COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 5244-06
Bill No.: HCS No. 2 for HB 1793
Subject: Health Care; Medicaid; Medical Procedures and Personnel; Hospitals
Type: Original
Date: April 11, 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	(Unknown, greater than $37,005,435)	(Unknown, greater than $39,160,535)	(Unknown, greater than $40,771,486)
Total Estimated Net Effect on General Revenue Fund	**(Unknown, greater than $37,005,435)**	**(Unknown, greater than $39,160,535)**	**(Unknown, greater than $40,771,486)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
Nursing Workforce Center*	$0	$0	$0
Medical Clinics in Medically Underserved Areas**	$0	$0	$0
University Funds	(Greater than $83,333)	(Greater than $100,000)	(Greater than $100,000)
Various Other State Funds	($15,733,059)	($19,672,617)	($20,498,867)
Total Estimated Net Effect on Other State Funds	**(Greater than $15,816,392)**	**(Greater than $19,772,617)**	**(Greater than $20,598,867)**

*** Fees and contract costs net to $0**
**** Income and expenditures net to $0.**

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
Federal	(Up to $505,688)	(Up to $607,068)	(Up to $607,068)
Total Estimated Net Effect on All Federal Funds	**(Up to $505,688)**	**(Up to $607,068)**	**(Up to $607,068)**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 32 pages.

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ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
General Revenue	5	5	5
Federal	1	1	1
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	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

§191.875 - Price Transparency and Reporting Prices for the Most Common Procedures

Officials from the **Department of Health and Senior Services (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 Information Technology Services Division (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, BHCADD to enable them to have ready access to the data for querying. Furthermore, it is likely that database support would also be needed from ITSD.

BHCADD will be tasked with identifying the one hundred most common DRG categories for hospitals and the fifty most common surgery procedures and fifty most common imaging procedures performed in hospital outpatient settings. 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. BHCADD may be asked to identify any underreporting by the facilities and validate the accuracy of the information reported. BHCADD may also be asked to 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).

The research analyst will be responsible for compiling, cleaning, and editing the iterative quarterly files of cost data to conduct the reports for publication on DHSS' website. The analyst will prepare and run computer programs to perform the analysis on these files. In addition, the analyst will provide any needed technical assistance or consultation on trend and/or comparison analysis that may be requested. The analyst will also be involved in developing and maintaining the confidentiality standards for reporting the cost data on the public site. Furthermore, the analyst will handle any inquiries related to the healthcare cost data.

It will be necessary for BHCADD and ITSD to work together 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 ITSD costs are unknown greater than $100,000.

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ASSUMPTION (continued)

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.

However, 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 FY18. 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 **Department of Mental Health (DMH)** state this section proposes that health care providers provide an estimate of the cost of health care services within 5 days of a patient request. The DMH assumes that this requirement would be absorbed within the existing administrative functions of the DMH providers; therefore, DMH anticipates no fiscal impact.

§208.010 - Asset Limits

Officials from the **Department of Social Services (DSS) - Family Support Division (FSD)** provide the following:

Section 208.010.2(4)

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 FY13, 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

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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 **Department of Social Services (DSS) - MO HealthNet Division (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).

ASSUMPTION (continued)

Officials from the **Office of Administration (OA) - Information Technology Services Division (ITSD)/DSS** provide the following:

Section 208.010 - Increases the Asset limits for Medicaid

This proposal would require changes to Family Assistance Management Information System (FAMIS) including:

1) Updating rules table with new resource maximum values will require 1 hour from a state staff member for all environments. This also includes update of technical specification documents.
2) Projecting 38 hours of effort for unit and systems test.

Assumptions:
- All effort associated with these changes will be completed in FY15 (no impact beyond 2015).
- 39 hours of effort will be completed at the state staff rate of $63.04/hr.

Total Cost: 39 hrs X $63.04 = $ 2,459 (rounded)

The match rate for Medicaid is 50% General Revenue, 50% Federal.

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

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, as provided by the Department of Social Services (DSS), Family Support Division (FSD), when determining 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 X 0.2026 = 1,656); 46 additional individuals for a total of 1,702 in FY16 (1,656 X 0.0278 growth factor = 46 + 1,656 = 1,702); and 47 additional individuals for a total of 1,749 in FY17 (1,702 X 0.02478 growth rate = 47 + 1,702 = 1,749).

