SECOND REGULAR SESSION

SENATE BILL NO. 1245

93RD GENERAL ASSEMBLY

INTRODUCED BY SENATORS GOODMAN, BARTLE AND WHEELER.

Read 1st time March 1, 2006, and ordered printed.

TERRY L. SPIELER, Secretary.

5485S.02I

AN ACT

To repeal sections 197.305, 197.315, 197.317, 197.318, 197.325, 197.340, 197.345, 197.355, 197.357, and 197.366, RSMo, and to enact in lieu thereof twenty-one new sections relating to health care facilities.

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

Section A. Sections 197.305, 197.315, 197.317, 197.318, 197.325, 197.340, 197.345, 197.355, 197.357, and 197.366, RSMo, are repealed and twenty-one new sections enacted in lieu thereof, to be known as sections 192.668, 197.124, 197.241, 197.242, 197.243, 197.244, 197.245, 197.246, 197.247, 197.305, 197.315, 197.317, 197.318, 197.325, 197.340, 197.345, 197.355, 197.357, 197.710, 334.113, and 334.115, to read as follows:

192.668. 1. The department of health and senior services shall implement a long-range plan for making available cost and quality outcome data on its Internet website that will allow consumers to compare health care services. The cost and quality outcome data the department must make available shall include, but is not limited to, licensed physicians, hospitals, and ambulatory surgical centers. As part of the plan, the department shall identify the process and time frames for implementation. The department shall submit the initial plan to the general assembly by January 1, 2007, and shall update the plan and report on the status of its implementation annually thereafter.

2. The department shall determine which medical conditions and procedures, quality outcomes, and patient charge data to disclose. When making such determinations, the department shall consider variation in costs, variation in outcomes, and magnitude of

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

variations and other relevant information.

3. The department shall determine which quality and performance outcome and patient charge data is currently collected from health care facilities under current state and federal law. The department may consider such additional measures that are adopted by the Centers of Medicare and Medicaid Services, National Quality Forum, the Joint Commission on Accreditations of Healthcare Organizations, the Agency for Healthcare Research and Quality, or any other similar state or national entity that establishes standards to measure the performance of health care providers.

4. The department shall not require the re-submission of data which has been submitted to the department of health and senior services or any other state departments under other provisions of law. The department of health and senior services shall accept data submitted by associations or related organizations on behalf of health care providers by entering into binding agreements negotiated with such associations or related organizations to obtain data deemed necessary by the department for compliance with the provisions of this section.

5. No later than January 1, 2010, the department of health and senior services shall make the cost and quality outcome data described under this section available on its Internet website. The data on the website shall be disclosed in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific physicians, hospitals or ambulatory surgical centers. The website must include such additional information as is deemed necessary to ensure that the website enhances informed decision making among consumers and health care purchasers.

197.124. 1. After August 28, 2006, no physician shall refer a patient to any health care facility in which the physician has an ownership interest or with which the physician has an employment relationship or contractual relationship, unless:

(1) The referring physician will continue to provide treatment to the patient at the hospital to which the patient is referred; or

(2) The physician provides written disclosure to the patient of the physician's ownership interest, employment relationship or contractual relationship with the hospital to which the patient is

referred.

Violations of this section shall constitute grounds for licensure denial, suspension or revocation under section 197.070.

2. For purposes of this section, the following terms shall mean:

(1) "Ownership interest", a direct or indirect interest held by the physician or the physician's spouse or dependent child as the term "dependent child" is defined in section 105.450, RSMo, through equity, debt or other means, including but not limited to a direct or indirect interest in an entity that holds an ownership or investment interest in the pertinent hospital but excluding the following:

(a) Ownership of investment securities which may be purchased on terms generally available to the public and which are:

a. Listed on the New York Stock Exchange, the American Stock Exchange, or any regional exchange in which quotations are published on a daily basis; or

b. Traded under an automated interdealer quotation system operated by the National Association of Securities Dealers; or

(b) Ownership of shares in a regulated investment company as defined in Section 851(a) of the Internal Revenue Code of 1986, if such company had, at the end of the company's most recent fiscal year or on average during the previous three fiscal years, total assets exceeding seventy-five million dollars;

(2) "Refer a patient", the act, by a physician of providing a request or order for one or more inpatient or nonemergency outpatient hospital services for or establishment of a plan of care that includes one or more inpatient or nonemergency outpatient hospital services for the patient.

197.241. 1. Every ambulatory surgical center licensed pursuant to chapter 197, RSMo, shall, in addition to all other fees and taxes now required or paid, pay an ambulatory surgical center federal reimbursement allowance for the privilege of engaging in the business of providing ambulatory surgical center services in this state.

