HB 1793 -- PROVISION OF HEALTH CARE

SPONSOR: Frederick

This bill changes the laws regarding the provision of health care.

STATE LEGAL EXPENSE FUND (Section 105.711, RSMo)

Moneys in the State Legal Expense Fund must also be available for the payment of any claim or any amount required by a final judgment by a court of competent jurisdiction against any physician licensed under Chapter 334 who is under contract to provide medical care to participants in the MO HealthNet pilot project under Section 208.188. In the case of a claim or judgment, the total amount of payments from the fund must be limited to a maximum of $500,000 for all claims arising out of and judgments based upon the same act or acts alleged in a single cause or for any one claimant. Liability or malpractice insurance obtained and maintained in force by or on behalf of any physician licensed under the chapter must not be considered available to pay the portion of a judgment or claim for which the Legal Expense Fund is liable under these provisions.

BOARD OF MEDICAL SCHOLARSHIP AWARDS (Section 173.228)

The Board of Medical Scholarship Awards is established within the Department of Higher Education to establish scholarships and loans to provide for the medical training of qualified applicants for admission or students in the University of Missouri School of Medicine or any other accredited or provisionally accredited school of medicine in this state. The recipients of loan awards must enter into a valid agreement with the board to practice the profession of medicine in those areas and localities of Missouri as may be determined by the board for a number of years to be stipulated in the agreement and the board must collaborate with the Lester R. Bryant Pre-Admissions Program established within the University of Missouri School of Medicine to participate in the scholarships and loans provided under these provisions, including the flexibility to provide financial incentives, such as forgiveness or repayment of all or a portion of educational loans.

The board must be composed of:

(a) Two members of the Board of Directors of the Missouri State Medical Association appointed by the President of the Missouri State Medical Association;

(b) One member of the Board of Trustees for the Missouri Association of Osteopathic Physicians and Surgeons appointed by the president of the board;

(c) The dean of each school of osteopathic or allopathic medicine in this state, or the dean's designee;

(d) The chair of the admissions committee of each school of osteopathic or allopathic medicine in this state;

(e) One member of the Senate appointed by the President Pro Tem of the Senate; and

(f) One member of the House of Representatives appointed by the Speaker of the House of Representatives.

The members of the Missouri State Medical Association and the Missouri Association of Osteopathic Physicians and Surgeons must serve four-year terms. The terms of the legislative members must be four years for the Senate member and two years for the House of Representatives member, concurrent with their legislative terms. All appointed members of the board may be reappointed.

The chair of the board must be selected from the members appointed from the Missouri Medical Association and the Missouri Association of Osteopathic Physicians and Surgeons.

The board must make a careful and thorough investigation of the ability, character, and qualifications of each applicant and award scholarships and loans according to the judgment of the board. Preference in granting loans must be given to applicants who sign agreements to practice in those areas in greatest need of medical service for periods of time stipulated by the board.

The board must make reasonable rules for implementing and administering these provisions.

The board must make two types of awards as follows:

(a) A number of loans equal in number to 20% of the student body of the medical schools in the State of Missouri, each in an amount of up to the average cost of tuition, fees, and living expenses as set forth in the current catalogs of the University of Missouri School of Medicine or other school of medicine in this state for the year of each enrollment. The loans must be available to any resident of Missouri of good character who has been accepted by one of the medical schools in Missouri with preference given to those applicants who can demonstrate an economic need and who commit in writing to practice in a rural area of generalists specialty as determined by the board. The board may, in its discretion, permit students to apply for a loan under these provisions in any scholastic year and for any previously completed scholastic year of

medical education. The loans must be repaid following graduation under the terms of a contract to practice clinical medicine in an area of Missouri identified by the board as medically underserved for a term of years as specified; and

(b) A number of merit scholarships equal in number to 5% of the student body of the medical schools in the State of Missouri, each in an amount not to exceed $5,000 per year or $20,000 over a four-year period to be granted to students with high scholastic achievement and excellent character who will attend one of the medical schools in the State of Missouri. The students to whom merit scholarships are granted must not be obligated to repay the amount of the scholarship award.

