

SECOND REGULAR SESSION
HOUSE COMMITTEE SUBSTITUTE FOR
SENATE SUBSTITUTE FOR
SENATE BILL NO. 608
98TH GENERAL ASSEMBLY

4834H.04C

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To amend chapters 197 and 208, RSMo, by adding thereto four new sections relating to health care.

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

Section A. Chapters 197 and 208, RSMo, are amended by adding thereto four new sections, to be known as sections 197.170, 208.142, 208.148, and 208.800, to read as follows:

197.170. 1. This section shall be known and may be cited as the "Health Care Cost Reduction and Transparency Act".

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

(1) "Ambulatory surgical center", as such term is defined under section 197.200;

(2) "Direct payment", as such term is defined under section 1.330;

(3) "Health care provider", the same meaning given to such term under section 376.1350. "Health care provider" shall also include any provider located in a Kansas border county, as defined under section 135.1670, who participates in the MO HealthNet program;

(4) "Hospital", as such term is defined under section 197.020;

(5) "Imaging center", any facility at which diagnostic imaging services are provided including, but not limited to, magnetic resonance imaging (MRI);

(6) "Medical treatment plan", a patient-specific plan of medical treatment for a particular illness, injury, or condition determined by such patient's physician, which includes the applicable current procedural terminology (CPT) code or codes.

3. Beginning July 1, 2018, ambulatory surgical centers and imaging centers shall make available to the public, in a manner that is easily understood, an estimate of the most

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

18 current direct payment price information for the twenty-five most common surgical
19 procedures or the twenty most common imaging procedures, as appropriate, performed
20 in ambulatory surgical centers or imaging centers. Disclosure of data under this subsection
21 shall constitute compliance with subsection 5 of this section regarding any surgical or
22 imaging procedure for which disclosure is required under this subsection.

23 4. Not later than July 1, 2017, hospitals shall make available to the public, in a
24 manner that is easily understood, the amount that would be charged without discounts for
25 each of the one hundred most prevalent diagnosis-related groups as defined by the
26 Medicare program, Title XVIII of the Social Security Act. The diagnosis-related groups
27 shall be described in layperson's language suitable for use by reasonably informed
28 patients. Disclosure of data under this subsection shall constitute compliance with
29 subsection 5 of this section regarding any diagnosis-related group for which disclosure is
30 required under this subsection.

31 5. Upon written request by a patient, which shall include a medical treatment plan
32 from the patient's physician, for the direct payment cost of a particular health care service
33 or procedure, imaging procedure, or surgery procedure, a health care provider, hospital,
34 ambulatory surgical center, or imaging center shall provide, in writing, an estimate of the
35 direct payment price information required by this section to the patient electronically, by
36 mail, or in person within three business days after receiving the written request. Providing
37 a patient a specific link to such estimated prices and making such estimated prices publicly
38 available or posting such estimated prices on a website of the health care provider,
39 hospital, ambulatory surgical center, or imaging center shall constitute compliance with
40 the provisions of this subsection.

41 6. No health care provider shall be required to report the information required by
42 this section if the reporting of such information reasonably could lead to the identification
43 of the person or persons receiving health care services or procedures in violation of the
44 federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other
45 federal law. This section shall not apply to emergency departments, which shall comply
46 with requirements of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C.
47 Section 1395dd.

48 7. It shall be a condition of participation in the MO HealthNet program for a health
49 care provider located in a Kansas border county, as defined under section 135.1670, to
50 comply with the provisions of this section. If such provider, for any reason, does not
51 comply with such condition of participation, then a health care provider, as defined under
52 this section, shall not include any provider located in a Missouri border county, as defined
53 under section 135.1670.

208.142. 1. Beginning October 1, 2016, a MO HealthNet participant who uses hospital emergency department services for the treatment of a medical condition that is not an emergency medical condition shall be required to pay a co-payment fee of eight dollars for such services. A participant shall be notified of the eight-dollar co-payment prior to services being rendered. A MO HealthNet participant's failure to pay the co-payment fee shall not in any way reduce or otherwise affect any MO HealthNet reimbursement to the health care provider for the services provided.

2. For purposes of this section, an "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

3. The department of social services shall promulgate rules for the implementation of this section, including setting forth rules for the required documentation by the physician and the informed consent to be provided to and signed by the parent or guardian of the participant. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly under chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2016, shall be invalid and void.

4. The department shall submit such state plan amendments and waivers to the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services as the department determines are necessary to implement the provisions of this section.

208.148. 1. Except as required to satisfy laws pertaining to the termination of patient care without adequate notice or without making other arrangements for the continued care of the patient, fee-for-service MO HealthNet health care providers shall be permitted to prohibit a MO HealthNet participant who misses an appointment or fails to provide notice of cancellation within twenty-four hours prior to the appointment from

6 scheduling another appointment until the participant has paid a missed appointment fee
7 to the health care provider as follows:

8 (1) For the first missed appointment in a three-year period, no fee shall be charged
9 but such missed appointment shall be documented in the patient's record;

10 (2) For the second missed appointment in a three-year period, a fee of no greater
11 than five dollars;

12 (3) For the third missed appointment in a three-year period, a fee of no greater
13 than ten dollars; and

14 (4) For the fourth and each subsequent missed appointment in a three-year period,
15 a fee of no greater than twenty dollars.

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17 Such health care providers shall waive the missed appointment fee in cases of inclement
18 weather.

19 2. Nothing in this section shall be construed in any way to limit MO HealthNet
20 managed care organizations from developing and implementing any incentive program to
21 encourage adherence to scheduled appointments.

22 3. The health care provider shall not charge to, nor shall the MO Healthnet
23 participant be reimbursed by, the MO HealthNet program for the missed appointment fee.

24 4. The department of social services shall submit such state plan amendments and
25 waivers to the Centers for Medicare and Medicaid Services of the federal Department of
26 Health and Human Services as the department determines are necessary to implement the
27 provisions of this section.

208.800. Notwithstanding any other provision of law, the department of social
2 services may utilize best clinical practices to achieve cost efficacy when administering the
3 MO HealthNet pharmacy program.

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