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ASSUMPTION (continued)

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

Prior to receiving HCBS, an eligible MO HealthNet recipient 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 X 2 = 3,312 hours for initial assessments ÷ 2,080 work hours/year = 1.59, rounded to 2.00 in FY15; [46 recipients (new recipients growth) X 2 = 92 hours for initial assessments] + [1,656 X 2 = 3,312 hours for reassessments] = 3,404 hours ÷ 2,080 = 1.64 FTE, rounded to 2.00 in FY16; [47 new recipients (growth) X 2 = 94 hours for initial assessments] + [1,702 X 2 = 3,404 hours for reassessments] = 1.68 FTE, rounded to 2.00 in FY17).

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

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 FY 2016 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 FY 2017, 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 FY15 is 36.905 percent GR and 63.095 percent federal.

Based on discussions with **Department of Social Services** 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.

ASSUMPTION (continued)

Officials from the **Department of Mental Health (DMH)** state 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 $4,000.00 for married couples. The Department of Social Services estimates this would add 8,174 new eligibles to the MO HealthNet program. DMH estimates 314 of these 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.

§208.187 - MO HealthNet Patient-Centered Care Act/Health Savings Accounts/ MO HealthNet Pilot Project - EBT for Health Services

Officials from the **Department of Social Services (DSS) - MO HealthNet Division (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.

The MHD shall contract for a system that shall: support an interoperable data analytics platform for analyzing clinical data for defined populations; be able to leverage cloud-based technology and be hosted remotely by the vendor of the application services system with interoperability capabilities to connect with disparate systems; interoperate using accepted industry standards and collect and aggregate data from disparate systems; provide a member portal; allow for real-time patient queries and present clinical information for the purpose of avoiding duplicate tests and improving care coordination; have the ability to create condition-specific registries for managing populations, providing predictive modeling and alerting providers of at-risk patients, with the ability to communicate between various systems; and operate on a statewide, regional or community-wide basis. MO HealthNet recently received an estimate for a similar system and the cost exceeded $50,000,000.

ASSUMPTION (continued)

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 effect 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: $20,600,000 < Unknown < $70,600,000 (GR $5,300,000 < Unknown < $17,800,000;
Federal $15,300,000 < Unknown < $52,800,000);
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).

Officials from the **Department of Social Services (DSS) - Division of Legal Services (DLS)** state section 208.187.7(10) of the proposed legislation would require the DLS "to act on behalf of the participating recipient" if the recipient is unable to act and does not otherwise have a designated third party to act on his/her behalf. The proposal does not define the parameters of the Division's duty to act on behalf of the participant. To the extent that the proposal would require the Division to determine a participant's eligibility and program compliance and at the same time require the Division to act on behalf of the participant, creates a clear conflict of interest for the department. It is unclear whether the courts would interpret this language to require the department to retain legal counsel to act on behalf of the participant. DLS, as legal representative of the MO HealthNet Division, could not legally act on behalf of the participant and represent the interests of the Department or the Division under this section because this is a clear conflict of interest. DLS, therefore, predicts an unknown fiscal impact based on the provisions of 208.187.7(10).

Oversight assumes the conflict of interest outlined by the DLS will either result in additional legislation to correct the issue or the issue will be dealt with in the court system. Therefore, Oversight is not presenting a fiscal impact for the DSS-DLS in the fiscal note.

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ASSUMPTION (continued)

Officials from the **Office of Administration (OA) - Information Technology Services Division (ITSD/DSS)** that this section describes the pilot project and requires MHD to contract for the system to support the pilot. ITSD/DSS would assist with the Request for Proposal (RFP) and subsequent implementation of the system, if necessary. The cost for this is unknown.

This section would require the Medicaid Management Information System (MMIS) to track the recipients of the pilot, amounts on the EBT cards issued, and services received and paid with the EBT card.

Family Assistance Management Information System (FAMIS) Estimates:

Medical history as such, is not captured during the FAMIS application intake process, except for disability, ophthalmology details, etc. ITSD would have to build a new screen(s) based on the degree of medical history details needed as well as for the preexisting conditions and "lifestyle choices." There may be other relevant factors to be determined by the division which ITSD is not currently aware.