Any recipient of a loan or scholarship who fails for any reason to continue his or her medical education may, at the discretion of the board, be required to repay all loan amounts immediately with simple interest of 8% annually from the date of his or her departure or removal from medical school.

The loan or any portion of the loan must be repaid by engaging in full-time clinical practice, as defined in the rules of the board, in one of the specified ways in accordance with a contract approved by the board.

Each recipient of a loan under these provisions must enter into an agreement with the board whereby the recipient agrees to practice in an area described in these provisions. In the event of a default or other breach of contract by the recipient of the loans provided under these provisions or other termination of contract prior to the completion of the period of medical education and training, the individual must be liable for immediate repayment of the total principal loan amount plus interest at the rate of 8% accruing from the date of default or termination and an additional penalty as specified.

The Attorney General, upon request of the board, must institute proceedings in the name of the state for the purpose of recovering any amount due the state under these provisions. Any moneys recovered from loan recipients or paid by recipients to the board must be retained by the board for funding of future scholarships. In the event of death of a recipient or upon the recipient's becoming permanently disabled to an extent that he or she is no longer able to engage in the practice of medicine, repayment of the loan may be excused by the board. The failure of a recipient of a loan to perform his or her agreement with the board or to pay the amount he or she is liable for under these provisions must constitute a ground for the revocation of his or her license to practice medicine.

Any municipality or locality in this state having a population of less than 15,000 inhabitants, desiring additional physicians and wishing to be designated as a locality needing additional physicians, may apply to the board to be placed on a list of localities in need of additional physicians, which must be maintained by the board. If the board determines that a locality is in need of physicians, the board must place the locality on the list of localities in need of physicians from which recipients of scholarships may, after graduation, select an area in which to practice. In compiling and maintaining the list, the board may place any locality thereon which, in its opinion, needs additional physicians.

The Board of Medical Scholarship Awards Fund is created consisting of money collected under these provisions; any state appropriations; and all gifts, bequests, grants, or donations from any source.

COST ESTIMATES (Section 191.875)

By January 1, 2015, any patient or consumer of health care services who requests an estimate of the cost of health care services must be provided the estimate of cost or insurance costs prior to the provision of the services, if feasible, but in no event later than three business days after the request. These provisions must not apply to emergency health care services. "Estimate of cost" is defined as an estimate based on the information entered and assumptions about typical utilization and costs for health care services. The estimate of cost must include:

(a) The amount that will be charged to a patient for the health services if all charges are paid in full without a public or private third party paying for any portion of the charges;

(b) The average negotiated settlement on the amount that will be charged to a patient;

(c) The amount of any MO HealthNet reimbursement for the health care services, including claims and pro rata supplemental payments, if known;

(d) The amount of any Medicare reimbursement for the medical services, if known; and

(e) The amount of any insurance co-payments for the health benefit plan of the patient, if known.

Health care providers and health carriers must include with any estimate a specified disclaimer stating that the estimated cost is

an estimate and may be different from the actual amount billed. Each health care provider must also make available the percentage or amount of any discounts for cash payment of any charges incurred by a posting on the provider's website and by making it available at the provider's location. Nothing in these provisions must be construed as violating any provider contract provisions with a health carrier that prohibits disclosure of the provider's fee schedule with a health carrier to third parties;

HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT (Sections 197.170 and 197.173)

The Health Care Cost Reduction and Transparency Act is established that requires the Department of Health and Senior Services to make available to the public on its Internet website the most current price information it receives from hospitals and ambulatory surgical centers. Beginning with the quarter ending June 30, 2015, and quarterly thereafter, each hospital must provide to the department specified information regarding 100 of the most frequently reported admissions by diagnosis related group for inpatients as established by the department. Beginning with the quarter ending September 30, 2015, and quarterly thereafter, each hospital and ambulatory surgical center must provide to the department information on the total costs for the 20 most common surgical procedures and 20 most common imaging procedures, by volume, conducted in outpatient hospital settings or in ambulatory surgical centers. Any data disclosed to the department by a hospital or ambulatory surgical center under these provisions must be the sole property of the hospital or center that submitted the data. Any data or product derived from the data disclosed pursuant to these provisions, including a consolidation or analysis of the data, must be the sole property of the state. The department must not allow proprietary information it receives pursuant to these provisions to be used by any person or entity for commercial purposes.

