COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 5244-02
Bill No.: HB 1793
Subject: Health Care; Medicaid; Medical Procedures and Personnel; Hospitals
Type: Original
Date: March 4, 2014

Bill Summary: This proposal changes various health care and MO HealthNet program provisions.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
General Revenue	(Could exceed $54,627,996)	(Could exceed $59,209,817)	(Could exceed $60,364,404)
Total Estimated Net Effect on General Revenue Fund	**(Could exceed $54,627,996)**	**(Could exceed $59,209,817)**	**(Could exceed $60,364,404)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
Insurance Dedicated	Up to $15,000	$0	$0
Various Other State Funds	(Unknown, greater than $16,239,184)	(Unknown, greater than $20,584,867)	(Unknown, greater than $21,411,117)
Total Estimated Net Effect on Other State Funds	**(Unknown, greater than $16,224,184)**	**(Unknown, greater than $20,584,867)**	**(Unknown, greater than $21,411,117)**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 49 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
Federal	(Unknown, greater than $23,195,155)	(Unknown, greater than $46,415,310)	(Unknown, greater than $46,415,310)
Total Estimated Net Effect on All Federal Funds	**(Unknown, greater than $23,195,155)**	**(Unknown, greater than $46,415,310)**	**(Unknown, greater than $46,415,310)**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
General Revenue	4.5	4.5	4.5
Federal	1.5	1.5	1.5
Total Estimated Net Effect on FTE	**6**	**6**	**6**

☐ Estimated Total Net Effect on All funds expected to exceed $100,000 savings or (cost).

☒ Estimated Net Effect on General Revenue Fund expected to exceed $100,000 (cost).

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
Local Government	**(Unknown, greater than $60,500)**	**(Unknown, greater than $121,000)**	**(Unknown, greater than $121,000)**

FISCAL ANALYSIS

ASSUMPTION

§105.711 - State Legal Expense Fund

Officials from the **Office of Administration (OA) - General Services Division (GS)** state 105.711.2.3(d) has the potential for minor additional cost to the Legal Expense Fund.

Section 105.711.2.3(g) provides that the MO HealthNet pilot project will initially cover at least 10% of the current MO HealthNet recipient adjusted population; however, without action by the General Assembly, coverage will expand to 100% of participants by July 1, 2018. This would extend medical malpractice coverage up to $500,000 per occurrence to all participating physicians providing services to MO HealthNet program participants. This could result in significant costs to the Legal Expense Fund.

Officials from the **Office of Attorney General (AGO)** state the proposal would add "any physician licensed under chapter 334 who is under contract to provide medical care to participants in the MO HealthNet pilot project established under section 208.188" to the list of entities covered by the state legal expense fund (LEF). The AGO is responsible for providing legal defense to the LEF, including when necessary, litigating legal claims which could result in a judgment against the LEF. The AGO assumes that the addition of this group to the scope of LEF coverage would result in additional claims against the fund. In addition to the costs to the state in LEF funds, the AGO would provide additional legal defense for the Fund. However, the number and nature of such claims are unknown. Therefore, costs to the state are unknown but could exceed $100,000. If significant cases result from the proposal, AGO may seek an additional future appropriation to handle the defense of the claims.

Oversight assumes because the potential for litigation is speculative that the AGO will not incur significant costs related to this proposal. If a fiscal impact were to result, the AGO may request additional funding through the appropriations process.

Officials from the **Department of Mental Health (DMH)** anticipates the provisions of section105.711 will have no fiscal impact on the DMH.

§173.228 - Medical Scholarship Awards

Officials from the **Department of Higher Education (DHE)** state this proposed program does not duplicate, but is very similar to the Primary Care Resource Initiative for Missouri (PRIMO) program already in operation within the Department of Health and Senior Services.

HWC:LR:OD

ASSUMPTION (continued)

DHE provides that because the program does not mandate the appropriation or dispersal of loan and scholarship funds to anyone, this fiscal impact statement does not include any cost related to the loans or scholarships. However, if the program were to be fully funded/utilized, the following are the estimated costs:

Based on information from U.S. News and World Report, the 2013 enrollment at the University of Missouri Medical School was 401 students and the enrollment at the Washington University School of Medicine was 478. DHE assumes a full 20 percent of the student body, as allowed by the statute, would opt to receive the loans and that the allowed costs would total $54,000 and $75,000 respectively. Based on those assumptions the total annual cost for the loan portion of the proposal could be as high as $11,445,000. [(401 students X 0.20 = 80 students X $54,000 = $4,320,000)] + [(478 students X 0.20 = 95 students X $75,000 = $7,125,000)]; ($4,320,000 + $7,125,000 = $11,445,000). The DHE assumes loan repayment and forgiveness would not occur during the first two years of the program. Once the repayments begin, those funds would reduce the demand on other sources of revenue to support this program component.

The scholarship component is limited to five percent of the student body, which would be 44 (401 + 478 = 879 X 0.05 = 44 rounded). If it is assumed all applicants would all receive the maximum award of $5,000, the cost for this component could be as high as $220,000.

The fiscal impact does assume that the DHE would need one additional FTE to adequately administer both the scholarship and the loan/loan forgiveness components of the program. This is due to the fact that loan/loan forgiveness programs are administratively difficult requiring the collection of substantial information, monitoring individual work and education history over time, providing timely and appropriate disclosures as required by federal regulatory agencies, and ensuring loan payments and forgiveness are handled appropriately.

The DHE estimates FY15 costs to the General Revenue Fund of $42,040; FY16 costs of $50,952; and FY17 costs of $51,463.

Officials from the **OA - Information Technology Services Division (ITSD)** state section 173.228 would create within the DHE the "Board of Medical Scholarship Awards" and would require a tracking system be developed for the DHE. This would include an online application, production and tracking of lending documents, management of award eligibility determination, distribution, returns, and similar reporting to other current programs administered in the Financial Assistance for Missouri Undergraduate Students (FAMOUS) Applications. This system would need to address activities related to administering the loan repayment determination, collections for defaulted loan satisfaction, or any data collection and distribution related to those activities with a third party loan servicer. This system would be developed using contract developers at an estimated cost of at least $500,000 from the General Revenue Fund.

ASSUMPTION (continued)

Officials from the **AGO** state this section of the proposal would create certain new scholarships and student loans, subject to various terms. If those terms are not met, the newly created Board of Medical Scholarship Awards can refer the matter to the AGO who must then seek collection. As the number of defaults on repayment of loans are unknown, the costs of these collections efforts are unknown. AGO assumes that costs are not likely to exceed $100,000, and may seek an additional appropriation to handle the additional caseload.

Officials from the **Department of Health and Senior Services (DHSS)** state that although this program does not duplicate the Primary Care Resource Initiative for Missouri (PRIMO) program, it is very similar (§§191.441 and 191.500 - 191.614, RSMo).

Officials from the **DMH** anticipate the provisions of 173.228 will have no fiscal impact on the DMH.

§191.875 - Health Care Cost Estimates

Officials from the **Department of Social Services (DSS) - MO HealthNet Division (MHD)** state MO HealthNet has most procedure fees currently available on the web. MO HealthNet may receive more calls at the participant and provider call centers if help is needed to interpret the fee schedules, but it is anticipated that this could be handled with current staff. Therefore, there is no fiscal impact to MO HealthNet from this section.

Officials from the **DMH** assume the provisions of section 191.875 would be absorbed within the existing administrative functions of DMH providers; therefore, the DMH anticipates no fiscal impact.

§197.170 - Health Care Cost Reduction and Transparency Act and Most Common Admissions

Officials from the **DHSS - Division of Community and Public Health (DCPH)** state it is assumed that the costs of healthcare reported by the healthcare facilities will be captured by a web-based data application developed by Office of Administration - Information Technology Services Division (OA-ITSD) and that the application will have query capability to provide ad hoc reports for periodic (e.g., quarterly) or annual reports needed for public dissemination. Given the time-sensitive nature of the reporting requirements, the Bureau of Health Care Analysis and Data Dissemination (BHCADD) assumes that this application would be a hands-on resource and data tool developed for, and residing in, the BHCADD to enable them to have ready access to the data for querying. Database support would also be needed from ITSD.

ASSUMPTION (continued)

The BHCADD would be tasked with identifying the 100 most common Diagnostic Related Group (DRG) categories for hospitals, the 20 most common surgery procedures, and 20 most common imaging procedures for outpatients and ambulatory surgical centers. Confidentiality rules will have to be developed and implemented to ensure that individuals cannot be identified in violation of the Health Information Portability and Accountability Act (HIPAA) or other federal law. The BHCADD may be asked to identify any under-reporting by the facilities; validate the accuracy of the information reported; and/or provide technical assistance with any statistical trend or comparison analysis of the data.

To perform BHCADD activities in accordance with the above assumptions, BHCADD will need one FTE Research Analyst III ($39,984 annually). This position would work with OA-ITSD to develop an application to collect the information to support this legislation, create reports on the information identified in this proposal, and maintain the system each year. The analyst would be responsible for compiling, cleaning, and editing the iterative quarterly files of cost data to conduct the reports for publication on the DHSS website. The analyst would prepare and run computer queries to perform the analysis on the various files. In addition, the analyst would provide any needed technical assistance or consultation on trend and/or comparison analysis that may be requested. The analyst would also be involved in developing and maintaining the confidentiality standards for reporting the cost data on the public site. Furthermore, the analyst would handle any inquiries related to the healthcare cost data.

DHSS estimates total General Revenue (GR) expenditures for this section of the proposal for FY15 to be $67,567; FY16 to be $74,374; and FY17 to be $75,315.

DHSS officials assume OA-ITSD support would be necessary to build an online application to support the data collection and reporting requirements of the Health Care Cost Reduction Transparency Act. Data will be collected from both hospitals and ambulatory surgical centers in a format yet to be determined. For the purpose of this fiscal note estimate it has been assumed that data will be submitted via a secure online application to be reported on the department's internet website.