2. Each ambulatory surgical center's assessment shall be based on a formula set forth in rules and regulations promulgated by the department of social services. The assessment rate for ambulatory surgical centers shall be comparable to the assessment rate for hospitals under the provisions of 208.453 to 208.480, RSMo. No

ambulatory surgical center reimbursement allowance shall be collected by the department of social services if the federal Center for Medicare and Medicaid Services determines that such reimbursement allowance is not authorized under Title XIX of the Social Security Act. If such determination is made by the federal Center for Medicare and Medicaid Services, any ambulatory surgical center reimbursement allowance collected prior to such determination shall be immediately returned to the ambulatory surgical center which have paid such allowance.

3. Each ambulatory surgical center shall keep such records as may be necessary to determine the amount of its ambulatory surgical center federal reimbursement allowance. On or before September 1, 2007, and the first day of January of each year thereafter every ambulatory surgical center shall submit to the department of social services a statement that accurately reflects its ownership. Every ambulatory surgical center required to pay the ambulatory surgical center federal reimbursement allowance shall submit a statement that accurately reflects the data necessary for the department of social services to calculate the assessment.

197.242. 1. The director of the department of social services shall make a determination as to the amount of ambulatory surgical center federal reimbursement allowance due from the various ambulatory surgical centers.

2. The director of the department of social services shall notify each ambulatory surgical center of the annual amount of its federal reimbursement allowance. Such amount may be paid in increments over the balance of the assessment period.

3. The department of social services is authorized to offset the ambulatory surgical center federal reimbursement allowance owed by an ambulatory surgical center against any Missouri Medicaid payment due that ambulatory surgical center, if the ambulatory surgical center requests such an offset. The amounts to be offset shall result, so far as practicable, in withholding from the ambulatory surgical center an amount substantially equivalent to the assessment to be due from the ambulatory surgical center. The office of administration and state treasurer are authorized to make any fund transfers necessary to execute the offset.

197.243. 1. Each ambulatory surgical center federal

reimbursement allowance assessment shall be final after a receipt of written notice from the department of social services, unless the ambulatory surgical center files a protest with the director of the department of social services setting forth the grounds on which the protest is based, within thirty days from the date of notice by the department of social services to the ambulatory surgical center.

2. If a timely protest is filed, the director of the department of social services shall reconsider the assessment and, if the ambulatory surgical center has so requested, the director shall grant the ambulatory surgical center a hearing within ninety days after the protest is filed, unless extended by agreement between the ambulatory surgical center and the director. The director shall issue a final decision within sixty days of completion of the hearing. After reconsideration of the assessment and a final decision by the director of the department of social services, an ambulatory surgical center's appeal of the director's final decision shall be to the administrative hearing commission in accordance with sections 208.156 and 621.055, RSMo.

197.244. 1. The department of social services shall promulgate rules to implement the provisions of sections 197.241 to 197.246, including but not limited to:

(1) The form and content of any documents required to be filed under sections 191.241 to 191.246, RSMo;

(2) The dates for the filing of documents by ambulatory surgical centers and for notification by the department to each ambulatory surgical center of the annual amount of its reimbursement allowance; and

(3) The formula for determining the amount of each ambulatory surgical center's reimbursement allowance.

2. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in sections 197.241 to 197.246 shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. Sections 197.241 to 197.246 and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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 the effective date of this section shall be invalid and void.

197.245. 1. The ambulatory surgical center federal reimbursement allowance owed or, if an offset has been requested, the balance, if any, after such offset, shall be remitted by the ambulatory surgical center to the department of social services. The remittance shall be made payable to the director of the department of revenue. The amount remitted shall be deposited in the state treasury to the credit of the "Ambulatory Surgical Center Federal Reimbursement Allowance Fund".

2. There is hereby created in the state treasury the "Ambulatory Surgical Center Federal Reimbursement Allowance Fund", which is hereby created for the purpose of providing payment to ambulatory surgical centers. The state treasurer shall be custodian of the fund and shall approve disbursements from the fund in accordance with sections 30.170 and 30.180, RSMo. Upon appropriation, money in the fund shall be used solely for the administration of this section. Notwithstanding the provisions of section 33.080, RSMo, to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

3. An offset as authorized by section 197.242 or a payment to the ambulatory surgical center federal reimbursement allowance fund shall be accepted as payment of the obligation of section 197.241.

4. 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.