The department must provide the information on its Internet website in a manner that is easily understood by the public. The information for each hospital must be listed separately and hospitals must be listed in groups by category as determined by the department through the promulgation of rules. Information for each hospital outpatient department and each ambulatory surgical center must also be listed separately.

The department must promulgate rules on or before March 1, 2015, outlining the information to be submitted by the hospitals and ambulatory surgical centers including payments made by Medicare, Medicaid, and the five largest health carriers.

MISSOURI CERTIFICATE OF NEED LAW (Sections 197.305 - 197.330)

The bill changes the laws regarding the Missouri Certificate of Need Law. The definition of "affected persons" is revised from the person proposing the development of a new institutional health service, the public to be served, and health care facilities within the service area in which the proposed new health care service is to be developed to the person proposing the development of a new institutional health service, the public to be served, and health care facilities within a 5-mile radius of the proposed new health care service to be developed and no consideration must be given to the facilities or equipment of any other health care facility located more than the 5-mile radius from the applying facility when determining if a certificate of need should be granted.

The bill specifies that the term "expenditure minimum" as it applies to a certificate of need must mean $1 million, instead of the current $600,000, in the case of capital expenditures for beds in existing or proposed specified health care facilities and long-term care beds in a hospital or $2 million, instead of the current $400,000, in the case of major medical equipment.

The membership of the Missouri Health Facilities Review Committee is revised as specified in the bill. The bill establishes four-year terms for all members.

A certificate of need cannot be required for a proposed project which creates five or more new full-time jobs or full-time equivalent jobs if the person proposing the project submits a letter of intent and a report of the number of jobs and other information as the committee may require to document the basis for not requiring a certificate of need. The committee must respond within 30 days to the person with an approval of the non-applicability of a certificate of need if the letter of intent and report document that the jobs will be created.

The bill changes the procedures and evidentiary standard at the certificate of need hearing and requires all testimony and other evidence taken during the hearings to be under oath and subject to the penalty of perjury. All ex parte communications between members of the committee and any interested party or witness must be prohibited if they are related to the subject matter of a hearing at any time prior to, during, or after the hearing.

PHYSICIAN CREDENTIALING (Section 197.710)

A hospital cannot require a physician to agree to make patient referrals to that hospital or any hospital-affiliated facility as a condition of receiving medical staff membership or medical staff

privileges. A hospital or hospital system cannot refuse to grant medical staff membership or privileges or participatory status in the hospital because the physician or his or her partner, associate, employee, or family member provides medical or health care services at, has ownership interest in, or has a leadership position on the medical staff of another hospital, hospital system, or health care facility. A hospital cannot refuse to grant a physician or a partner, associate, employee, or family member of the physician participatory status in a hospital or hospital system health plan because he or she leases or offers for lease medical office, clinical, or other medical facility space in close proximity to or within the same geographic service area of the hospital. The Department of Health and Senior Services may impose administration sanctions or otherwise sanction the license of a hospital in any case in which the department finds that there has been a substantial failure to comply with the requirements of these provisions.

MO HEALTHNET ASSET LIMITS (Section 208.010)

The maximum amount of cash, securities, or other total non-exempt assets an aged or disabled person is allowed to own or possess in order to qualify for MO HealthNet benefits is increased, from $1,000 to $2,000, for a single person and, from $2,000 to $4,000, for a married couple. The bill also increases, from $1,000 to $2,000, the resource limit excluding the home occupied by the claimant for benefits under the Temporary Assistance for Needy Families (TANF) Program.