ASSUMPTION (continued)

The following costs will apply:

COST CATEGORY	FY 15	ONGOING
Information Technology Specialist II – This position will provide project management for the project.	0.5 FTE	0.125 FTE
Information Technology Specialist I – This position will provide business analysis and technical support services for the project.	0.5 FTE	0.25 FTE
Information Technology Specialist II – This position will provide application architecture, programming and support of the application.	0.5 FTE	0.125 FTE
Information Technology Specialist I – This position will provide programming and support of the application.	1 FTE	0.5 FTE
TOTAL	2.50 FTE	1.00 FTE

Estimated OA-ITSD costs to GR total $228,435 for FY15; $123,547 for FY16; and $125,384 for FY17.

Oversight notes OA-ITSD has provided a response for the total impact of this proposal on all agencies and systems. Oversight will use OA-ITSD's estimate of the fiscal impact.

Officials from the **DSS-MHD** state this section requires hospitals and ambulatory surgical centers to submit to the DHSS prices for the most common procedures. DHSS shall provide this information on its website in a manner that is easily understood by the public.

There is likely to be additional administrative costs to a hospital for gathering, compiling and transmitting the required information to DHSS in the required form, but the amount is unknown. MO HealthNet bases hospital reimbursement for a given year on the fourth prior year cost report. Since the first reporting requirement is effective beginning with the quarter ending June 30, 2015, the additional cost would begin to be reflected in 2014 or 2015 cost reports. MO HealthNet would use 2014 cost reports to establish reimbursement for SFY18. Therefore, there would not be a fiscal impact to the MO HealthNet Division for FY15, FY16, and FY17 but starting FY18 there could be additional costs, but the amount is unknown.

Officials from the **DMH** provide that DMH state-operated hospitals are currently not subject to the provisions of chapter 197 licensure requirements. Therefore, the proposal has no anticipated fiscal impact.

ASSUMPTION (continued)

Officials from the **OA-ITSD** state ITSD support will be necessary to build an online application to support the data collection and reporting requirements of the Health Care Cost Reduction Transparency Act. Data will be collected from both hospitals and ambulatory surgical centers in a format yet to be determined. For the purpose of this estimate it has been assumed that data will be submitted via a secure online application to be reported on the department's internet website.

§197.305 - Capital Improvements/Major Medical Equipment

Officials from the **DHSS - Division of Regulation and Licensure (DRL)** state section 197.305(6)(a) increases the expenditure minimums for capital improvements and major medical equipment related to beds in existing or proposed health care facilities licensed pursuant to chapter 198 and long-term care beds in a hospital. This change would likely reduce the number of applications to be reviewed by the Missouri Health Facilities Review Committee. Based on an analysis of program data from state fiscal year (SFY) 2013, two projects with fees totaling $2,000 would not have been reviewable under the revised criteria.

Officials from the **DSS-MHD** state this section requires hospitals and ambulatory surgical centers to submit to the DHSS prices for the most common procedures. DHSS shall provide this information on its website in a manner that is easily understood by the public.

There is likely to be additional administrative costs to a hospital for gathering, compiling and transmitting the required information to DHSS in the required form, but the amount is unknown. MO HealthNet bases hospital reimbursement for a given year on the fourth prior year cost report.

Since the first reporting requirement is effective beginning with the quarter ending June 30, 2015, the additional cost would begin to be reflected in 2014 or 2015 cost reports. MO HealthNet would use 2014 cost reports to establish reimbursement for SFY18. Therefore, there would not be a fiscal impact to the MO HealthNet Division for FY15, FY16, and FY17 but starting FY18 there could be additional costs, but the amount is unknown.

§197.315 - Certificate of Need

Officials from the **DHSS-DRL** state the proposal eliminates the requirement to obtain a certificate of need prior to developing or offering a new institutional health service that results in the creation of five or more new full-time jobs. It is not possible to quantify the impact that this change would have on the amount of fees collected by the Certificate of Need Program. The current Certificate of Need application process does not require the submission of information on potential job creation, the availability of health insurance to employees, or the source of insurance premium payment, so there is no historical data on which to base a projection.

ASSUMPTION (continued)

This section would also modify the amount of the application fee required from 'The application fee is one thousand dollars, or one-tenth of one percent of the total cost of the proposed project, whichever is greater' to 'The application fee is one thousand dollars.' Based on an analysis of program data from SFY13, application of this fee reduction criteria only would decrease application fees received from approximately $333,000 to $61,000.

Given that the highest fee amount collected in recent years was $440,402 in SFY11 and the DRL would anticipate that some amount of fees would continue to be collected, the DHSS assumes this proposal could result in an unknown loss of fee revenue to the General Revenue Fund of less than $400,000.

Because the Certificate of Need program has a staff of only two and there will continue to be proposed projects to review, as well as review of the information required to be submitted related to the creation of five jobs, DHSS assumes no reduction in staff.

Officials from the **DSS-MHD** state this section requires hospitals and ambulatory surgical centers to submit to the DHSS prices for the most common procedures. DHSS shall provide this information on its website in a manner that is easily understood by the public.

There is likely to be additional administrative costs to a hospital for gathering, compiling and transmitting the required information to DHSS in the required form, but the amount is unknown. MO HealthNet bases hospital reimbursement for a given year on the fourth prior year cost report.

Since the first reporting requirement is effective beginning with the quarter ending June 30, 2015, the additional cost would begin to be reflected in 2014 or 2015 cost reports. MO HealthNet would use 2014 cost reports to establish reimbursement for SFY18. Therefore, there would not be a fiscal impact to the MO HealthNet Division for FY15, FY16, and FY17 but starting FY18 there could be additional costs, but the amount is unknown.

§208.010 - Asset Limits

Officials from the **DSS - Family Support Division (FSD)** state the FSD has determined there would be a total of 8,174 new cases for the MO HealthNet for the Aged, Blind, and Disabled (MHABD) program(s) if the resource limits are increased as proposed. The FSD arrived at 8,174 new cases in this manner:

In state fiscal year (SFY) 13, the FSD rejected 7,433 MO HealthNet (MHN) applications due to resources. Of these rejected applications, 5,622 were rejected for all FSD MO HealthNet programs. The remaining 1,811 (7,433-5,622) cases were eligible for Qualified Medicare

ASSUMPTION (continued)

Beneficiary (QMB)/Specified Low-income Medicare Beneficiary (SLMB), which have higher resource limits, and are included in the QMB/SLMB population below. The FSD estimates that 1,005 of the 5,622 applications rejected for all FSD MO HealthNet programs would be eligible if the resource limit was increased.

In SFY13, the FSD closed 1,137 MO HealthNet for the Aged, Blind, and Disabled cases due to resources. Of these closed cases, 267 were not eligible for other MHN programs. The remaining 870 cases (1,137-267) were eligible QMB/SLMB and are included in the QMB/SLMB population below. The FSD estimates that 133 of the 267 cases closed and not eligible for other MHN programs would be eligible if the resource limit was increased.

The FSD would also see an increase in MHN eligibles from the QMB/SLMB population. In SFY13 there was an average of 4,025 QMB persons. Of these, 3,826 live alone and 199 live with a spouse. Of those living alone, 713 would be eligible if the resource limit was increased. Of those living with a spouse, 62 would be eligible.
Total new MHN cases from QMB: 713 + 62 = 775

In SFY13 there was an average of 10,798 SLMB persons. Of these, 9,059 live alone and 1,739 live with a spouse. Of those living alone, 915 would be eligible if the resource limit was increased. Of those living with a spouse, 210 would be eligible.
Total new MHN cases from SLMB: 915 + 210 = 1,125.

The FSD anticipates an increase in applications as the result of the increased resource limits. These applications would come from a previously unknown population who currently chooses not to apply due to the current resource limits. According to U.S. Census Bureau data, 51,364 uninsured Missouri individuals, age 19 or above, have a disability. If 10% of these individuals were to apply and be found eligible for MHN benefits, the FSD would see an increase of 5,136 (51,364 x 10%) new MHN cases as the result of the increased resource limits.

Total new cases:

1,005 (rejections)
133 (closings)
775 (QMB)
1,125 (SLMB)
5,136 (unknown population)
8,174 new MHN cases

HWC:LR:OD

ASSUMPTION (continued)

Section 208.010.2(6)
The FSD has determined there would be a total of 219 new cases for the Temporary Assistance (TA) program if the resource limits are increased as proposed. The FSD arrived at 219 new cases in this manner:

In SFY13, the FSD rejected 520 Temporary Assistance (TA) applications due to resources. The FSD estimates that 219 of these applications rejected would be eligible if the resource limit was increased as their resources at the time of rejection were above the current limit but below the proposed increased limit. The average TA grant for SFY 13 was $231 per family. Therefore, the FSD anticipates increased TA expenditures of $607,068 annually (219 cases x $231 x 12 months) as a result of this change. Currently, the TANF block grant is fully obligated, however not fully expended. If caseloads were to increase and TANF expenditures exceed the block grant, DSS-FSD would need additional General Revenue to meet the expenditures.

Officials from the **DSS-MHD** state the MHD expects a fiscal impact because of changes to the resource limits. Higher cost will result from one group of Medicaid eligibles who currently receive limited medical benefits but will receive full Medicaid benefits under this legislation. New eligibles are also expected to enter the Medicaid program because of the change in eligibility rules.

The populations that are being proposed for full medical assistance are Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB).

There are a total of 8,174 new cases. This includes 6,274 new cases (1,005 rejections + 133 closings + 5,136 unknown population), 775 QMBs, and 1,125 SLMBs.

The total costs for the new cases are:

FY 15 (10 months): $125,385,999 (Federal $79,112,296; GR $30,540,644; Other $15,733,059);
FY 16: $156,782,654 (Federal $98,922,016; GR $38,188,021; Other $19,672,617);
FY 17: $163,367,525 (Federal $103,076,740; GR $39,791,918; Other $20,498,867).

Officials from the **DSS - Division of Legal Services (DLS)** state 208.010 seeks to increase the resource limit for MO HealthNet benefits from $1,000 to $2,000 for single individuals and from $2,000.00 to $4,000.00 for married couples living together. Within DLS, only the Hearings Unit would be affected by the proposed changes. Because the proposed legislation increases the asset limit, the population of MO HealthNet participants should also increase. The MO HealthNet Division estimates this asset increase to result in 8,174 additional MO HealthNet participants. The DLS Hearings Unit anticipates that approximately 10 percent of MO HealthNet participants will request a DLS hearing. A DLS administrative hearing officer's caseload is presumed to be

ASSUMPTION (continued)

900 hearings per year. In FY 13 there were 18 hearing officers. Therefore, the estimated effect of this provision would be to add 45 hearings per year for each hearings officer (817 ÷ 18), or approximately one extra hearing per week. It is not expected that hearings would increase in such a way that current staffing levels could not effectively absorb. Thus, this provision appears to have a negligible fiscal impact on the DLS.

