

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Section A. Sections 190.839, 191.227, 198.439, 208.437, 208.480, 338.550, and 633.401, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as sections 190.839, 191.227, 198.439, 208.437, 208.480, 338.550, 376.1190, 633.401, and 1, to read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

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

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

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

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

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

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

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

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

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

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:

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

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

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

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

17 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
2 amount of cost-sharing, including deductibles, copayments, and
3 coinsurance, under the individual's health benefit plan or coverage that
4 the individual would be responsible for paying with respect to the
5 furnishing of a specific item or service by a participating provider in
6 a timely manner upon the request of the individual. At a minimum,
7 such information shall be made available to such individual through an
8 internet website and such other means for individuals without access
9 to the internet. As used in this section, the terms "health carrier" and
10 "health benefit plans" shall have the same meanings assigned to them
11 in section 376.1350.**

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

18 **3. Any health care benefit mandate proposed after August 28,
19 2011, shall be subject to review by the oversight division of the joint
20 committee on legislative research. The oversight division shall perform
21 an actuarial analysis of the cost impact to private and public payers of**

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

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

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

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

4 (2) "Intermediate care facility for the mentally retarded", a private or
5 department of mental health facility which admits persons who are mentally
6 retarded or developmentally disabled for residential habilitation and other
7 services pursuant to chapter 630. Such term shall include habilitation centers
8 and private or public intermediate care facilities for the mentally retarded that
9 have been certified to meet the conditions of participation under 42 CFR, Section
10 483, Subpart 1;

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

18 (4) "Services of intermediate care facilities for the mentally retarded" has
19 the same meaning as the term used in Title 42 United States Code, Section
20 1396b(w)(7)(A)(iv), as amended, and as such qualifies as a class of health care
21 services recognized in federal Public Law 102-234, the Medicaid Voluntary
22 Contribution and Provider Specific Tax Amendment of 1991.

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

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

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

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

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

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

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

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

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

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

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

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

82 12. In the event a provider objects to the estimate described in subsection
83 11 of this section, or any other decision of the department of mental health
84 related to this section, the provider of services may request a hearing. If a
85 hearing is requested, the director of the department of mental health shall
86 provide the provider of services an opportunity to be heard and to present
87 evidence bearing on the amount due for an assessment or other issue related to
88 this section within thirty days after collection of an amount due or receipt of a
89 request for a hearing, whichever is later. The director shall issue a final decision
90 within forty-five days of the completion of the hearing. After reconsideration of
91 the assessment determination and a final decision by the director of the
92 department of mental health, an intermediate care facility for the mentally
93 retarded provider's appeal of the director's final decision shall be to the
94 administrative hearing commission in accordance with sections 208.156 and
95 621.055.

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

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

103 15. The director of the department of mental health shall promulgate
104 rules and regulations to implement this section. Any rule or portion of a rule, as
105 that term is defined in section 536.010, that is created under the authority
106 delegated in this section shall become effective only if it complies with and is
107 subject to all of the provisions of chapter 536 and, if applicable, section
108 536.028. This section and chapter 536 are nonseverable and if any of the powers
109 vested with the general assembly pursuant to chapter 536 to review, to delay the
110 effective date, or to disapprove and annul a rule are subsequently held
111 unconstitutional, then the grant of rulemaking authority and any rule proposed
112 or adopted after August 28, 2008, shall be invalid and void.

113 16. The provisions of this section shall expire on September 30, [2011]
114 **2015.**

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

Bill ✓

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