MO HEALTHNET PATIENT-CENTERED CARE ACT OF 2014 (Section 208.187)

The MO HealthNet Patient-centered Care Act of 2014 is established that requires, beginning July 1, 2015, or upon termination of any current contracted health plan in the pilot project areas and subject to receipt of any necessary state plan amendments or waivers from the federal Department of Health and Human Services, the MO HealthNet Division within the Department of Social Services to establish a pilot project that transfers current MO HealthNet recipients in the pilot project areas to an approved health plan arrangement wherein recipients may purchase health services through individual health savings accounts.

The pilot project must be supported by a health management and population analytics system that tracks and monitors health outcomes in traditionally challenging populations, such as mothers at risk for premature births, frequent utilizers of emergency departments, and those suffering from chronic pain conditions. The system must implement clinically based predictive models and interventions to improve the care coordination for the targeted

populations within the pilot area. Under the pilot project, the eligible government assistance amount must be determined annually based on a survey of the commercial health market in this state and establishing the average cost of an approved health plan arrangement which is composed of direct primary care services and a high-deductible insurance plan. The average cost must be the government assistance amount. These provisions specify the requirements regarding the health savings accounts.

Beginning July 1, 2017, unless these provisions are repealed by an act of the General Assembly, the pilot project must automatically be implemented on a statewide basis for all MO HealthNet recipients who are eligible to receive MO HealthNet benefits in accordance with federal law and state plan amendments and waivers.

MO HEALTHNET ELECTRONIC BENEFIT TRANSFER PAYMENT SYSTEM (Section 208.188)

Beginning July 1, 2015, subject to appropriations and subject to receipt of waivers from the Department of Health and Human Services, the MO HealthNet Division within the Department of Social Services must establish a pilot program implementing an electronic benefit transfer (EBT) payment system for the receipt of MO HealthNet services by participating recipients. These provisions must not apply to aged, blind, and disabled recipients. The system must:

(a) Allow participating recipients to receive MO HealthNet services from providers they select through direct pay to the provider, a health insurance plan, a managed care plan, a health services plan, or any other available health care product providing benefits and payment for services in an approved health plan arrangement;

(b) Require recipients to use EBT cards to pay for MO HealthNet services;

(c) Require recipients to receive an annual examination within six months of enrollment;

(d) Provide educational opportunities for recipients relating to budgeting, planning, and appropriate use of health care options;

(e) Provide incentives to encourage recipients to seek health care services as needed while retaining a portion of any savings achieved from efficient use of their EBT cards;

(f) Provide additional money to recipients for health savings accounts, payment of health insurance premiums, and other

health-related costs not covered under the MO HealthNet Program;

(g) Provide reimbursement of any willing providers licensed in Missouri and eligible to provide services under the terms of the pilot project at a rate of 100% of the Medicare reimbursement rate for the same or similar services provided; and

(h) Provide demographic and cost efficiency information to determine the feasibility of a statewide implementation of the EBT payment system.

The Department of Social Services must seek all waivers from the Department of Health and Human Services necessary to implement these provisions. If the waivers are not granted, the Department of Social Services cannot be required to implement these provisions.

The division must establish at least three, but not more than six, pilot project areas within Missouri that must include at least 10% of the total MO HealthNet recipient population, excluding the aged, blind, and disabled population, in the first two years of the pilot project. In the third year, the division may increase the total number of pilot project areas to up to 10 areas and the number of participants must increase to at least 20% of the total recipient population, excluding the aged, blind, and disabled population.

The EBT payment system must apply to every MO HealthNet recipient if the pilot project is automatically implemented on a statewide basis, excluding the aged, blind, and disabled population.

The demographics of the pilot project population must reflect, to the extent practicable, the current percentages of recipients in the MO HealthNet Program population regarding age, gender, socioeconomic status, healthy versus chronically ill populations, urban versus rural populations, and other demographics as determined by the division. These provisions cannot be construed as requiring the division to obtain the exact and precise demographics of the current recipient population in the pilot project or to include or exclude recipients based solely on the pilot project's demographic requirements.

The division must compile and include a summary of the demographic information for the pilot project and the current MO HealthNet Program in all required reports to the General Assembly and the Governor and must permit MO HealthNet recipients in the pilot project areas to volunteer to participate in the pilot project. In order to obtain the necessary demographics of the pilot program, the division may require all or a portion of the recipients in a pilot program area to participate.