Officials from the **DHSS - Division of Senior and Disability Services (DSDS)** provide the following:

Section 208.010.2(4)
New Eligibles

For fiscal note purposes DSDS estimates 8,174 additional cases for MO HealthNet for Aged, Blind, and Disabled programs provided by the Department of Social Services (DSS), Family Support Division (FSD) to determine the number of additional individuals who would utilize MO HealthNet Home and Community Based Services (HCBS).

The utilization rate for MO HealthNet HCBS for by the Aged, Blind, and Disabled (ABD) population is 20.26 percent. Using this rate and a growth factor of 2.78 percent annually in HCBS participants, DSDS estimates that 1,656 additional individuals would utilize HCBS in FY15 (8,174 new cases X 0.2026 utilization rate = 1,656 Mo HealthNet HCBS cases); 46 additional individuals for a total of 1,702 in FY16 (1,656 X 0.0278 = 46 + 1656 = 1,702); and 47 additional individuals for a total of 1,749 in FY17 (1,702 X .02478 = 47 + 1,702 = 1,749).

MO HealthNet Home and Community Based Services (HCBS) Assessments and Reassessments

Prior to receiving HCBS, an eligible MO HealthNet must be assessed and authorized for services by a DSDS Adult Protective and Community Worker (APCW II) to determine HCBS eligibility, the Level of Care (LOC) required, and identify any unmet needs. Participants are then reassessed annually by APCW IIs to ensure services are still of the appropriate amount and type and care plans are adjusted as necessary.

Each initial assessment and annual reassessment takes approximately two hours to complete. Using this assumption, DSDS estimates it will need an additional two APCW II FTE to meet the demand for additional assessments. (1,656 new eligibles X 2 hours = 3,312 hours for initial assessments ÷ 2,080 = 1.59, rounded to 2.00 in FY15; [46 new eligibles X 2 hours = 92 hours for initial assessments] + [1,656 eligibles X 2 hours = 3,312 hours for reassessments] = 3,404 hours ÷ 2,080 = 1.64 FTE, rounded to 2 in FY16; [47 new eligibles X 2 hours = 94 hours for initial assessments] + [1,702 eligibles X 2 hours = 3,404 hours for reassessments] = 1.68 FTE, rounded to 2 in FY17).

ASSUMPTION (continued)

The personal services and expense and equipment are paid at the Medicaid administrative matching rate of 50 percent GR and 50 percent federal.

DSDS estimates personal service related expenditures for this section of the proposal to be $101,334 for FY15 (GR $50,667; Federal $50,667); FY16 total of $115,679 (GR $57,649; Federal $57,649); and FY17 total of $116,324 (GR $58,324; Federal $58,325).

MO HealthNet Home and Community Based Services (HCBS)

The estimated average cost per MO HealthNet HCBS participant for FY15 is $12,923. DSDS estimates the cost of HCBS services for FY15 for the additional 1,656 participants at $21,400,488 (1,656 X $12,923). Using an annual growth factor of 9.90 percent, DSDS estimates the FY16 costs for the 1,702 participants at $24,171,804 ($12,923 X .099 =$1,279 + $12,923 = $14,202 X 1,702 = $24,171,804); for FY17, costs for 1,749 participants would be $27,298,392 ($14,202 X .099 = $1,406 + $14,202 = $15,608 X 1,749 = $27,298,392).

MO HealthNet HCBS are reimbursed using the Federal Medical Assistance Percentage (FMAP). The blended FMAP rate for FY 15 is 36.905 percent GR and 63.095 percent federal.

Based on discussions with **DSS** officials, **Oversight** is assuming that HCBS expenditures for the new group of eligibles due to the asset limit increase provided by DHSS has been included DSS' fiscal note response. If this assumption is not correct, it would add approximately $21.4 million to the total FY15 impact, $24.1 million to the FY16 total impact, and $27.3 million to the FY17 total impact.

Officials from the **DMH** provide that section 208.010 increases the available asset limit for persons age 65 and over and persons with disabilities to $1,999.99 for single individuals and $4,000 for married couples. The Department of Social Services (DSS) estimates this would add 8,174 new eligibles to the MO HealthNet program. DMH estimates 314 of these newly eligible currently receive community psychiatric rehabilitation (CPR) services and 92 receive substance abuse treatment as non-Medicaid consumers at an annual cost of approximately $318,400. Covering these consumers under MO HealthNet would allow DMH to re-direct state funds currently used for the services to provide additional CPR and substance abuse treatment. There also will be additional individuals with substance use disorders or serious mental illness who would qualify due to the increased asset limit. Costs for CPR and Comprehensive Substance Treatment and Rehabilitation (CSTAR) for the additional individuals and the current DMH consumers moving to MO HealthNet are included in the DSS estimate. This section also increases the asset limit for the temporary assistance for needy families (TANF) cash assistance program, which has no impact on DMH.

ASSUMPTION (continued)

Officials from the **OA-ITSD** state section 208.010.2(4) would require changes to the Family Assistance Management Information System (FAMIS system) of the Department of Social Services. It is projected that it will take 38 hours to complete the changes. All effort associated with these changes will be completed in FY15 (no impact beyond 2015).

Match rate for FAMIS is 50% GR and 50% Federal.

§208.187 - MO HealthNet Patient-Centered Care Act

Officials from the **DMH** provide that section 208.187 of the proposal creates the "MO HealthNet Patient-Centered Care Act of 2014". This proposal creates pilot project areas beginning July 1, 2015 in which current MO HealthNet recipients in the pilot project areas are transferred to an approved health plan arrangement which is composed of individual health savings accounts. The health savings accounts are to be used to purchase a high deductible health insurance plan and health care services. Unless repealed, the pilot project will be implemented on a statewide basis for all MO HealthNet recipients effective July 1, 2017.

To maximize available coverage options, the proposed language requires the MO HealthNet Division (MHD) to approve any health plan arrangement that offers coverage that is at least equal to coverage required for a catastrophic plan under 42 U.S.C. 18022(e). It is unclear if this requirement covers all services provided under current Medicaid covered services, and specifically DMH Community Psychiatric Services (CPR), Comprehensive Substance Treatment and Rehabilitation (CSTAR), and Developmental Disability (DD) services. DMH assumes the plans would provide mental health services and substance abuse treatment, but it is unknown if it is to the same extent that DMH clients currently receive those services under Medicaid. It is unclear if recipients would be allowed to purchase these services with the funds in the health savings account if not covered by the health plan, or if these services would be carved out and provided as a wrap-around benefit. If DMH participants are required to receive these services through a health plan, DMH will lose its funding mechanisms and the fiscal impact is a cost of $51 million ($6 million General Revenue and $45 million Federal Funds).

The proposed language also requires MHD to contract for an interoperable data analytics platform to analyze clinical data for traditionally challenging populations. MO HealthNet providers are required to participate in this system. As a MHD provider, DMH will have to come into compliance with this system. The anticipated fiscal impact of changing DMH current reporting systems to comply with new MHD reporting system is unknown.

The proposed language creates the "MO HealthNet Health Savings Account Trust Fund". DMH anticipates no fiscal impact.

HWC:LR:OD

ASSUMPTION (continued)

Officials from the **DSS-MHD** state this legislation does not specifically mention behavioral health and substance abuse providers. Therefore, it is unclear if behavioral health and substance abuse services will be covered in the pilot project.

This pilot project shall be supported by a health management and population analytics system that must have the ability to interoperate using accepted industry standards, provide a member portal, allow for real-time patient queries, have the ability to create condition-specific registries for managing populations, provide predictive modeling and communicate between various systems. MO HealthNet estimates that this system will cost $20 million.

MO HealthNet does not currently have the ability to administer a Health Savings Account (HSA) and, therefore, assumes that there would be an additional unknown cost greater than $100,000 to administer the HSA. MO HealthNet further assumes, that until they develop experience with this program, they will continue to incur the same costs for persons in the HSA.

MO HealthNet assumes that participants in the HSA program will utilize funds from their account to pay for services. Since MO HealthNet will not be paying the provider directly, this section will have an unknown affect on the ambulance, hospital and pharmacy provider taxes. MO HealthNet shall provide quarterly reports detailing participants, amount of government assistance, transfer savings and grant moneys. MO HealthNet shall also produce an annual report detailing demographics, provider and recipient participation and cost of the pilot project. MO HealthNet may contract with an outside entity for these reports. The cost of the quarterly and annual reports could be $100,000 or more per report but will depend on the complexities of the compilation and analysis of the data.

FY15: unknown > $20,600,000 (GR unknown >$5,300,000; Federal unknown > $15,300,000);
FY16: unknown > $600,000 (GR unknown >$300,000; Federal unknown > $300,000); and,
FY17: unknown > $600,000 (GR unknown >$300,000; Federal unknown > $300,000).

§208.188 - Pilot Project for EBT Delivery of Services

Officials from the **DSS-FSD** state based on a preliminary estimate from the FSD's current Electronic Benefit Transfer (EBT) contractor, the first year costs for development and implementation would be at least $1.5 million. Ongoing costs are estimated to be at least $50,000 per month or $600,000 per year. Both the first year costs and the ongoing costs are dependent on the number of participants as well as a number of currently unknown factors. Therefore, the FSD estimates the cost to implement this section to be unknown but greater than $1.5 million for the first year and unknown but greater than $600,000 for the second and subsequent years.

HWC:LR:OD

ASSUMPTION (continued)

Officials from the **DSS-MHD** state this legislation states beginning July 1, 2015, subject to appropriations, the MHD shall establish a pilot project which implements an electronic benefit transfer (EBT) payment system for receipt of MO HealthNet services by participating recipients.

