FIRST REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED**]**

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE NO. 2

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 62

96TH GENERAL ASSEMBLY

2011

0521L.07T

AN ACT

To repeal sections 190.839, 191.227, 198.439, 208.437, 208.480, 338.550, and 633.401, RSMo, and to enact in lieu thereof nine new sections relating to health care providers.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 190.839, 191.227, 198.439, 208.437, 208.480, 338.550, and 633.401, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as sections 190.839, 191.227, 198.439, 208.437, 208.480, 338.550, 376.1190, 633.401, and 1, to read as follows:

190.839. Sections 190.800 to 190.839 shall expire on September 30, **[**2011**]** **2015**.

191.227. 1. All physicians, chiropractors, hospitals, dentists, and other duly licensed practitioners in this state, herein called "providers", shall, upon written request of a patient, or guardian or legally authorized representative of a patient, furnish a copy of his or her record of that patient's health history and treatment rendered to the person submitting a written request, except that such right shall be limited to access consistent with the patient's condition and sound therapeutic treatment as determined by the provider. Beginning August 28, 1994, such record shall be furnished within a reasonable time of the receipt of the request therefor and upon payment of a fee as provided in this section.

2. Health care providers may condition the furnishing of the patient's health care records to the patient, the patient's authorized representative or any

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

other person or entity authorized by law to obtain or reproduce such records upon payment of a fee for:

(1) **(a)** Copying, in an amount not more than **[**seventeen**]** **twenty-one** dollars and **[**five**]** **thirty-six** cents plus **[**forty**]** **fifty** cents per page for the cost of supplies and labor **plus, if the health care provider has contracted for off-site records storage and management, any additional labor costs of outside storage retrieval, not to exceed twenty dollars, as adjusted annually pursuant to subsection 5 of this section; or**

(b) If the health care provider stores records in an electronic or digital format, and provides the requested records and affidavit, if requested, in an electronic or digital format, not more than five dollars plus fifty cents per page or twenty-five dollars total, whichever is less;

(2) Postage, to include packaging and delivery cost; and

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

3. Notwithstanding provisions of this section to the contrary, providers may charge for the reasonable cost of all duplications of health care record material or information which cannot routinely be copied or duplicated on a standard commercial photocopy machine.

4. The transfer of the patient's record done in good faith shall not render the provider liable to the patient or any other person for any consequences which resulted or may result from disclosure of the patient's record as required by this section.

5. Effective February first of each year, the fees listed in subsection 2 of this section shall be increased or decreased annually based on the annual percentage change in the unadjusted, U.S. city average, annual average inflation rate of the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). The current reference base of the index, as published by the Bureau of Labor Statistics of the United States Department of Labor, shall be used as the reference base. For purposes of this subsection, the annual average inflation rate shall be based on a twelve-month calendar year beginning in January and ending in December of each preceding calendar year. The department of health and senior services shall report the annual adjustment and the adjusted fees authorized in this section on the department's Internet website by February first of each year.

198.439. Sections 198.401 to 198.436 shall expire on September 30, **[**2011**]** **2015**.

208.437. 1. A Medicaid managed care organization reimbursement allowance period as provided in sections 208.431 to 208.437 shall be from the first day of July to the thirtieth day of June. The department shall notify each Medicaid managed care organization with a balance due on the thirtieth day of June of each year the amount of such balance due. If any managed care organization fails to pay its managed care organization reimbursement allowance within thirty days of such notice, the reimbursement allowance shall be delinquent. The reimbursement allowance may remain unpaid during an appeal.

2. Except as otherwise provided in this section, if any reimbursement allowance imposed under the provisions of sections 208.431 to 208.437 is unpaid and delinquent, the department of social services may compel the payment of such reimbursement allowance in the circuit court having jurisdiction in the county where the main offices of the Medicaid managed care organization are located. In addition, the director of the department of social services or the director's designee may cancel or refuse to issue, extend or reinstate a Medicaid contract agreement to any Medicaid managed care organization which fails to pay such delinquent reimbursement allowance required by sections 208.431 to 208.437 unless under appeal.