Any willing provider eligible to provide services under the terms of the pilot project must be reimbursed for services to pilot project recipients at a rate of 100% of the Medicare reimbursement rate for the same or similar provided services.

Moneys from the State Legal Expense Fund must be available for physicians participating in the pilot project for payment of any claim or final judgment rendered against the physician for services provided under the pilot project.

The division must determine the amount credited to each EBT card for each recipient on a risk adjusted basis and for currently enrolled recipients on historical usage of benefits by assessing the estimated health care costs for services required and the method selected for delivery of the services, as well as other specified criteria.

Participating recipients must be permitted to designate a third party to act on behalf of the participating recipient in the case of incapacity, incompetence, or other physical or mental condition which necessitates a designee to act on behalf of the participating recipient.

A participating providers in the project must swipe a recipient's EBT card for every visit or service received regardless of the balance on the EBT card and requires, subject to any federal and state laws, the division to maintain a record of every visit or service received by a recipient, regardless of whether payment was obtained from the recipient's EBT card.

Any balance, up to 25% of the total amount credited at the beginning of the benefit year, remaining on a recipient's EBT card at the end of the benefit year must be apportioned to the recipient if he or she receives the mandated health services or revert to the division if a recipient does not receive the mandatory health services.

The division must prepare and submit specified reports to the General Assembly and the Governor.

The disclosure, use, or sale of any information provided to or obtained by a provider, business, or vendor under the pilot project is prohibited unless the disclosure is expressly authorized under the program or pursuant to a court order. A violation of this provision is a class A misdemeanor.

The pilot project must automatically be implemented on a statewide basis beginning July 1, 2018, unless these provisions are repealed

by an act of the General Assembly.

MO HEALTHNET CLAIMS UTILIZATION DATA (Section 208.440)

By December 31, 2014, and updated once per calendar quarter, each MO HealthNet managed care organization must provide to the MO HealthNet Division all utilization, access, and spending data for the cost of care to each MO HealthNet participant covered under the organization. The data must be in the form of all payments made to health care providers for services rendered to MO HealthNet participants, identify claim-specific data for each patient service or procedure, and include any other information the division may require by rule to meet the specified requirements.

ASSISTANT PHYSICIANS (Sections 334.036 - 334.735)

The bill establishes provisions for the licensing of an assistant physician. An assistant physician is any medical school graduate who is a resident and citizen of the United States or is a legal resident alien, has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination or the equivalent of the steps of any other board-approved medical licensing examination within the 18-month period immediately preceding application for licensure as an assistant physician, has not entered into postgraduate residency training prescribed by rule of the board under Section 334.035 and has proficiency in the English language.

An assistant physician collaborative practice arrangement must limit the assistant physician to providing only primary care services and only in medically underserved rural or urban areas of this state or in areas served under the MO HealthNet Patient-centered Care Act of 2014. 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, an assistant physician must be considered a physician assistant for purposes of regulations of the Centers for Medicare and Medicaid Services (CMS) and no supervision requirements in addition to the minimum federal law must be required.

For purposes of these provisions, the licensure of assistant physicians must take place within processes established by rules of the State Board of Registration for the Healing Arts within the Department of Insurance, Financial Institutions and Professional Registration. 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 the other standards of conduct set by the board by rule.

An assistant physician must clearly identify himself or herself as an assistant physician and must be permitted to use the terms "doctor," "Dr.," or "doc." An assistant physician is prohibited from practicing or attempting to practice without an assistant physician collaborative practice arrangement, except as otherwise provided in these provisions and in an emergency situation. 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.

The provisions of Section 334.104, governing collaborative practice agreements, must apply to all assistant physician collaborative practice arrangements. To be eligible to practice as an assistant physician, a licensed assistant physician must enter into an assistant physician collaborative practice arrangement within six months of his or her initial licensure and must not have more than a six-month time period between collaborative practice arrangements during his or her licensure period. Any renewal of licensure under these provisions must include verification of actual practice under a collaborative practice arrangement during the immediately preceding licensure period.