MO HealthNet would incur cost if this proposed legislation were enacted. The costs below assume the U.S. Department of Health and Human Services approves the necessary waivers to implement this legislation and the necessary funding is appropriated.

208.188.5: Any willing provider for the pilot project shall be reimbursed for services provided to pilot project recipients at a rate of 100% of the Medicare reimbursement rate. In FY14 MO HealthNet paid 56.72% of the Medicare rate for the following services: ambulance, audiology, dental, durable medical equipment, optical, physician and rehab center therapy. The cost to increase these services to 100% of Medicare reimbursement would be $256.5 million. If the pilot project included 10% of the MO HealthNet population, the cost would be $25.6 million. This cost does not include hospital or pharmacy cost so the cost shown is unknown greater than $25.6 million annually. The proposed legislation begins July 1, 2015. If the FY14 cost is inflated by 2.9% annually, the FY15 cost would be unknown greater than $26.4 million.

208.188.6 and .7: Pilot project recipients shall receive a prepaid EBT card to pay for MO HealthNet services. The MHD shall determine the amount credited to the EBT card. Providers shall be required to swipe a recipient's EBT card for every visit or service received. MO HealthNet assumes this function would be contracted and this cost is included in the Family Support Division response.

These sections of the legislation would also require system modifications to integrate the EBT cards and information about the visit or service into MO HealthNet's Medicaid Management Information System (MMIS system). The following are some system requirements: modifications to calculate and track the amount credited to each participant's EBT card; setting up payments to the EBT vendor to fund the EBT cards; addition of new medical eligibility codes to track participants in the EBT program; modifications to financial reporting; modifications to receive and process encounter data from the EBT vendor and/or providers and price using the Medicare fee schedule and potentially verifying amount expended against the original amount credited; modifications to process the participant's claims after the participant has exhausted their EBT card. The estimated cost for these system modifications would be unknown but could be greater than $3.0 million. This would be a one-time cost and would occur in FY16. The match rate for these expenditures would be 75% federal.

ASSUMPTION (continued)

208.188.8: Any remaining balance on a recipient's EBT card at the end of the benefit year shall be apportioned. At the beginning of the EBT pilot project MO HealthNet may see an unknown increase in cost to pay for the incentives until participant behavior is modified. Since the legislation begins July 1, 2015 there is no fiscal impact for FY 2015.

FY16: Total cost is unknown > $30,160,098 (GR > $10,773,434; Federal > $19,386,664)
FY17: Total cost is unknown > $27,947,741 (GR > $10,314,114; Federal > $17,633,627)

Officials from the **DMH** provide that section 208.188 establishes a pilot project to implement an electronic benefit transfer (EBT) for MO HealthNet services; however, this section does not apply to aged, blind, and disabled recipients. It allows participants to choose the method of delivery of the MO HealthNet benefits through direct pay to the provider, a health insurance plan, managed care plan, health services plan, health savings account, or any other available health care product providing benefits and payment for services.

- DMH is the provider of behavioral health services for certain MO HealthNet benefits such as CPR and CSTAR as approved in the Medicaid State Plan. The Community Mental Health Centers (CMHC) are the DMH subcontractors for these services; therefore, it is unknown how the direct pay to the CMHC provider would impact the DMH and its subcontractors.

- For participants choosing a health insurance plan, managed care plan, health services plan, or health savings account, the existing managed care contracts provide the following DMH services on a fee-for-service basis when provided by a DMH certified provider: Community Psychiatric Rehabilitation, Comprehensive Substance Abuse Treatment and Rehabilitation, Targeted Case Management, and Developmental Disabilities waiver services. Based on previous proposed language within the proposal, it is unknown if DMH CPR and CSTAR services would continue to be carved-out of the health plan benefit package; therefore, the fiscal impact to DMH is unknown.

- The proposed language also requires the EBT system to provide reimbursement of any willing providers at a rate of 100% of the Medicare reimbursement rate. It is unclear if this affects the DMH CPR and CSTAR services; therefore, DMH assumes that CPR and CSTAR providers would be paid at 100% of Medicare. DMH anticipates a fiscal impact Unknown > $100,000.

ASSUMPTION (continued)

Oversight assumes the potential fiscal impact of reimbursing CPR and CSTAR providers at 100% of the Medicare reimbursement rate will be greater than $100,000 for each the General Revenue Fund and Federal Funds. Oversight also assumes an Unknown to (Unknown) impact on the direct pay to CMHC providers. Based on DMH's response to Section 1 of the proposal, Oversight assumes CPR and CSTAR services will be carved-out of managed care and that the provisions of this section will have no fiscal impact on the CPR and CSTAR programs.

Officials from the **OA-ITSD** state section 208.188 would require changes to systems of the DSS. The majority of the changes would be required to Medicaid Management Information System (MMIS system) of to track the recipients in the pilot, amounts on the EBT cards issued, services received and paid with the EBT card.

FAMIS Estimates:

Medical History as such is not captured during the Family Assistance Management Information System (FAMIS) application intake process - except for disability, ophthalmology details etc. ITSD would have to build a new screen or screens based on the degree of medical history details needed as well as for the preexisting conditions and 'lifestyle choices'. This proposal also talks of other relevant factors as determined by the division which ITSD is not aware of today.

Age is the only factor from this list already being captured during the FAMIS application intake process.

This all will need to be done with little or no impact to existing functionality of other benefit programs in FAMIS.

Analysis/Design/Create/Modify Specs	100 hours
Build 5-8 new screens	1280 hours
Database changes	40 hours
Batch program to relay information to MHD	160 hours
Testing	160 hours
Total	1740 hours

Match rates for FAMIS Food Stamps is 50% GR and 50% Federal.

ASSUMPTION (continued)

MHD Estimates:

The medical history and eligibility information collected by FAMIS would be passed to Medicaid Management Information System (MMIS) through the MHD systems.

Analysis/Design/Create/Modify Specs	80 hours
Coding	120 hours
Testing	40 hours
Total	240 hours

Match rates is 50% GR and 50% Federal.

EBT Estimates:

This proposal would require modifications to the Electron Benefit Transfer (EBT) system to add Medicaid information and pass to the EBT vendor.

Analysis/Design/Create/Modify Specs	80 hours
Coding	200 hours
Testing	200 hours
Implementation	20 hours
Total	500 hours

Match rates is 50% GR and 50% Federal.

§208.325 - Asset limit changes

Officials from the **DSS - FSD** state section 208.325.9 will have no fiscal impact on the FSD.

Due to the change in organization structure and the new eligibility system, the FSD assumes existing staff will be able to maintain any changes in applications and caseload sizes as a result of the changes proposed under Section 208.010.2(4) and (6).

HWC:LR:OD

ASSUMPTION (continued)

The FSD assumes existing Central Office Program Development Specialists in the Policy Unit will be able to complete necessary policy and/or forms changes.

The FSD assumes OA-ITSD will include the FAMIS/Missouri Eligibility Determination and Enrollment System (MEDES) programming costs for the system changes needed to implement provisions of this proposal in their fiscal note response.

§208.440 - Managed Care Organization (MCO) Utilization, Access, and Spending Data

Officials from the **DSS-MHD** state this legislation requires that Managed Care Organizations (MCO) provide certain information to MO HealthNet regarding encounters with Managed Care participants. Currently, the MCOs provide encounter data for all services provided by patient, claim and procedure code. Under the Managed Care delivery model the MCO may make sub-capitated payments based on a per member per month (PMPM) rate, global payments, or payments based on a fee schedule to providers. The sub-capitated or global payments cover all of the care provided by the provider regardless of the number or nature of the services required in a specified contract. Therefore, similar to other state Medicaid programs, sub-capitated payments are not fully identifiable at the patient, claim and procedure code level. The proposal requires the data provided to MO HealthNet be in the form of all payments made to providers by patient, claim and procedure or service. The encounter data for payments made on a fee schedule includes the information required under this proposal. However, the encounter data for the sub-capitated or global payments cannot include the payment information due to the MCOs' reimbursement methodology.

MCOs may need to revise the manner in which they pay providers and how the payment is documented. This revision may create an increase in the cost of doing business for the MCOs and lead to rate increases to the MHD. In order to determine if the rates will need to be increased an actuarial analysis will be needed.

The actuarial analysis would need to occur in the first month of the first year and is a one-time cost. The cost of the analysis will depend on the complexity of the changes. This cost is unknown but may be as high as $100,000. Since this is an administrative cost there will be a 50% federal match rate.

If the actuary requires an increase in capitated rates to ensure actuarial soundness, the cost to MO HealthNet is unknown. Normally, these additional costs would occur in the second and third years, but since the required date of implementation is December 31, 2014, any rate increase would occur for dates of service in the first year (FY15).

ASSUMPTION (continued)

Contract amendments will need to be written for each MCO and approved by the Centers for Medicare and Medicaid Services (CMS). The contract amendments must be submitted to CMS by September 30, 2014. Upon receipt, CMS has 90 days to approve the contract amendments. After signing the contract amendments, the MCOs are given 60 days to make system changes.

The MHD will need additional staff to set-up and maintain a process for receiving, storing, compiling, manipulating, analyzing and possibly reporting the data. The proposal requires that the data be provided on a quarterly basis. There are about 2.1 million managed care encounter claims each quarter. The MHD will need one additional Auditor I/II ($34,092 annually) to handle this process. The Auditor I will promote to an Auditor II in the third year. There will also be associated equipment and expense costs for the Auditor.

FY15 total cost: Unknown > $250,752 (GR > $112,281; Federal > $138,471);
FY16 total cost: Unknown > $154,573 (GR > $63,720; Federal > $90,853); and,
FY17 total cost: Unknown > $168,894 (GR > $70,392; Federal > $98,502).

Oversight assumes, for fiscal note purposes, that the FTE Auditor related expenditures will have a federal match rate of 50%.

Officials from the **DMH** state section 208.440 applies to MO HealthNet managed care utilization, access, and spending data reported to MO HealthNet Division. There is no fiscal impact to DMH.

§208.955 - Repeal of MO HealthNet Oversight Committee

Officials from the **DSS-MHD** state MO HealthNet pays the cost of the oversight committee meetings. In FY13, the cost for these quarterly meetings was $3,775. It is estimates in FY15, FY16 and FY17 the costs would remain the same.