3. Except as otherwise provided in this section, failure to pay a delinquent reimbursement allowance imposed under sections 208.431 to 208.437 shall be grounds for denial, suspension or revocation of a license granted by the department of insurance, financial institutions and professional registration. The director of the department of insurance, financial institutions and professional registration may deny, suspend or revoke the license of a Medicaid managed care organization with a contract under 42 U.S.C. Section 1396b(m) which fails to pay a managed care organization's delinquent reimbursement allowance unless under appeal.

4. Nothing in sections 208.431 to 208.437 shall be deemed to effect or in any way limit the tax-exempt or nonprofit status of any Medicaid managed care organization with a contract under 42 U.S.C. Section 1396b(m) granted by state law.

5. Sections 208.431 to 208.437 shall expire on September 30, **[**2011**]** **2015**.

208.480. Notwithstanding the provisions of section 208.471 to the contrary, sections 208.453 to 208.480 shall expire on September 30, **[**2011**]** **2015**.

338.550. 1. The pharmacy tax required by sections 338.500 to 338.550 shall expire ninety days after any one or more of the following conditions are met:

(1) The aggregate dispensing fee as appropriated by the general assembly paid to pharmacists per prescription is less than the fiscal year 2003 dispensing fees reimbursement amount; or

(2) The formula used to calculate the reimbursement as appropriated by the general assembly for products dispensed by pharmacies is changed resulting in lower reimbursement to the pharmacist in the aggregate than provided in fiscal year 2003; or

(3) September 30, **[**2011**]** **2015**.

The director of the department of social services shall notify the revisor of statutes of the expiration date as provided in this subsection. The provisions of sections 338.500 to 338.550 shall not apply to pharmacies domiciled or headquartered outside this state which are engaged in prescription drug sales that are delivered directly to patients within this state via common carrier, mail or a carrier service.

2. Sections 338.500 to 338.550 shall expire on September 30, **[**2011**]** **2015**.

376.1190. 1. Health carriers shall permit individuals to learn the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's health benefit plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an internet website and such other means for individuals without access to the internet. As used in this section, the terms "health carrier" and "health benefit plans" shall have the same meanings assigned to them in section 376.1350.

2. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy.

3. Any health care benefit mandate proposed after August 28, 2011, shall be subject to review by the oversight division of the joint committee on legislative research. The oversight division shall perform an actuarial analysis of the cost impact to private and public payers of

any new or revised mandated health care benefit proposed by the General Assembly after August 28, 2011 and a recommendation shall be delivered to the Speaker and the President Pro Tem prior to mandate being enacted.

4. The provisions of subsections 1 and 2 shall become effective on January 1, 2014.

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

(1) "Engaging in the business of providing health benefit services", accepting payment for health benefit services;

(2) "Intermediate care facility for the mentally retarded", a private or department of mental health facility which admits persons who are mentally retarded or developmentally disabled for residential habilitation and other services pursuant to chapter 630. Such term shall include habilitation centers and private or public intermediate care facilities for the mentally retarded that have been certified to meet the conditions of participation under 42 CFR, Section 483, Subpart 1;

(3) "Net operating revenues from providing services of intermediate care facilities for the mentally retarded" shall include, without limitation, all moneys received on account of such services pursuant to rates of reimbursement established and paid by the department of social services, but shall not include charitable contributions, grants, donations, bequests and income from nonservice related fund-raising activities and government deficit financing, contractual allowance, discounts or bad debt;

(4) "Services of intermediate care facilities for the mentally retarded" has the same meaning as the term used in Title 42 United States Code, Section 1396b(w)(7)(A)(iv), as amended, and as such qualifies as a class of health care services recognized in federal Public Law 102-234, the Medicaid Voluntary Contribution and Provider Specific Tax Amendment of 1991.

2. Beginning July 1, 2008, each provider of services of intermediate care facilities for the mentally retarded shall, in addition to all other fees and taxes now required or paid, pay assessments on their net operating revenues for the privilege of engaging in the business of providing services of the intermediate care facilities for the mentally retarded or developmentally disabled in this state.