Assistant physicians and physician assistants are added to those health professionals who may enter into a collaborative practice arrangement with a physician. A collaborative practice arrangement may delegate an assistant physician or physician assistant the authority to dispense or prescribe drugs and provide treatment to the extent permitted within the physician assistant's or assistant physician's scope of practice and licensure.

The State Board of Registration for the Healing Arts, in consultation with the Board of Nursing, must promulgate rules regulating the use of collaborative practice arrangements for assistant physicians, physician assistants, and nurses, including the development and implementation of proficiency benchmarks and period skills assessment. All rules promulgated by the State Board of Registration for the Healing Arts under these provisions must apply to assistant physicians, physician assistants, and advanced practice registered nurses.

All assistant physicians, physician assistants, and advanced practice registered nurses in collaborative practice arrangements are required to wear identification badges while acting within the scope of their collaborative practice agreement. The identification badges must prominently display the licensure status of the assistant physicians, physician assistants, and advanced practice registered nurses.

The bill changes the provisions of Section 334.735 regarding

physician assistants to include assistant physicians and their participation in collaborative practice arrangements;

PRESCRIPTION CO-PAYMENTS (Sections 354.535 and 376.387)

If the co-payment applied by a health maintenance organization, health insurer, or health carrier exceeds the usual and customary retail price of the prescription drug, the enrollee must only be required to pay the usual and customary retail price of the prescription drug and any further charge to the enrollee or plan sponsor cannot be incurred on the prescription.

HEALTH INSURANCE PROVIDERS (Sections 376.393 - 376.1425)

Every health carrier must provide each contracted health care provider, including a licensed pharmacy and home health agency, with access to the carrier's standard fee schedule, specific to the provider's geographic area, through a secure website that reflects the current payment rates for all goods and services. All contracted providers in the geographic area must be paid at those rates with specified exceptions. The fee schedule cannot include a rate for a specific good or service that is less than the lowest contracted rate for a specific good or service in a geographic area if all of the providers in the area have different individually contracted rates. A health carrier cannot refuse to contract with any Missouri provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation in the health benefit plan if the provider is willing to be paid a reimbursement rate equal to the specified standard rates.

Any agreement between a health carrier and a participating licensed health care provider is prohibited from containing a provision that:

(a) Prohibits or grants the carrier an option to prohibit the participating provider from contracting with another health carrier to provide health care services at a lower price than the payment specified in the agreement;

(b) Requires or grants the health carrier an option to require the provider to accept a lower reimbursement from the carrier in the event the provider agrees to provide health care services to another health carrier at a lower price;

(c) Requires or grants the health carrier an option to require termination or renegotiation of the existing agreement if the participating provider agrees to provide health care services to any other health carrier at a lower price; or

(d) Requires the participating provider to disclose his or her contractual reimbursement rates with other health providers. A violation of any of these provisions will make an agreement void and unenforceable.

Every health care provider who refers a patient to a medical facility for health care services must fully inform the patient of every medical facility within the health carrier's or health benefit plan's provider network at which the provider has privileges to provide the services for which the patient is being referred and which are medically appropriate. A health care provider must fully inform an uninsured patient of every medical facility at which the provider has privileges to provide the services for which the patient is being referred and which are medically appropriate. A health care provider must provide the health care services at the medical facility of the patient's choosing.

If the medical facility referred to and selected by a patient is in the provider network and is medically appropriate for the health care service to be provided, no referral by a provider or selection of a facility by a patient can be required or otherwise be restricted by the health carrier or plan. A carrier or plan cannot discriminate between medically appropriate facilities within the provider network regarding benefit coverage or reimbursement for provider services for the same health care service.

A health care provider, health carrier, or health benefit plan must be subject to licensure sanction for failure to comply with these provisions;

PRICE TRANSPARENCY (Section 376.2020)

A provision in a contract in existence or entered into, amended, or renewed on or after August 28, 2014, between a health carrier and a health care provider cannot be enforceable if the provision prohibits, conditions, or in any way restricts any party to the contract from disclosing to an enrollee, patient, potential patient, or the person's parent or legal guardian, the contractual payment amount for a health care service if the payment amount is less than the health care provider's usual charge for the health care service, and if the contractual provision prevents the determination of the potential out-of-pocket cost for the health care service by the enrollee, patient, potential patient, parent or legal guardian.