§§334.035 through 334.735 - Assistant Physician Licensing

Officials from the **Department of Insurance, Financial Institutions and Professional Registration (DIFP)** state the provisions of this proposal do not set up a fund or statutory authority for charging fees for the licensure of assistant physicians (APs). The legislation requires the Board of Registration for Healing Arts to license APs.

The Board will need to receive funding from the General Revenue (GR) Fund in order to license these individuals.

HWC:LR:OD

ASSUMPTION (continued)

The DIFP states, based on projections from the Executive Director of Healing Arts, that it is estimated that 121 individuals in the state of Missouri will be required to be licensed. In addition, a 3 percent growth rate has been estimated.

It is assumed the Board will need 1 FTE Processing Technician I ($23,640 annually) to provide technical support, process applications for licensure, and respond to inquiries related to the licensure law and/or rules and regulations.

Printing and postage expenses for the first year include printing of rules, applications, letterhead and envelopes, as well as costs for mailings associated with initial licensure. Estimated FY15 printing and postage costs total $1,513; subsequent year's printing and postage costs, based on a board of similar size, are estimated to be $547 annually.

A licensure system will have to be implemented the first year. Costs include design, program development and implementation. Total one-year costs fro the licensure system are estimated to be $540.

The legislation does not provide any guidelines for processing, responding to, and investigating complaints and gives no authority to the board to handle complaints. Therefore, no enforcement costs have been figured for the fiscal note.

Boards within the division incur division-wide expenses based on specific board licensee averages in addition to the department cost allocation plans. The DIFP notes these expenses are based on a board of similar size and will not require additional appropriation for the PR Transfer Department of Corrections budget. However, the estimated $755 in additional annual expenses will be considered in calculating the anticipated license and renewal fees.

This legislation does not set up a source of revenue. It is assumed that without the authority to charge fees to the licensees, that funding would need to come from GR to pay for the expenses related to licensure.

The DIFP estimates total FY15 costs to the GR Fund of $41,037; FY16 costs of $38,632; and FY17 costs of $39,055.

Oversight assumes costs associated with the allocation of department-wide costs to the Board of Registration for Healing Arts for the licensure of APs will reduce the costs allocated to other boards and is not including these costs in the total AP licensure costs charged to GR.

ASSUMPTION (continued)

Officials from the **DSS-MHD** state this legislation is similar to current federal regulations. Rural Health Clinics can now employ Physician Assistants and Nurse Practitioners who are under a physician's supervision. It is anticipated that this will have no fiscal impact on MO HealthNet.

Officials from the **DMH** state section 334 proposes to consider an assistant physician providing primary care services as a physician assistant. DMH does not provide primary care services; therefore, there is no fiscal impact to DMH.

§§334.735 and 354.535 - Prescription Copays

Officials from the **DSS-MHD** state this language does not revise Chapter 208, RSMo, therefore, it does not affect MO HealthNet eligibility or benefits. Pharmacy benefits were carved out of the MO HealthNet Managed Care health plans as of October 1, 2009; therefore, these provisions also will not affect the health maintenance organizations that provide benefits to MO HealthNet participants.

§§376.393 and 376.1425 - Any Willing Provider

Officials from the **Missouri Consolidated Health Care Plan (MCHCP)** state they do not currently have a primary source of research to determine the fiscal impact of this legislation. However, a search of the literature indicates a probable fiscal impact as demonstrated in other studies. Research indicates any will provider laws have increased the cost of health care by varying degrees.

The Federal Trade Commission's Office (FTC) of Planning, Bureau of Competition and Bureau of Economics have noted concern that any willing provider laws lead to higher prices and fewer choices for health care consumers. In a letter to state officials in Rhode Island, the FTE cited a study found in the Journal of Health Economics (2001) that indicated states with highly restrictive any willing provider/freedom of choice laws spent approximately 2 percent more on health care than did states without such policies.

An industry-sponsored study conducted by Milliman predicts a 1.5 to 2.7 percent increase in overall health care costs for the state of Missouri. Research also indicates the impact to pharmacy costs is likely greater than medical costs. An International Atlantic Economic Society study predicts a 3.9 percent increase for medical expenses and a 6.4 percent increase for prescription drug expenses.

ASSUMPTION (continued)

MCHCP contracts with vendors whose provider networks are subject to these laws, so MCHCP assumes this legislation will have an impact on its health care expenditures. MCHCP assumes it will be required to pay increased administrative fees from health carrier vendors to cover the cost of negotiating, credentialing and servicing additional providers. MCHCP also assumes a decrease in the level of discounts provided by its vendors due to a vendor's inability to selectively contract. MCHCP assumes the impact to its medical plans may be less compared to plans with more limited networks because MCHCP networks include a substantial number of providers.

Based on these assumptions, MCHCP applied a conservative estimate of a 1.5 percent increase in overall health care costs, including prescription drugs, to calculate a fiscal impact. The fiscal impact to MCHCP is "unknown, but greater than $5.7 million annually". The fiscal impact to state employees and retirees is estimated at $1.8 million annually. For MCHCP's public entity membership, the annual fiscal impact of this legislation is "unknown, but greater than $121,000".

Oversight notes the actual cost of the provisions of section 376.393 to the MCHCP is greater than $7.5 million. However, the MCHCP will only receive reimbursement from the state in an amount of approximately $5.7 million. The additional $1.8 million needed by MCHCP will be received from state employees and retirees by way of increases in the share of insurance premiums. For fiscal note purposes, Oversight will present MCHCP's costs as "unknown, greater than $5.7 million" split between General Revenue, Federal, and Various Other State Funds.

Oversight assumes the provisions of this proposal would become effective January 1, 2015 and will, therefore, reflect six months of impact in FY15.

Officials from the **DIFP** state sections 376.393 and 376.1425 would require insurers to submit amendments to their policies to comply with the legislation. Policy amendments must be submitted to the department for review along with a $50 filing fee. The number of insurance companies writing these policies in Missouri fluctuates each year. One-time additional revenues to the Insurance Dedicated Fund are estimated to be up to $15,000.

Additional staff and expenses are not being requested with this single proposal, but if multiple proposals pass during the legislative session which require policy form reviews, the DIFP will need to request additional staff to handle the increase in workload.

Officials from the **DSS-MHD** state this legislation does not revise Chapter 208, RSMo. Therefore, it does not affect MO HealthNet eligibility or benefits.

HWC:LR:OD

ASSUMPTION (continued)

This legislation does revise Chapter 376, RSMo. The MHD assumes that since there is no specific exemption for contracts with the state, the legislation will pertain to HMOs that contract with the state to provide health benefits to MO HealthNet Managed Care participants.

The proposed legislation would impact the MO HealthNet Managed Care program by requiring all health plans to provide contracted providers with access to standard fee schedules. This legislation affects the make-up of the HMO networks and also reduces the ability of the HMOs to negotiate contract terms. The cost impact will be incurred during the bidding process and when contracts are renewed. The first year cost is for an actuarial study to determine the actuarially sound impact of this requirement on rate ranges to ensure actuarial soundness as required by the Centers for Medicare and Medicaid Services. The cost to evaluate could be up to $25,000. It is assumed that capitated rates would increase in year 2 and forward and could exceed $300,000 each year. This fiscal impact was prepared after consulting with the state's contracted actuary.

FY15 match rate for the actuarial study is calculated at a 50% federal match.
FY16 and FY17 match rate for capitated rates are calculated at a 63.095% federal match.

FY15: Total cost unknown < $25,000 (GR unknown < $12,500; Federal unknown < $12,500);
FY16: Total cost unknown >$300,000 (GR unknown >$110,715; Federal unknown > $189,285);
FY17: Total cost unknown >$300,000 (GR unknown >$110,715; Federal unknown > $189,285).

Officials from the **DMH** state chapter 376 applies to insurance companies. There is no fiscal impact to the DMH.

§376.2020 - Price Transparency

Officials from the **DSS-MHD** state this section restricts cost disclosure provisions in the contracts between managed care organizations and the managed care organizations sub contractors. There is no fiscal impact to MO HealthNet. If the provision becomes law the sub contractor requirements in the MO HealthNet managed care contracts will be updated.

§§484.400 - 484.430 - Contingent Fee Arrangements

Officials from the **DSS-MHD** state there may be a positive fiscal impact to MO HealthNet's Third Party Liability (TPL) recoveries by reducing attorney fee payments, but the savings are unknown.

ASSUMPTION (continued)

§538.220 - Tort Reform, Attorney's Fees and Witness Fees

Officials from the **DSS-MHD** state MO HealthNet currently pays its pro rata share of attorney fees in TPL suits, and this section changes the attorney fee structure arrangement in personal injury cases.

There may be a positive fiscal impact to MO HealthNet's TPL recoveries by reducing attorney fee payments, but the savings are unknown.

Section 1 - Accountability System

Officials from the **DSS-MHD** state an accountability system will need to have the ability to interoperate to collect and aggregate data from disparate systems. Such disparate systems shall 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. Additionally, this system will need to 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.

MO HealthNet recently received an estimate for a similar system and the cost exceeded $50,000,000. Costs to the GR fund are unknown, greater than $12,500,000 (Federal unknown greater than $37,500,000) for FY 15.

Officials from the **DMH** state Section 1 requires the State of Missouri to establish and maintain an accountability system utilizing health information technology to help determine if MO HealthNet participants are improving in health outcomes under a managed care organization. It also requires a quarterly analysis of each managed care organization as compared to fee-for-service providers. It is unclear if DMH care management services, CPR, and CSTAR continue to be carved out of managed care as they are today. DMH assumes care management services will continue to be carved out of Managed Care and anticipates no fiscal impact.

Bill as a whole:

Officials from the **University of Missouri (UM)** state the proposed legislation could have a significant negative impact on the University; an impact in excess of $100,000 annually. The actual potential impact is uncertain due to the multiple topics address in the legislation.

HWC:LR:OD

ASSUMPTION (continued)

Officials from the **Office of the Governor (GOV)** do not anticipate the GOV will incur added costs as a result of this proposal. However, if additional duties are placed on the office related to appointments in other TAFP legislation, there may be the need for additional staff resources in future years.