3. Each facility's assessment shall be based on a formula set forth in rules and regulations promulgated by the department of mental health.

4. For purposes of determining rates of payment under the medical

assistance program for providers of services of intermediate care facilities for the mentally retarded, the assessment imposed pursuant to this section on net operating revenues shall be a reimbursable cost to be reflected as timely as practicable in rates of payment applicable within the assessment period, contingent, for payments by governmental agencies, on all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under Title XIX of the federal Social Security Act.

5. Assessments shall be submitted by or on behalf of each provider of services of intermediate care facilities for the mentally retarded on a monthly basis to the director of the department of mental health or his or her designee and shall be made payable to the director of the department of revenue.

6. In the alternative, a provider may direct that the director of the department of social services offset, from the amount of any payment to be made by the state to the provider, the amount of the assessment payment owed for any month.

7. Assessment payments shall be deposited in the state treasury to the credit of the "Intermediate Care Facility Mentally Retarded Reimbursement Allowance Fund", which is hereby created in the state treasury. All investment earnings of this fund shall be credited to the fund. Notwithstanding the provisions of section 33.080 to the contrary, any unexpended balance in the intermediate care facility mentally retarded reimbursement allowance fund at the end of the biennium shall not revert to the general revenue fund but shall accumulate from year to year. The state treasurer shall maintain records that show the amount of money in the fund at any time and the amount of any investment earnings on that amount.

8. Each provider of services of intermediate care facilities for the mentally retarded shall keep such records as may be necessary to determine the amount of the assessment for which it is liable under this section. On or before the forty-fifth day after the end of each month commencing July 1, 2008, each provider of services of intermediate care facilities for the mentally retarded shall submit to the department of social services a report on a cash basis that reflects such information as is necessary to determine the amount of the assessment payable for that month.

9. Every provider of services of intermediate care facilities for the mentally retarded shall submit a certified annual report of net operating

revenues from the furnishing of services of intermediate care facilities for the mentally retarded. The reports shall be in such form as may be prescribed by rule by the director of the department of mental health. Final payments of the assessment for each year shall be due for all providers of services of intermediate care facilities for the mentally retarded upon the due date for submission of the certified annual report.

10. The director of the department of mental health shall prescribe by rule the form and content of any document required to be filed pursuant to the provisions of this section.

11. Upon receipt of notification from the director of the department of mental health of a provider's delinquency in paying assessments required under this section, the director of the department of social services shall withhold, and shall remit to the director of the department of revenue, an assessment amount estimated by the director of the department of mental health from any payment to be made by the state to the provider.

12. In the event a provider objects to the estimate described in subsection 11 of this section, or any other decision of the department of mental health related to this section, the provider of services may request a hearing. If a hearing is requested, the director of the department of mental health shall provide the provider of services an opportunity to be heard and to present evidence bearing on the amount due for an assessment or other issue related to this section within thirty days after collection of an amount due or receipt of a request for a hearing, whichever is later. The director shall issue a final decision within forty-five days of the completion of the hearing. After reconsideration of the assessment determination and a final decision by the director of the department of mental health, an intermediate care facility for the mentally retarded provider's appeal of the director's final decision shall be to the administrative hearing commission in accordance with sections 208.156 and 621.055.

13. Notwithstanding any other provision of law to the contrary, appeals regarding this assessment shall be to the circuit court of Cole County or the circuit court in the county in which the facility is located. The circuit court shall hear the matter as the court of original jurisdiction.

14. Nothing in this section shall be deemed to affect or in any way limit the tax-exempt or nonprofit status of any intermediate care facility for the mentally retarded granted by state law.

15. The director of the department of mental health shall promulgate rules and regulations to implement 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, 2008, shall be invalid and void.

16. The provisions of this section shall expire on September 30, **[**2011**]** **2015**.

Section 1. Notwithstanding the provisions of section 1.140 to the contrary, the provisions of this act shall be nonseverable, and if any provision is for any reason held to be invalid, such decision shall invalidate all of the remaining provisions of this act.

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