for 96-Hour Involuntary Hold Application

I. What Changed

HB 2372 amends Mo. Rev. Stat. § 632.305 (the 96-hour emergency involuntary detention process) to remove any notarization requirement for an application (or the supporting affidavits and declarations) when the filer is a peace officer, a licensed physician, a designated mental health professional, a registered professional nurse, or a hospital employee acting on the hospital's behalf.

In other words, when qualified clinical or law-enforcement personnel initiate a 96-hour hold, no notary is required. Instead, the application and any supporting materials may be executed as declarations under penalty of perjury consistent with § 492.060.

II. Why This Matters

This change will save time, reduce risk, and may save lives. Behavioral health providers should update policies and procedures to remove notary steps for applications filed by covered professionals and reinforce documentation and patient-rights safeguards.

- Emergency departments and crisis centers can initiate 96-hour holds based on clinical judgment alone without this administrative burden.
- Facilities in rural Missouri, where notaries can be scarce at any hour, gain the most. Delayed holds have meant patients left on their own will before receiving the necessary care, creating safety risks for the patient, staff, and the community.
- Liability exposure from delayed involuntary holds is alleviated. When a clinician determines a patient meets hold criteria, the path from assessment to application is now expedited.

The notary requirement was a well-intentioned safeguard for applications from non-healthcare professionals, such as friends or family. Removing it for healthcare professionals recognizes that their clinical training and professional licensure are more than sufficient to support the integrity of the application.

III. Act Now

Revise your 96-hour hold application forms and intake workflows now to remove the notary step for covered filers. Retrain frontline clinicians, charge nurses, crisis teams, and registration staff. Update intake checklists and EHR prompts.

4. 340B Drug Pricing Protections for Covered Entities

I. What Changed

HB 2372 enacts new § 376.417, which prohibits health (insurance) carriers, pharmacy benefits managers (PBMs), and their agents or affiliates from discriminating against 340B covered entities. Specifically, the statute bars the following:

- reimbursing a 340B entity less than a similarly situated non-340B pharmacy;
- imposing different fees, chargebacks, clawbacks, network restrictions, or audit requirements on 340B entities;

- discriminating in reimbursement based on a drug being a 340B drug;
- requiring identification of 340B drugs;
- refusing to cover 340B-purchased drugs; and,
- requiring post-adjudication reversal or resubmission of 340B claims unless required by federal law or in the normal course of business.

II. Why This Matters

For federally qualified health centers (FQHCs), safety-net hospitals, and other 340B covered entities, this is a significant win. PBM practices that have eroded 340B savings through discriminatory reimbursement, mandatory 340B claim identification, and network exclusions are now explicitly unlawful in Missouri. Violations carry civil penalties of up to \$5,000 per violation per day, enforced by the Director of the Department of Commerce and Insurance. This creates a state-law enforcement mechanism for covered entities to complement federal 340B program protections.

III. Act Now

Covered entities should review their current PBM contracts and reimbursement data for any practices that may violate the new law once effective. Document any existing discriminatory conduct including differential reimbursement, 340B identification requirements, or network restrictions—so you are prepared to enforce your rights under § 376.417. PBMs and health carriers, conversely, should audit their policies and contract terms now to ensure compliance.

5. Hospital Price Transparency: Collection Ban for Non-Compliant Hospitals

I. What Changed

HB 2372 creates new § 197.1045, which prohibits a hospital from initiating or pursuing any collection action against a patient or patient guarantor for services furnished during a period when the hospital was materially out of compliance with federal hospital price transparency laws. Non-compliance is established by either (1) an assessment of a civil monetary penalty by the U.S. Department of Health and Human Services under 45 CFR 180.90, or (2) an official HHS notification that the hospital has failed to remedy material deficiencies through warning letters or corrective action plans.

II. Why This Matters

Hospitals that have received a CMS penalty or an HHS deficiency notification for price transparency violations will lose the ability to collect on patient debts incurred during any period of non-compliance. The financial exposure is potentially enormous, particularly for large health systems with high patient volumes. This effectively transforms a federal regulatory compliance issue into a direct revenue threat under state law, giving hospitals an additional and powerful incentive to achieve and maintain full compliance with CMS price transparency requirements.

III. Act Now

Hospitals should audit their current compliance with federal price transparency rules (45 CFR Part 180) immediately. If your facility has received any HHS correspondence regarding deficiencies, even a warning, treat it as urgent. Cure the deficiency or risk losing the ability to collect on patient accounts for services rendered during any period of non-compliance.

6. The Bottom Line

Missouri's healthcare regulations are evolving. Your practice should follow to establish itself as a leader in the industry. These five laws represent a clear legislative signal that the state is modernizing its healthcare regulatory framework, rewarding providers who adapt quickly, and exposing those who do not.

New telehealth authority means new market opportunities to take advantage of and challenges to protect from. A CON challenge mechanism creates new competitive dynamics. A streamlined involuntary hold process results in faster and safer behavioral health care. A collection ban incentivizes hospitals to comply with price transparency laws and protects patients from illegal collections. The providers who update their policies, retrain their teams, and establish compliance first will capitalize on opportunities to increase and protect revenues.

Calhoun, Bhella & Sechrest is prepared to help you strengthen and streamline policies and procedures, create CON applications and challenges, build telehealth compliance checklists, and ensure price transparency. [Contact me today](#) to prepare your Missouri operations for these changes beginning on August 28, 2026.



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