Officials from the **Office of State Courts Administrator (CTS)** state the proposal may have some impact, but there is no way to quantify that impact at the present time. Any significant changes will be reflected in future budget requests.

Officials from the **Office of Secretary of State (SOS)** state many bills considered by the General Assembly include provisions allowing or requiring agencies to submit rules and regulations to implement the act. The Secretary of State's office is provided with core funding to handle a certain amount of normal activity resulting from each year's legislative session. The fiscal impact for this fiscal note to the SOS for Administrative Rules is less than $2,500. The SOS recognizes this is a small amount and does not expect that additional funding would be required to meet these costs. However, it is also recognized that many such bills may be passed by the General Assembly in a given year and that collectively the costs may be in excess of what the office can sustain within its core budget. Therefore, the SOS reserves the right to request funding for the cost of supporting administrative rules requirements should the need arise based on a review of the finally approved bills signed by the governor.

Officials from the **Joint Committee on Administrative Rules (JCAR)** state the legislation is not anticipated to cause a fiscal impact to JCAR beyond its current appropriation.

Officials from the **Department of Revenue**, the **Missouri Department of Transportation**, the **Missouri Department of Conservation**, the **Missouri House of Representatives**, the **OA - Division of Purchasing and Materials Management**, the **Missouri Senate**, and the **Office of State Treasurer** each assume the proposal would not fiscally impact their respective agencies.

Officials from the **Department of Public Safety - Missouri State Highway Patrol** defer to the Missouri Department of Transportation Employee Benefits Section for response on behalf of the Highway Patrol. Please see their fiscal note for the potential fiscal impact of this proposal.

Officials from the following **hospitals**: Barton County Memorial Hospital, Bates County Memorial Hospital, Cedar County Memorial Hospital, Cooper County Hospital, Excelsior Springs Medical Center, Putnam County Memorial Hospital, and Washington County Memorial Hospital did not respond to **Oversight's** request for fiscal impact.

HWC:LR:OD

ASSUMPTION (continued)

Officials from the **Office of Prosecution Services** did not respond to **Oversight's** request for a statement of fiscal impact.

Officials from the **counties** of: Holt, Knox, and Worth did not respond to **Oversight's** request for a statement of fiscal impact.

Officials from the **cities** of: Pineville and California did not respond to **Oversight's** request for a statement of fiscal impact.

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
GENERAL REVENUE FUND			
Savings - DSS-MHD (§208.995) Reduction in Oversight Committee meeting expenditures	$1,887	$1,887	$1,887
Savings - DSS-MHD (§§484.400 to 484.430) Reduction in attorney fee payments	Unknown	Unknown	Unknown
Savings - DSS-MHD (§538.220) Reduction in attorney fee payments	Unknown	Unknown	Unknown
Total All Savings	Unknown, greater than $1,887	Unknown, greater than $1,887	Unknown, greater than $1,887
Costs - OA-GS (§105.711) Expansion of medical malpractice coverage	(Unknown)	(Unknown)	(Unknown)

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
GENERAL REVENUE FUND (cont.)			
Costs - OA-ITSD			
Tracking system for medical scholarship awards (§173.228)	(Could exceed $500,000)	$0	$0
Computer system updates, program changes, and related expenditures for all departments	($290,182)	($82,542)	($83,368)
Total Costs - OA-ITSD	(Could exceed $790,182)	($82,542)	($83,368)
Costs - DHE (§173.228)			
Personal services	($27,840)	($33,742)	($34,080)
Fringe benefits	($14,200)	($17,210)	($17,383)
Total Costs - DHE	($42,040)	($50,952)	($51,463)
FTE Change - DHE	1 FTE	1 FTE	1 FTE
Costs - DHSS-DCPH (§§197.170 and 197.173)			
Personal service	($33,320)	($40,384)	($40,788)
Fringe benefits	($16,995)	($20,598)	($20,804)
Equipment and expense	($17,252)	($13,391)	($13,723)
Total Costs - DHSS-DCPH	($67,567)	($74,373)	($75,315)
FTE Change - DHSS	1 FTE	1 FTE	1 FTE
Costs - DSS-MHD (§208.010.2(4))			
Increase in program costs due to increase in asset limits	($30,540,644)	($38,188,021)	($39,791,918)
Costs - DHSS-DSDS (§208.010.2(4))			
Personal service	($27,840)	($33,742)	($34,079)
Fringe benefits	($14,200)	($17,210)	($17,382)
Equipment and expense	($8,627)	($6,697)	($6,863)
Total Costs - DHSS-DCPH	($50,667)	($57,649)	($58,324)
FTE Change - DHSS	1 FTE	1 FTE	1 FTE

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
GENERAL REVENUE FUND (cont.)			
Costs - DSS-MHD (§208.187)			
Patient-centered care/HSAs	(Unknown, greater than $5,300,000)	(Unknown, greater than $300,000)	(Unknown, greater than $300,000)
Costs - DSS-FSD (§208.188)			
EBT pilot program costs	(Unknown, greater than $750,000)	(Unknown, greater than $300,000)	(Unknown, greater than $300,000)
Costs - DSS-MHD (§208.188)			
EBT pilot project costs	$0	(Unknown, greater than $10,773,434)	(Unknown, greater than $10,314,114)
Costs - DMH (§208.188)			
Increase in provider payments to 100% of Medicare	(Unknown, greater than $100,000)	(Unknown, greater than $100,000)	(Unknown, greater than $100,000)
Pilot project implementation impact on CMHC providers	Unknown to (Unknown)	Unknown to (Unknown)	Unknown to (Unknown)
Total Costs - DMH	Unknown to (Unknown, greater than $100,000)	Unknown to (Unknown, greater than $100,000)	Unknown to (Unknown, greater than $100,000)
Costs - DSS-MHD (§208.440)			
Personal service	($14,205)	($17,216)	($17,388)
Fringe benefits	($7,245)	($8,781)	($8,869)
Equipment and expense	($90,831)	($37,723)	($44,135)
Total Costs - DSS-MHD	(Unknown, greater than $112,281)	(Unknown, greater than $63,720)	(Unknown, greater than $70,392)
FTE Change - DSS-MHD	0.5 FTE	0.5 FTE	0.5 FTE

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
GENERAL REVENUE FUND (cont.)			
Costs - MCHCP (§376.393)			
Increase in state share of insurance costs	(Unknown, greater than $1,736,220	(Unknown, greater than $3,472,440)	(Unknown, greater than $3,472,440)
Costs - DSS-MHD (§§376.393 and 376.1425)			
Actuarial study	(Less than $12,500)	$0	$0
Capitated rate increases	$0	(Unknown, greater than $110,715)	(Unknown, greater than $110,715)
Total Costs - DSS-MHD	(Less than $12,500)	(Unknown, greater than $110,715)	(Unknown, greater than $110,715)
Costs - DIFP (§§334.035 through 334.735)			
Personal service	($19,700)	($23,876)	($24,115)
Fringe benefits	($10,048)	($12,178)	($12,300)
Equipment and expense	($10,534)	($1,804)	($1,827)
Total Costs - DIFP	($40,282)	($37,858)	($38,242)
FTE Change - DIFP	1 FTE	1 FTE	1 FTE
Costs - DSS-MHD (Section 1)			
Accountability system	(Unknown, greater than $12,500,000)	$0	$0
Total All Costs	(Unknown, greater than $52,029,883)	(Unknown, greater than $53,611,704)	(Unknown, greater than $54,766,291)

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
GENERAL REVENUE FUND (cont.)			
Loss - DHSS-DRL (§197.315)			
Reduction in CON fees	(Unknown, less than $400,000)	(Unknown, less than $400,000)	(Unknown, less than $400,000)
Loss - DMH (§208.187)			
Reduction in local tax match monies	(Greater than $3,000,000)	(Greater than $6,000,000)	(Greater than $6,000,000)
Total All Loss	(Greater than $2,600,000)	(Greater than $5,600,000)	(Greater than $5,600,000)
TOTAL ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**(Could exceed $54,627,996)**	**(Could exceed $59,209,817)**	**(Could exceed $60,364,404)**
Estimated Net FTE Change on the General Revenue Fund	4.5 FTE	4.5 FTE	4.5 FTE
INSURANCE DEDICATED FUND			
Income - DIFP (§§376.393 and 376.1425)			
Form filing fees	Up to $15,000	$0	$0
ESTIMATED NET EFFECT ON THE INSURANCE DEDICATED FUND	**Up to $15,000**	**$0**	**$0**

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
VARIOUS OTHER STATE FUNDS			
Costs - DSS-MHD (§208.010.2(4))			
Increase in program costs resulting from an increase in asset limits	($15,733,059)	($19,672,617)	($20,498,867)
Costs - MCHCP (§376.393)			
Increase in state share of insurance costs	(Unknown, greater than $406,125)	(Unknown, greater than $812,250)	(Unknown, greater than $812,250)
Costs - University of Missouri			
Various provisions	(Unknown, greater than $100,000)	(Unknown, greater than $100,000)	(Unknown, greater than $100,000)
ESTIMATED NET EFFECT ON VARIOUS OTHER STATE FUNDS	**(Unknown, greater than $16,239,184)**	**(Unknown, greater than $20,584,867)**	**(Unknown, greater than $21,411,117)**
FEDERAL FUNDS			
Income - OA-ITSD			
Reimbursement for program expenditures	$78,171	$0	$0
Income - DSS-MHD (§208.010.2(4))			
Increase in program reimbursements due to increasing asset limits	$79,112,296	$98,922,015	$103,076,740
Income - DHSS-DSDS (§208.010.2(4))			
Increase in program reimbursements	$59,495	$68,349	$69,132