197.246. 1. A federal reimbursement allowance period shall be from the first day of October until the thirtieth day of September of the following year. The department shall notify each ambulatory surgical center with a balance due on September thirtieth of each year the amount of such balance due. If any ambulatory surgical center fails to pay its federal reimbursement allowance within thirty days of such notice, the assessment shall be delinquent.

2. If any assessment imposed under the provisions of sections 197.241 to 197.246 for a previous assessment period is unpaid and delinquent, the department of social services may proceed to enforce the state's lien against the property of the ambulatory surgical center and to compel the payment of such assessment in the circuit court having jurisdiction in the county where the ambulatory surgical center is 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 provider agreement to any ambulatory surgical center which fails to pay the allowance required by section 197.241.

3. Failure to pay an assessment imposed under sections 197.241 to 197.246 shall be grounds for denial, suspension or revocation of a license granted under this chapter. The director of the department of social services may request that the director of the department of health and senior services deny, suspend or revoke the license of any ambulatory surgical center which fails to pay its assessment.

4. Nothing in sections 197.241 to 197.246 shall be deemed to affect or in any way limit the tax exempt or nonprofit status of any ambulatory surgical center granted by state law.

5. The department of social services shall make payments to those ambulatory surgical centers which have a Medicaid provider agreement with the department. The uses of the proceeds of the ambulatory surgical center federal reimbursement allowance shall be determined by appropriation of the general assembly, with first priority to fund Medicaid payments to ambulatory surgical centers.

6. The requirements of sections 197.241 to 197.246 shall apply only as long as the revenues generated under section 197.241 are eligible for federal financial participation and payments are made pursuant to the provisions of subsection 5 of this section. For the purposes of this section, "federal financial participation" is the federal government's share of Missouri's expenditures under the Medicaid program.

197.247. Sections 197.241 to 197.246 shall expire on September 30, 2008.

197.305. As used in sections 197.300 to 197.366, the following terms mean:

(1) "Affected persons", the person proposing the development of a new

institutional **[**health**]** **long-term care** service **or long-term acute care service**, the public to be served, and **[**health**]** **long-term** care facilities **or long-term acute care hospitals** within the service area in which the proposed new **[**health**]** **long-term** care service **or long-term acute care service** is to be developed;

(2) "Agency", the certificate of need program of the Missouri department of health and senior services;

(3) "Capital expenditure", an expenditure by or on behalf of a **[**health**]** **long-term** care facility **or long-term acute care hospital** which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance;

(4) "Certificate of need", a written certificate issued by the committee setting forth the committee's affirmative finding that a proposed project sufficiently satisfies the criteria prescribed for such projects by sections 197.300 to 197.366;

(5) "Develop", to undertake those activities which on their completion will result in the offering of a new institutional **[**health**]** **long-term care** service **or long-term acute care service** or the incurring of a financial obligation in relation to the offering of such a service;

(6) "Expenditure minimum" shall mean:

(a) For beds in existing or proposed **[**health**]** **long-term** care facilities **or long-term acute care hospitals** licensed pursuant to chapter 198, RSMo, and long-term care beds in a hospital as described in subdivision (3) of subsection 1 of section 198.012, RSMo, six hundred thousand dollars in the case of capital expenditures, or four hundred thousand dollars in the case of major medical equipment**[**, provided, however, that prior to January 1, 2003, the expenditure minimum for beds in such a facility and long-term care beds in a hospital described in section 198.012, RSMo, shall be zero, subject to the provisions of subsection 7 of section 197.318**]**;

(b) For beds or equipment in a long-term care hospital meeting the requirements described in 42 CFR, Section 412.23(e), the expenditure minimum shall be zero; **[**and

(c) For health care facilities, new institutional health services or beds not described in paragraph (a) or (b) of this subdivision one million dollars in the case of capital expenditures, excluding major medical equipment, and one million dollars in the case of medical equipment;**]**

(7) **[**"Health care facilities", hospitals, health maintenance organizations, tuberculosis hospitals, psychiatric hospitals, intermediate care facilities, skilled nursing facilities, residential care facilities I and II, kidney disease treatment centers, including freestanding hemodialysis units, diagnostic imaging centers, radiation therapy centers and ambulatory surgical facilities, but excluding the private offices of physicians, dentists and other practitioners of the healing arts, and Christian Science sanatoriums, also known as Christian Science Nursing facilities listed and certified by the Commission for Accreditation of Christian Science Nursing Organization/Facilities, Inc., and facilities of not-for-profit corporations in existence on October 1, 1980, subject either to the provisions and regulations of Section 302 of the Labor-Management Relations Act, 29 U.S.C. 186 or the Labor-Management Reporting and Disclosure Act, 29 U.S.C. 401-538, and any residential care facility I or residential care facility II operated by a religious organization qualified pursuant to Section 501(c)(3) of the federal Internal Revenue Code, as amended, which does not require the expenditure of public funds for purchase or operation, with a total licensed bed capacity of one hundred beds or fewer;