RESTRICTIVE PHYSICIAN EMPLOYMENT CONTRACTS (Section 431.205)

Any contract or agreement which creates or establishes the terms of a partnership, employment, or any other form of professional relationship between a physician and a nonprofit organization or entity that includes any restriction of the right of the physician to practice medicine in any geographic area for any period of time after the termination of the partnership, employment, or professional relationship as described in these provisions must be void or unenforceable with respect to the restriction. However, these provisions cannot render void or unenforceable the remaining provisions of the contract or agreement.

ATTORNEY CONTINGENT FEE ARRANGEMENTS (Sections 484.400 - 484.430)

The bill specifies that a fiduciary relationship commences when a claimant consults a contingent fee attorney to seek professional services. Contingent fee agreements for the representation of parties with claims must also include alternate hourly rate fees. If a contingent fee attorney has not entered into a written agreement with a claimant at the time of retention setting forth the attorney's hourly rate, a reasonable hourly rate is payable, subject to certain limitations specified under these provisions.

At any time after retention, a contingent fee attorney pursuing a claim must send a demand for compensation by certified mail to an allegedly responsible party and further delineates how the demand must be made.

A fee received by or contracted for by a contingent fee attorney that exceeds 10% of any settlement or judgment received by his or her client after reasonable expenses have been deducted is unreasonable and excessive if the attorney has sent a timely demand for compensation but has omitted information of a material nature that is required by these provisions which he or she had in his or her possession or which was readily available to him or her at the time of filing. These provisions also specify the terms and relationship under these contingent fees with respect to settlement offers.

It must be a violation of these provisions for an attorney retained after the claimant has received a pre-retention offer to enter into an agreement with a claimant to receive a contingent fee based upon or payable from the proceeds of the pre-retention offer, provided that the pre-retention offer remains in effect or is renewed until the time has elapsed for issuing a response containing a settlement offer.

An attorney entering into a fee agreement that would effectively result in payment of a percentage of a pre-retention offer to a claimant must be deemed to have charged an unreasonable and

excessive fee. Also, an attorney who contracts with a claimant for a reasonable hourly rate or a reasonable fixed fee, or who is paid such a fee for advising a claimant regarding the fairness of the pre-retention offer, has charged a presumptively reasonable fee.

TORT REFORM, ATTORNEY FEES, AND WITNESS FEES (Section 538.220)

The bill changes the laws regarding any action against a health care provider for damages for personal injury or death arising out of the rendering of or the failure to render health care services. If the case is settled prior to trial, attorneys' fees must be limited to the attorney's regular hourly rate of compensation. If the case proceeds to trial, the prevailing party must recover all expert witness fees and costs incurred by the prevailing party.

ACCOUNTABILITY SYSTEM (Section 1)

To aid the discovery of how and if MO HealthNet recipients covered under managed care organization health plans are improving in health outcomes and to provide data to the state to target health disparities, the state must establish and maintain an accountability system utilizing health information technology. The system must:

(a) Have the ability to interoperate to collect and aggregate data from disparate systems. The disparate systems must include, but not be limited to, electronic medical records, claims and eligibility databases, state-managed registries such as public health and immunizations registries, and health information organizations;

(b) Provide a quarterly analysis of each of the state managed care organizations to ensure such organizations are meeting required metrics, goals, and quality measurements as defined in the managed care contract such as costs of managed care services as compared to fee-for-service providers, and to provide the state with needed data for future contract negotiations and incentive management;

(c) Meet all state health privacy laws and federal Health Insurance Portability and Accountability Act (HIPAA) requirements; and

(d) Meet federal data security requirements.

MO HEALTHNET OVERSIGHT COMMITTEE (Section 208.955)

The bill repeals the provisions regarding the MO HealthNet Oversight Committee.