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Income- DSS-MHD (§208.187)			
Patient-centered care/HSAs reimbursement	Unknown, greater than $15,300,000	Unknown, greater than $300,000	Unknown, greater than $300,000
Income - DSS-FSD (§208.188)			
Increase in program reimbursements	Unknown, greater than $750,000	Unknown, greater than $300,000	Unknown, greater than $300,000
Income - DSS-MHD (§208.188)			
EBT pilot project reimbursements	$0	Unknown, greater than $19,386,664	Unknown, greater than $17,633,627
Income - DMH (§208.188)			
Increase in reimbursement for provider payments to 100% of Medicare	Unknown, greater than $100,000	Unknown, greater than $100,000	Unknown, greater than $100,000
Pilot project implementation impact on CMHC providers	Unknown to (Unknown)	Unknown to (Unknown)	Unknown to (Unknown)
Total Income - DMH	Unknown to (Unknown)	Unknown to (Unknown)	Unknown to (Unknown)
Income - DSS-MHD (§208.440)			
Reimbursement for expenditures	Unknown, greater than $138,471	Unknown, greater than $90,853	Unknown, greater than $98,502

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Income - DSS-MHD (§§376.393 and 376.1425)			
Increase in program reimbursements	Unknown, less than $12,500	Unknown, greater than $189,285	Unknown, greater than $189,285
Income - DSS-MHD (Section 1)			
Program reimbursements	Unknown, greater than $37,500,000	$0	$0
Total All Income	Could exceed $133,050,933	Could exceed $119,357,166	Could exceed $121,767,286
Savings - DSS-MHD (§208.995)			
Reduction in Oversight Committee meeting expenditures	$1,887	$1,887	$1,887
Savings - DSS-MHD (§§484.400 to 484.430)			
Reduction in attorney fee payments	Unknown	Unknown	Unknown
Savings - DSS-MHD (§§484.400 to 484.430)			
Reduction in attorney fee payments	Unknown	Unknown	Unknown
Total All Savings	Unknown, greater than $1,887	Unknown, greater than $1,887	Unknown, greater than $1,887

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Costs - OA-ITSD			
Computer system updates, program changes, and related expenditures for all departments	($78,171)	$0	$0
Costs - DSS-MHD (§208.010.2(4))			
Increase in program expenditures due to increasing asset limits	($79,112,296)	($98,922,015)	($103,076,740)
Costs - DHSS-DSDS (§208.010.2(4))			
Personal service	($27,840)	($33,742)	($34,080)
Fringe benefits	($14,200)	($17,210)	($17,382)
Equipment and expense	($17,455)	($17,397)	($17,670)
Total Costs - DHSS-DCPH	($59,495)	($68,349)	($69,132)
FTE Change - DHSS	1 FTE	1 FTE	1 FTE
Costs - DSS-FSD (§208.010.2(6))			
Additional temporary assistance program payments	(Up to $505,688)	(Up to $607,068)	(Up to $607,068)
Costs - DSS-MHD (§208.187)			
Patient-centered care/HSAs	(Unknown, greater than $15,300,000)	(Unknown, greater than $300,000)	(Unknown, greater than $300,000)
Costs - DSS-FSD (§208.188)			
EBT pilot program costs	(Unknown, greater than $750,000)	(Unknown, greater than $300,000)	(Unknown, greater than $300,000)
Costs - DSS-MHD (§208.188)			
EBT pilot project costs	$0	(Unknown, greater than $19,386,664)	(Unknown, greater than $17,633,627)

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Costs - DMH (§208.188)			
Increase in provider payments to 100% of Medicare	(Unknown, greater than $100,000)	(Unknown, greater than $100,000)	(Unknown, greater than $100,000)
Pilot project implementation impact on CMHC providers	Unknown to (Unknown)	Unknown to (Unknown)	Unknown to (Unknown)
Total Costs - DMH	Unknown to (Unknown)	Unknown to (Unknown)	Unknown to (Unknown)
Costs - DSS-MHD (§208.440)			
Personal service	($14,205)	($17,217)	($17,389)
Fringe benefits	($7,246)	($8,782)	($8,869)
Equipment and expense	(Unknown, greater than $117,020)	(Unknown, greater than $64,854)	(Unknown, greater than $72,244)
Total Costs - DSS-MHD	(Unknown, greater than $138,471)	(Unknown, greater than $90,853)	(Unknown, greater than $98,502)
FTE Change - DSS-MHD	0.5 FTE	0.5 FTE	0.5 FTE
Costs - MCHCP (§376.393)			
Increase in state share of insurance costs	(Unknown, greater than $707,655)	(Unknown, greater than $1,415,310)	(Unknown, greater than $1,415,310)
Costs - DSS-MHD (§§376.393 and 376.1425)			
Increase in program expenditures	(Unknown, less than $12,500)	(Unknown, greater than $189,285)	(Unknown, greater than $189,285)

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Costs - DSS-MHD (Section 1)			
Accountability system expenditures	(Unknown, greater than $37,500,000)	$0	$0
Total All Costs	(Unknown, greater than $133,746,088)	(Unknown, greater than $120,772,476)	(Unknown, greater than $123,182,596)
Loss- DSS-MHD (§208.995)			
Reduction in Oversight Committee meeting reimbursements	($1,887)	($1,887)	($1,887)
Loss - DMH (§§208.998 and 208.1503)			
Reduction in federal funds	(Greater than $22,500,000)	(Greater than $45,000,000)	(Greater than $45,000,000)
Loss - DSS-MHD (§§484.400 to 484.430)			
Reduction in reimbursements	(Unknown)	(Unknown)	(Unknown)
Loss - DSS-MHD (§§484.400 to 484.430)			
Reduction in reimbursements	(Unknown)	(Unknown)	(Unknown)
Total All Loss	(Unknown, greater than $22,501,887)	(Unknown, greater than $45,001,887)	(Unknown, greater than $45,001,887)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**(Unknown, greater than $23,195,155)**	**(Unknown, greater than $46,415,310)**	**(Unknown, greater than $46,415,310)**
Estimated Net FTE Effect on Federal Funds	1.5 FTE	1.5 FTE	1.5 FTE

HWC:LR:OD

FISCAL IMPACT - Local Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
LOCAL GOVERNMENTS - ALL			
Costs - All Local Governments			
Increase in share of health care costs	(Unknown, greater than $60,500)	(Unknown, greater than $121,000)	(Unknown, greater than $121,000)
ESTIMATED NET EFFECT ON ALL LOCAL GOVERNMENTS	**(Unknown, greater than $60,500)**	**(Unknown, greater than $121,000)**	**(Unknown, greater than $121,000)**

FISCAL IMPACT - Small Business

This proposal may have an impact on small business health care providers.

FISCAL DESCRIPTION

STATE LEGAL EXPENSE FUND-MO HEALTHNET PILOT PROJECT PROVIDERS (SECTION 105.711)

This proposal includes under the State Legal Expense Fund certain licensed physicians under contract to provide medical care to participants in the MO HealthNet pilot project created under this proposal in Section 208.188. Under such circumstances, the aggregate of payments from the State Legal Expense Fund shall be limited to a maximum of 500 thousand dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed 500 thousand dollars for any one claimant. Liability or malpractice insurance obtained and maintained in force by or on behalf of any licensed physician shall not be considered available to pay that portion of a judgment or claim for which the fund is liable under this provision.

SCHOLARSHIP AND LOANS FOR RURAL PHYSICIANS (SECTION 173.228)

This proposal creates within the Department of Higher Education the "Board of Medical Scholarship Awards", for the purpose of awarding scholarships and loans to provide for current and prospective medical 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

FISCAL DESCRIPTION (continued)

awards shall 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. There is also established the Board of Medical Scholarship Awards Fund.

The proposal specifies the makeup and duties of the Board, including promulgating rules for implementing and administering the provisions of scholarship programs. Any recipient 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 percent annually from the date of his or her departure or removal from medical school.

The attorney general, upon request of the Board, shall institute proceedings in the name of the state for the purpose of recovering any amount due the state under this proposal. Any moneys recovered under this act from loan recipients or paid by recipients to the board shall be retained by the board for funding of future scholarships.

PRICE TRANSPARENCY (SECTION 191.875)

By January 1, 2015,this proposal requires all health care providers and insurers to provide cost estimates prior to the provision of such services, if feasible, but in no event later than 3 business days after such request. These provisions shall not apply to emergency health care services.

REPORTING OF PRICES FOR MOST COMMON PROCEDURES (SECTIONS 197.170 & 197.173)

This proposal requires hospitals and ambulatory surgical centers to submit to the Department of Health and Senior Services prices for 140 of the most common procedures, including 100 of the most common procedures in hospital inpatient settings as well as 20 of the most common surgery and 20 of the most common imaging procedures conducted in both outpatient hospital and ambulatory surgical settings.

The Department shall provide such information on its internet website in a manner that is easily understood by the public. Information for each hospital shall be listed separately and hospitals shall 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 shall also be listed separately.

HWC:LR:OD

FISCAL DESCRIPTION (continued)

The information regarding hospital inpatient procedures shall be submitted beginning with the quarter ending June 30, 2015, and quarterly thereafter. The information regarding outpatient surgical and imaging procedures shall be submitted beginning with the quarter ending September 30, 2015, and quarterly thereafter.

CERTIFICATE OF NEED (SECTIONS 197.300 TO 197.367)

This proposal amends the certificate of need (CON) law as follows: (1) Limits the radius area for "affected persons" to a 5 mile radius of proposed new development as well as when consideration shall be given to the facilities located within the 5 mile radius when determining if a CON shall be issued; (2) Provides that a certificate of need shall not be required for a proposed project which creates ten or more new full-time jobs; (3) Raises the expenditure minimum for falling under CON review for capital expenditures to one million dollars and for major medical equipment to 2 million dollars; (4) Requires all testimony and other evidence taken during the hearings to be under oath and subject to penalty of perjury; (5) Changes the procedures and evidentiary standard at the certificate of need hearing; (6) Prohibits all ex parte communications between members of the committee and any interested party or witness regarding the subject matter of the hearing at any time prior to, during, or after the hearing and (7) Modifies the membership and requirements for Missouri Health Facilities Review Committee for the Certificate of Need Program.

ECONOMIC CREDENTIALING (SECTION 197.710)

This proposal prohibits a hospital from requiring a physician to agree to make patient referrals to the hospital-affiliated facility as a condition of receiving medical staff membership or medical staff privileges at the hospital. This proposal also prohibits a hospital from refusing 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. Nor shall such physician be refused such privileges 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 such 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 this action.