(8)**]** "Health service area", a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources, consisting of a population of not less than five hundred thousand or more than three million;

(8) "Long-term care facilities", intermediate care facilities, skilled nursing facilities, residential care facilities I and II, but excluding facilities of not-for-profit corporations in existence on October 1, 1980, subject either to the provisions and regulations of Section 302 of the Labor-Management Relations Act, 29 U.S.C. Section 186 or the Labor-Management Reporting and Disclosure Act, 29 U.S.C. Sections 401-531, and any residential care facility I or residential care facility II operated by a religious organization qualified under Section 501(c)(3) of the federal Internal Revenue Code of 1986, as amended, which does not require the expenditure of public funds for purchase or operation, with a total licensed bed capacity of one hundred beds or fewer;

(9) **"Long-term acute care hospital", an acute care hospital designed for extended-stay patients with chronic and complex medical complications, and designated such by calculating the average length of stay for patients. The long-term acute care hospital shall either:**

(a) Have an average Medicare inpatient length of stay of greater than twenty-five days, including all covered and non-covered days of stay of Medicare patients, where the average Medicare inpatient length of stay is calculated by dividing the total number of covered and non-covered days of stay of Medicare inpatients, less leave or pass days, by the number of total Medicare discharges for the hospital's most recent complete cost reporting period; or

(b) Meet the length of stay criterion if it has an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater that twenty days, where the average inpatient length of stay is calculated by dividing the total number of days for all patients, including both Medicare and non-Medicare inpatients, less leave or pass days, by the number of total discharges for the hospital's most recent complete cost reporting period;

(10) "Major medical equipment", medical equipment used for the provision of medical and other **[**health**]** **long-term care** services **or long-term acute care services**;

[(10)**]** **(11)** "New institutional **[**health**]** **long-term care or acute care** service":

(a) The development of a new **[**health**]** **long-term** care facility **or long-term acute care hospital** costing in excess of the applicable expenditure minimum;

(b) The acquisition, including acquisition by lease, of any **[**health**]** **long-term** care facility **or long-term acute care hospital**, or major medical equipment costing in excess of the expenditure minimum;

(c) Any capital expenditure by or on behalf of a **[**health**]** **long-term** care facility **or long-term acute care hospital** in excess of the expenditure minimum;

(d) Predevelopment activities as defined in subdivision (13) hereof costing in excess of one hundred fifty thousand dollars;

(e) Any change in licensed bed capacity of a **[**health**]** **long-term** care facility **or long-term acute care hospital** which increases the total number of beds by more than ten or more than ten percent of total bed capacity, whichever is less, over a two-year period;

(f) **[**Health**]** **Long-term care** services, excluding home health services,

which are offered in a **[**health**]** **long-term** care facility **or long-term acute care hospital** and which were not offered on a regular basis in such **[**health**]** **long-term** care facility within the twelve-month period prior to the time such services would be offered;

(g) A reallocation by an existing **[**health**]** **long-term** care facility **or long-term acute care hospital** of licensed beds among major types of service or reallocation of licensed beds from one physical facility or site to another by more than ten beds or more than ten percent of total licensed bed capacity, whichever is less, over a two-year period;

[(11)**]** **(12)** "Nonsubstantive projects", projects which do not involve the addition, replacement, modernization or conversion of beds or the provision of a new **[**health**]** **long-term care** service but which include a capital expenditure which exceeds the expenditure minimum and are due to an act of God or a normal consequence of maintaining **[**health**]** **long-term** care services **or long-term acute care services**, facility or equipment;

[(12)**]** **(13)** "Person", any individual, trust, estate, partnership, corporation, including associations and joint stock companies, state or political subdivision or instrumentality thereof, including a municipal corporation;

[(13)**]** **(14)** "Predevelopment activities", expenditures for architectural designs, plans, working drawings and specifications, and any arrangement or commitment made for financing; but excluding submission of an application for a certificate of need.

197.315. 1. Any person who proposes to develop or offer a new institutional **[**health**]** **long-term care** service **or long-term acute care service** within the state must obtain a certificate of need from the committee prior to the time such services are offered.

2. Only those new institutional **[**health**]** **long-term care** services **or long-term acute care services** which are found by the committee to be needed shall be granted a certificate of need. Only those new institutional **[**health**]** **long-term care** services **or long-term acute care services** which are granted certificates of need shall be offered or developed within the state. No expenditures for new institutional **[**health**]** **long-term care** services **or long-term acute care services** in excess of the applicable expenditure minimum shall be made by any person unless a certificate of need has been granted.

3. After October 1, 1980, no state agency charged by statute to license or certify **[**health**]** **long-term** care facilities **or long-term acute care hospitals**

shall issue a license to or certify any such facility, or distinct part of such facility, that is developed without obtaining a certificate of need.

4. If any person proposes to develop any new institutional **[**health**]** **long-term** care service **or long-term acute care service** without a certificate of need as required by sections 197.300 to 197.366, the committee shall notify the attorney general, and **[**he**]** **the attorney general** shall apply for an injunction or other appropriate legal action in any court of this state against that person.

5. After October 1, 1980, no agency of state government may appropriate or grant funds to or make payment of any funds to any person or **[**health**]** **long-term** care facility **or long-term acute care hospital** which has not first obtained every certificate of need required pursuant to sections 197.300 to 197.366.

6. A certificate of need shall be issued only for the premises and persons named in the application and is not transferable except by consent of the committee.

7. Project cost increases, due to changes in the project application as approved or due to project change orders, exceeding the initial estimate by more than ten percent shall not be incurred without consent of the committee.

8. Periodic reports to the committee shall be required of any applicant who has been granted a certificate of need until the project has been completed. The committee may order the forfeiture of the certificate of need upon failure of the applicant to file any such report.

9. A certificate of need shall be subject to forfeiture for failure to incur a capital expenditure on any approved project within six months after the date of the order. The applicant may request an extension from the committee of not more than six additional months based upon substantial expenditure made.

10. Each application for a certificate of need must be accompanied by an application fee. The time of filing commences with the receipt of the application and the application fee. The application fee is one thousand dollars, or one-tenth of one percent of the total cost of the proposed project, whichever is greater. All application fees shall be deposited in the state treasury. Because of the loss of federal funds, the general assembly will appropriate funds to the Missouri health facilities review committee.

11. **[**In determining whether a certificate of need should be granted, no consideration shall be given to the facilities or equipment of any other health care facility located more than a fifteen-mile radius from the applying facility.**]** **In**

determining whether a certificate of need should be granted to a long-term care facility, no consideration shall be given to the facilities or equipment of any other long-term care facility located more than a fifteen-mile radius of the applying facility; and in determining whether a certificate of need should be granted to a long-term acute care hospital, no consideration shall be given to the facilities or equipment of any other long-term acute care hospital located more than a fifty-mile radius of the applying facility.

12. When a nursing facility shifts from a skilled to an intermediate level of nursing care, it may return to the higher level of care if it meets the licensure requirements, without obtaining a certificate of need.

13. In no event shall a certificate of need be denied because the applicant refuses to provide abortion services or information.

14. A certificate of need shall not be required for the transfer of ownership of an existing and operational **[**health**] long-term care** facility **or long-term acute care hospital** in its entirety.

15. A certificate of need may be granted to a facility for an expansion, an addition of services, a new institutional service, or for a new **[**hospital**] long-term care** facility **or long-term acute care hospital** which provides for something less than that which was sought in the application.

16. The provisions of this section shall not apply to facilities operated by the state, and appropriation of funds to such facilities by the general assembly shall be deemed in compliance with this section, and such facilities shall be deemed to have received an appropriate certificate of need without payment of any fee or charge.

17. Notwithstanding other provisions of this section, a certificate of need may be issued after July 1, 1983, for an intermediate care facility operated exclusively for the mentally retarded.

18. To assure the safe, appropriate, and cost-effective transfer of new medical technology throughout the state, a certificate of need shall not be required for the purchase and operation of research equipment that is to be used in a clinical trial that has received written approval from a duly constituted institutional review board of an accredited school of medicine or osteopathy located in Missouri to establish its safety and efficacy and does not increase the bed complement of the institution in which the equipment is to be located. After the clinical trial has been completed, a certificate of need must be obtained for

continued use in such facility.