HWC:LR:OD

FISCAL DESCRIPTION (continued)

MO HEALTHNET ASSET LIMITS RAISED (SECTION 208.010)

This proposal modifies the amount of cash, securities or other total non-exempt assets an aged or disabled participant is allowed to retain in order to qualify for MO HealthNet benefits from less than $1,000 to $2,000 for a single person and from $2,000 to $4,000 for a married couple.

MO HEALTHNET PATIENT-CENTERED CARE ACT/HEALTH SAVINGS ACCOUNTS (SECTION 208.187)

Beginning July 1, 2015, or upon termination of any current contracted health plans in the pilot project areas and subject to federal approval, the MO HealthNet Division shall establish a pilot project which 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 shall 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 shall 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 shall 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. Such average cost shall be the government assistance amount. The proposal specifies the parameters for the health savings accounts.

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

MO HEALTHNET PILOT PROJECT-EBT FOR HEALTH SERVICES (SECTION 208.188)

Beginning July 1, 2015, subject to appropriations and subject to receipt of federal approval, the MO HealthNet Division shall establish a pilot project which implements an electronic benefit transfer (EBT) payment system for receipt of MO HealthNet services by participating recipients.

HWC:LR:OD

FISCAL DESCRIPTION (continued)

The provisions of this proposal shall not apply to aged, blind, and disabled recipients. Such system shall: (1) Allow participating recipients to receive MO HealthNet services from providers selected by the recipients through direct pay to the provider, a health insurance plan, managed care plan, health services plan, or any other available health care product providing benefits and payment for services in an approved health plan arrangement; (2) Require the use of electronic benefit transfer (EBT) cards issued to participating recipients to pay for MO HealthNet services; (3) Require recipients to receive an annual examination within six months of enrollment; (4) Provide educational opportunities for recipients relating to budgeting, planning, and appropriate use of health care options; (5) Provide incentives for recipients to seek health care services as needed, while retaining a portion of any savings achieved from efficient use of their EBT cards; (6) Provide additional moneys to recipients for health savings accounts, payment of health insurance premiums, and other health-related costs to recipients not covered under the MO HealthNet program; (7) Provide reimbursement of any willing providers licensed in this state and eligible to provide services under the terms of the pilot project at a rate of one hundred percent of the Medicare reimbursement rate for the same or similar services provided; and (8) Provide demographic and cost efficiency information to determine feasibility of statewide implementation of the EBT payment system.

The proposal specifies how the balance of the health savings account and amount in the EBT card will be apportioned.

The MO HealthNet Division shall establish a minimum of 3, but not more than 6, pilot project areas in this state which shall include at least 10 percent of the total MO HealthNet recipient population, excluding the aged, blind, and disabled population, in the first 2 years of the pilot project. In the third year of the pilot project, the Division may increase the total number of pilot project areas to not more than 10 and shall increase the number of participants to at least 20 percent of the total MO HealthNet recipient population, excluding the aged, blind, and disabled population. If the pilot project is automatically implemented on a statewide basis, the EBT payment system shall apply to every MO HealthNet recipient, excluding the aged, blind, and disabled population.

Any willing provider eligible to provide services under the terms of the pilot project shall be reimbursed for services provided to pilot project recipients at a rate of one hundred percent of the Medicare reimbursement rate for the same or similar services provided.

The Division shall submit annual reports to the General Assembly. Beginning July 1, 2018, unless the provisions of this act are repealed by an act of the General Assembly, the pilot project described in this action shall automatically be implemented on a statewide basis for all MO HealthNet recipients.

FISCAL DESCRIPTION (continued)

MO HEALTHNET CLAIMS UTILIZATION DATA (SECTION 208.440)

This proposal requires each MO HealthNet managed care organization to 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. Such data shall be in the form of all payments made to health care providers for services rendered to MO HealthNet participants and shall also identify claim-specific data for each patient service or procedure. The Department of Social Services may require additional information through the promulgation of rules to meet the requirements of this act.

PRESCRIPTION COPAYS (SECTIONS 334.735 AND 354.535)

Under this proposal, if the co-payment applied by a HMO or health insurer exceeds the usual and customary retail price of a prescription drug, the enrollee shall only be required to pay the usual and customary retail price of the prescription drug and there will be no further charge to the enrollee or plan sponsor for the prescription (Sections 354.535 and 376.387).

COLLABORATIVE PRACTICE ARRANGEMENTS WITH PHYSICIAN ASSISTANTS, ADVANCED PRACTICE REGISTERED NURSES AND NEWLY CREATED ASSISTANT PHYSICIANS TO SERVE RURAL OR UNDERSERVED AREAS (SECTIONS 334.035, 334.036, 334.104; 334.735)

This proposal allows certain medical school graduates to obtain a temporary assistant physician license in order to enter into "assistant physician collaborative practice arrangements" with a physician. An assistant physician collaborative practice arrangement shall limit the assistant physician to providing only primary care services and only in medically underserved rural or urban areas of this state. An "assistant physician", is defined as any medical school graduate who has passed the prescribed medical examinations and who has not entered into postgraduate residency training prescribed by rule of the State Board of Registration for the Healing Arts. The proposal prescribes the other requirements to be licensed as an assistant physician and specifies certain practices an assistant physician cannot perform.

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. A licensed assistant physician shall enter into an assistant physician collaborative practice arrangement within six months of his or her initial licensure and shall not have more than a six-month time period between collaborative practice arrangements during his or her licensure period.

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FISCAL DESCRIPTION (continued)

The State Board of Registration for the Healing Arts shall promulgate one set of rules applicable to all three licensure categories; physician assistants, advance practice registered nurses and the newly created assistant physicians, and shall not promulgate separate rules applicable to only one licensure category.

ANY WILLING PROVIDER (SECTIONS 376.393 & 376.1425)

Under this proposal, each health carrier shall provide each contracted provider with access to the health carrier's standard fee schedule, specific to the provider's geographic area, through a secure website. Such fee schedule shall reflect the current payment rates for all goods and services pertinent to the provider's practice or business, defined by procedure codes, diagnosis related groups, or defined by another payment mechanism, and all contracted providers in such geographic area shall be paid for the goods and services provided at such rates, unless different rates have been specifically agreed upon contractually with an individual provider. In no case shall the standard fee schedule include a rate for a specific good or service that is less than the lowest rate individually contracted for by the providers of such good or service in the applicable geographic area if all the providers in such area have individually contracted to be paid at different rates for such good or service.

Under the proposal, no health carrier shall refuse to contract with any Missouri provider who is located within the geographic coverage area of a health benefit plan and who is willing to meet the terms and conditions for provider participation established for such health benefit plan if the provider is willing, as a term of such contract, to be paid at rates equal to 99% of the standard rates established pursuant to this proposal. (Section 376.393)

Every health care provider who refers a patient to a medical facility for health care services shall 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.

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 otherwise restricted by the health carrier or plan. A health 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.

FISCAL DESCRIPTION (continued)

A health care provider, health carrier, or health benefit plan shall be subject to licensure sanction for failure to comply with the provisions of this proposal.

PRICE TRANSPARENCY (SECTION 376.2020)

Under this proposal, no contract provision between a health carrier and a health care provider shall be enforceable if such provision prohibits, conditions, or in any way restricts any party to such contract from disclosing to an enrollee, patient, potential patient, or such person's parent or legal guardian, the contractual payment amount for a health care service if such payment amount is less than the health care provider's usual charge for the health care service, and if such 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.

CONTINGENT FEE ARRANGEMENTS (SECTIONS 484.400 TO 484.430)

This proposal provides 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 shall 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 this proposal.

This proposal specifies that at any time after retention, a contingent fee attorney pursuing a claim shall send a demand for compensation by certified mail to an allegedly responsible party and further delineates how such demand shall be made.

A fee received by or contracted for by a contingent fee attorney that exceeds ten percent 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 this proposal which he or she had in his or her possession or which was readily available to him or her at the time of filing. This proposal also specifies the terms and relationship under these contingent fees with respect to settlement offers.

It shall be a violation of this proposal 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.

HWC:LR:OD

FISCAL DESCRIPTION (continued)

Under this proposal, an attorney entering into a fee agreement that would effectively result in payment of a percentage of a pre-retention offer to a claimant has 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'S FEES AND WITNESS FEES (SECTION 538.220)

This proposal provides that in 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: (1) If the case is settled prior to trial, attorneys' fees shall be limited to the attorney's regular hourly rate of compensation; and (2) If the case proceeds to trial, the prevailing party shall recover all expert witness fees and costs incurred by such prevailing party.

ACCOUNTABILITY SYSTEM (SECTION 1)

The state shall establish and maintain an accountability system utilizing health information technology. Such system shall: (1) Have the ability to interoperate to collect and aggregate data from disparate systems. Such disparate systems shall 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; (2) 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; (3) Meet all state health privacy laws and federal Health Insurance Portability and Accountability Act (HIPAA) requirements; and (4) Meet federal data security requirements.

MO HEALTHNET OVERSIGHT COMMITTEE REPEALED (SECTION 208.955)

This proposal repeals the MO HealthNet Oversight Committee.

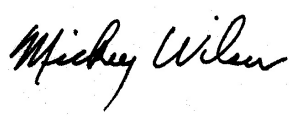
This legislation is not federally mandated, would not duplicate any other program but may require additional capital improvements or rental space.

HWC:LR:OD

SOURCES OF INFORMATION

Office of Attorney General
Office of State Courts Administrator
Department of Higher Education
Department of Insurance, Financial Institutions and Professional Registration
Department of Mental Health
Department of Health and Senior Services
Department of Revenue
Department of Social Services -
    Division of Legal Services
    Family Support Division
    MO HealthNet Division
Missouri Department of Transportation
Department of Public Safety -
    Missouri State Highway Patrol
Office of the Governor
Missouri Consolidated Health Care Plan
Joint Commission on Administrative Rules
Missouri Department of Conservation
Missouri House of Representatives
Office of Administration -
    General Services Division
    Information Technology Services Division
    Division of Purchasing and Materials Management
Missouri Senate
Office of Secretary of State
Office of State Treasurer
University of Missouri

Not Responding:
Office of Prosecution Services



Mickey Wilson, CPA
Director
March 4, 2014

HWC:LR:OD

Ross Strope
Assistant Director
March 4, 2014

HWC:LR:OD