197.317. 1. After July 1, 1983, no certificate of need shall be issued for the following:

(1) Additional residential care facility I, residential care facility II, intermediate care facility or skilled nursing facility beds above the number then licensed by this state;

(2) Beds in a licensed hospital to be reallocated on a temporary or permanent basis to nursing care or beds in a long-term care hospital meeting the requirements described in 42 CFR, Section 412.23(e), excepting those which are not subject to a certificate of need pursuant to paragraphs (e) and (g) of subdivision (10) of section 197.305; nor

(3) The reallocation of intermediate care facility or skilled nursing facility beds of existing licensed beds by transfer or sale of licensed beds between a hospital licensed pursuant to this chapter or a nursing care facility licensed pursuant to chapter 198, RSMo; except for beds in counties in which there is no existing nursing care facility. No certificate of need shall be issued for the reallocation of existing residential care facility I or II, or intermediate care facilities operated exclusively for the mentally retarded to intermediate care or skilled nursing facilities or beds. However, after January 1, 2003, nothing in this section shall prohibit the Missouri health facilities review committee from issuing a certificate of need for additional beds in existing **[**health**]** **long-term** care facilities **or long-term acute care hospitals** or for new beds in new **[**health**]** **long-term** care facilities **or long-term acute care hospitals** or for the reallocation of licensed beds, provided that no construction shall begin prior to January 1, 2004. The provisions of subsections 16 and 17 of section 197.315 shall apply to the provisions of this section.

2. The health facilities review committee shall utilize demographic data from the office of social and economic data analysis, or its successor organization, at the University of Missouri as their source of information in considering applications for new institutional long-term care facilities.

197.318. 1. The provisions of section 197.317 shall not apply to a residential care facility I, residential care facility II, intermediate care facility or skilled nursing facility only where the department of social services has first determined that there presently exists a need for additional beds of that classification because the average occupancy of all licensed and available residential care facility I, residential care facility II, intermediate care facility

and skilled nursing facility beds exceeds ninety percent for at least four consecutive calendar quarters, in a particular county, and within a fifteen-mile radius of the proposed facility, and the facility otherwise appears to qualify for a certificate of need. The department's certification that there is no need for additional beds shall serve as the final determination and decision of the committee. In determining ninety percent occupancy, residential care facility I and II shall be one separate classification and intermediate care and skilled nursing facilities are another separate classification.

2. **The provisions of section 197.317 shall not apply to a long-term acute care hospital where the department of social services has first determined that there presently exists a need for additional beds of that classification because the average occupancy of all licensed and available long-term acute care hospital beds exceeds ninety percent for at least four consecutive calendar quarters, in a particular county, and within a fifty-mile radius of the proposed long-term acute care hospital, and the long-term acute care hospital otherwise appears to qualify for a certificate of need.**

3. The Missouri health facilities review committee may, for any facility certified to it by the department, consider the predominant ethnic or religious composition of the residents to be served by that facility in considering whether to grant a certificate of need.

[3.**]** **4.** There shall be no expenditure minimum for facilities, beds, or services referred to in subdivisions (1), (2) and (3) of section 197.317. The provisions of this subsection shall expire January 1, 2003.

[4.**]** **5.** As used in this section, the term "licensed and available" means beds which are actually in place and for which a license has been issued.

[5.**]** **6.** The provisions of section 197.317 shall not apply to any facility where at least ninety-five percent of the patients require diets meeting the dietary standards defined by section 196.165, RSMo.

[6.**]** **7.** The committee shall review all letters of intent and applications for long-term care hospital beds meeting the requirements described in 42 CFR, Section 412.23(e) under its criteria and standards for long-term care beds.

[7.**]** **8.** Sections 197.300 to 197.366 shall not be construed to apply to litigation pending in state court on or before April 1, 1996, in which the Missouri health facilities review committee is a defendant in an action concerning the application of sections 197.300 to 197.366 to long-term care hospital beds meeting

the requirements described in 42 CFR, Section 412.23(e).

[8.**]** **9.** Notwithstanding any other provision of this chapter to the contrary:

(1) A facility licensed pursuant to chapter 198, RSMo, may increase its licensed bed capacity by:

(a) Submitting a letter of intent to expand to the division of aging and the health facilities review committee;

(b) Certification from the division of aging that the facility:

a. Has no patient care class I deficiencies within the last eighteen months; and

b. Has maintained a ninety-percent average occupancy rate for the previous six quarters;

(c) Has made an effort to purchase beds for eighteen months following the date the letter of intent to expand is submitted pursuant to paragraph (a) of this subdivision. For purposes of this paragraph, an "effort to purchase" means a copy certified by the offeror as an offer to purchase beds from another licensed facility in the same licensure category; and

(d) If an agreement is reached by the selling and purchasing entities, the health facilities review committee shall issue a certificate of need for the expansion of the purchaser facility upon surrender of the seller's license; or

(e) If no agreement is reached by the selling and purchasing entities, the health facilities review committee shall permit an expansion for:

a. A facility with more than forty beds may expand its licensed bed capacity within the same licensure category by twenty-five percent or thirty beds, whichever is greater, if that same licensure category in such facility has experienced an average occupancy of ninety-three percent or greater over the previous six quarters;

b. A facility with fewer than forty beds may expand its licensed bed capacity within the same licensure category by twenty-five percent or ten beds, whichever is greater, if that same licensure category in such facility has experienced an average occupancy of ninety-two percent or greater over the previous six quarters;

c. A facility adding beds pursuant to subparagraphs a. or b. of this paragraph shall not expand by more than fifty percent of its then licensed bed capacity in the qualifying licensure category;

(2) Any beds sold shall, for five years from the date of relicensure by the

purchaser, remain unlicensed and unused for any long-term care service in the selling facility, whether they do or do not require a license;

(3) The beds purchased shall, for two years from the date of purchase, remain in the bed inventory attributed to the selling facility and be considered by the department of social services as licensed and available for purposes of this section;

(4) Any residential care facility licensed pursuant to chapter 198, RSMo, may relocate any portion of such facility's current licensed beds to any other facility to be licensed within the same licensure category if both facilities are under the same licensure ownership or control, and are located within six miles of each other;

(5) A facility licensed pursuant to chapter 198, RSMo, may transfer or sell individual long-term care licensed beds to facilities qualifying pursuant to paragraphs (a) and (b) of subdivision (1) of this subsection. Any facility which transfers or sells licensed beds shall not expand its licensed bed capacity in that licensure category for a period of five years from the date the licensure is relinquished.

[9.**]** **10.** Any existing licensed and operating health care facility offering long-term care services may replace one-half of its licensed beds at the same site or a site not more than thirty miles from its current location if, for at least the most recent four consecutive calendar quarters, the facility operates only fifty percent of its then licensed capacity with every resident residing in a private room. In such case:

(1) The facility shall report to the division of aging vacant beds as unavailable for occupancy for at least the most recent four consecutive calendar quarters;

(2) The replacement beds shall be built to private room specifications and only used for single occupancy; and

(3) The existing facility and proposed facility shall have the same owner or owners, regardless of corporate or business structure, and such owner or owners shall stipulate in writing that the existing facility beds to be replaced will not later be used to provide long-term care services. If the facility is being operated under a lease, both the lessee and the owner of the existing facility shall stipulate the same in writing.

[10.**]** **11.** Nothing in this section shall prohibit a health care facility licensed pursuant to chapter 198, RSMo, from being replaced in its entirety

within fifteen miles of its existing site so long as the existing facility and proposed or replacement facility have the same owner or owners regardless of corporate or business structure and the health care facility being replaced remains unlicensed and unused for any long-term care services whether they do or do not require a license from the date of licensure of the replacement facility.

197.325. Any person who proposes to develop or offer a new institutional **[**health**]** **long-term care** service **or long-term acute care service** shall submit a letter of intent to the committee at least thirty days prior to the filing of the application.

197.340. Any **[**health**]** **long-term care** facility **or long-term acute care hospital** providing a **[**health**]** **long-term care** service **or long-term acute care service** must notify the committee of any discontinuance of any previously provided **[**health**]** **long-term** care service, a decrease in the number of licensed beds by ten percent or more, or the change in licensure category for any such facility.

197.345. Any **[**health**]** **long-term care** facility **or long-term acute care hospital** with a project for facilities or services for which a binding construction or purchase contract has been executed prior to October 1, 1980, or **[**health**]** **long-term** care facility **or long-term acute care hospital** which has commenced operations prior to October 1, 1980, shall be deemed to have received a certificate of need, except that such certificate of need shall be subject to forfeiture under the provisions of subsections 8 and 9 of section 197.315.

197.355. The legislature may not appropriate any money for capital expenditures for **[**health**]** **long-term** care facilities **or long-term acute care hospitals** until a certificate of need has been issued for such expenditures.

197.357. For the purposes of reimbursement under section 208.152, RSMo, project costs for new institutional **[**health**]** **long-term care** services **or long-term acute care services** in excess of ten percent of the initial project estimate whether or not approval was obtained under subsection 7 of section 197.315 shall not be eligible for reimbursement for the first three years that a facility receives payment for services provided under section 208.152, RSMo. The initial estimate shall be that amount for which the original certificate of need was obtained or, in the case of facilities for which a binding construction or purchase contract was executed prior to October 1, 1980, the amount of that contract. Reimbursement for these excess costs after the first three years shall not be made until a certificate of need has been granted for the excess project costs. The provisions

of this section shall apply only to facilities which file an application for a certificate of need or make application for cost-overrun review of their original application or waiver after August 13, 1982.

197.710. No hospital shall refuse or fail to grant or renew staff privileges or condition staff privileges, based in whole or in part on the fact that the physician or a partner, associate, or employee of the physician is providing medical or health care services at a different hospital system or any other health care facility.

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

(1) "Covenantee", a physician licensed pursuant to this chapter that enters into a physician employment covenant not to compete;

(2) "Covenantor", a hospital as defined in section 197.020, RSMo, an ambulatory surgical center as defined in section 197.200, a health carrier as defined in section 376.1350, RSMo, or a physician group practice, however organized, that enters into a physician employment covenant not to compete;

(3) "Independent practice", the delivery of medical services by a physician which is not performed under the auspices of a contractual or other employment or investment arrangement with another hospital, ambulatory surgical center, health carrier or other organization that competes directly against the original covenantor;

(4) "Physician employment covenant not to compete", an agreement or part of a contract of employment in which the covenantee agrees for a specific period of time, not to exceed five years, and within a particular area to refrain from competition with the covenantor. An agreement or contract of employment shall not be deemed to be a physician employment covenant not to compete if it does not restrict the ability of the physician to establish an independent practice within the same geographical area after leaving the employ of the covenantor.

2. A physician employment covenant not to compete is enforceable if it:

(1) Is ancillary to or part of an otherwise enforceable agreement between the covenantee and covenantor;

(2) Includes provisions concerning the physician's right of access to a list of his or her patients treated prior to the physician's buying out or otherwise lawfully terminating the physician employment

covenant not to compete. Such access shall be subject to federal and state laws governing privacy of medical information;

(3) Provides access to medical records of the physician's patients upon written authorization of the patient. Copies of such medical records shall be made available in accordance with sections 191.227 and 191.233, RSMo;

(4) Includes provisions for the physician to buy out the covenant not to compete by compensating the covenator for the remaining amortized cost of recruitment, investments, remuneration and other expenses incurred pursuant to the contract. Such provisions of the contract shall identify the costs of recruitment, investments, and remuneration at the time of the contractual agreement. However, the costs may be amended by agreement of the parties; and

(5) Permits the physician to provide continuing care and treatment to a specific patient or patients during the course of an acute illness which continues after the contract or employment has been terminated. This subdivision shall not supersede the requirements of section 354.612, RSMo, for health carriers.

3. Medical records described in subdivision (3) of subsection 2 of this section shall be provided in the format that such records are maintained except by mutual consent of the parties to the physician employment covenant not to compete.

4. This section shall apply only to a physician employment covenant not to compete initially entered into on or after January 1, 2007.

334.115. 1. Before a physician licensed under this chapter refers an individual to a health care facility in which the physician has an ownership interest or refers an individual to a hospital licensed under chapter 197, RSMo, where the physician is employed, the physician must disclose to the individual in writing the following:

(1) The physician's ownership interest in the health care facility or employment status with the licensed hospital; and

(2) The individual's right to be referred to another health care facility or hospital.

2. The individual shall acknowledge receipt of the notice required under this section by signing the notice. The physician shall keep a copy of the signed notice.

3. The required disclosure under this section does not apply if a delay in treatment caused by the compliance with the requirements of subsection 1 of this section would reasonably be expected by the referring physician to result in the following:

(1) Serious jeopardy to the individual's health;

(2) Serious impairment to the individual's bodily functions; or

(3) Serious dysfunction of a bodily organ or part of the individual.

4. For purposes of this section, "ownership interest" shall have the same meaning as it is defined in subsection 2 of section 197.125, RSMo. "Health care facility" means an organization or a business licensed under sections 197.200 to 197.240, RSMo.

5. Violations of the provisions of this section shall subject the license of the physician to disciplinary action under section 334.100.

[197.366. The provisions of subdivision (8) of section 197.305 to the contrary notwithstanding, after December 31, 2001, the term "health care facilities" in sections 197.300 to 197.366 shall mean:

(1) Facilities licensed under chapter 198, RSMo;

(2) Long-term care beds in a hospital as described in subdivision (3) of subsection 1 of section 198.012, RSMo;

(3) Long-term care hospitals or beds in a long-term care hospital meeting the requirements described in 42 CFR, section 412.23(e); and

(4) Construction of a new hospital as defined in chapter 197.**]**

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