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

- Current rate for ITSD staff averages $63.04 per hour.
- Match rates for FAMIS Food Stamps is 50% GR and 50% Federal.

1740 hours X $63.04/hr = $ 109,690 (rounded)

ASSUMPTION (continued)

MO HealthNet Division (MHD) Estimates:

The medical history and eligibility information collected by FAMIS would be passed to MMIS through the MHD systems.

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

240 hours X $63.04/hr = $ 15,30 (rounded)

Electronic Benefit Transfer (EBT) Estimates:

This proposal would require modifications to the 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

500 hours X $63.04/hr = $ 31,520

Impact for section 208.187:

FAMIS	$ 109,690 (rounded
MHD	15,130 (rounded)
EBT	31,520
	$ 156,340 (rounded)

The match rate for Medicaid is 50% General Revenue, 50% Federal.

HWC:LR:OD

ASSUMPTION (continued)

Officials from the **Department of Mental Health (DMH)** provide section 208.187 of the proposed language 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 services by qualified providers selected by the recipient through direct pay to the provider or other cost-effective health care products approved by the MO HealthNet Division (MHD). The pilot project also implements an electronic benefit transfer payment system (EBT) for recipients participating in the pilot project. However, the proposed language requires MHD to exclude the aged, blind, and disabled (ABD) population. Unless repealed, the pilot project will be implemented on a statewide basis for all MO HealthNet recipients, excluding the ABD population effective July 1, 2017. Since the pilot projects are excluding the ABD population, DMH assumes no fiscal impact.

However, transferring recipients to health plan arrangements puts the state at risk for losing the clinic Upper Payment Limit (UPL) supplemental payments made to the Community Mental Health Centers (CMHCs). State Fiscal Year 2014 Clinic UPL Supplemental payments are $10.8 million ($4.1 million State and $6.7 million Federal).

DMH is responsible for the state portion of the current clinic UPL supplemental payments, and assumes the current UPL payment levels would continue to be the responsibility of DMH through the Managed Care Program. It is unknown if this payment level would have to be incorporated into the CMHCs within the current managed care counties. If it is intended that managed care reimbursement be consistent for the current managed care areas and the statewide expansion areas, there may be an impact on the current managed care rates. If DMH is required to pay the state portion of UPL payments for CMHC's within the current managed care counties there would be a cost to DMH.

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.

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 proposed language within the bill it is unknown if DMH CPR and CSTAR services would continue to be carved-out of the health plan arrangements; therefore, the fiscal impact to DMH is unknown.

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ASSUMPTION (continued)

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 annually.

However, if ABD is included in the pilot project, DMH anticipates the following:

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". Moneys in the fund shall be used to pay for health plan arrangement costs and to credit recipient EBT cards. DMH anticipates no fiscal impact.

Oversight assumes, for fiscal note purposes, that DMH's estimated increase in CPR and CSTAR provider rates as a result of reimbursing any willing provider at 100% of the Medicare rate will be split 60% Federal funds/40% State funds.

ASSUMPTION (continued)

§208.188 - Pilot Project for EBT Delivery of Services

Officials from the **Department of Social Services (DSS) - Family Support Division (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.

§208.325 - Asset limit changes

Officials from the **Office of Administration (OA) - Information Technology Services Division (ITSD/DSS)** provide that section 208.325 increases the asset limits for Aid to Families with Dependent Children (AFDC). These provisions will require the following changes to FAMIS:

1) Updating rules table with new resource maximum values will require 1 hour from a state staff member for all environments. This also includes update of technical specification documents.
2) Projecting 38 hours of effort for unit and systems test.

Assumptions:
- All effort associated with these changes will be completed in FY15 (no impact beyond 2015).
- 39 hours of effort will be completed at the state staff rate of $63.04/hr.

Total Cost: 39 hrs X $63.04 = $ 2,459 (rounded)

The match rate for Medicaid is 50% General Revenue, 50% Federal.

Officials from the **Department of Social Services (DSS) - Family Support Division (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.

§§334.035 and 334.036 - 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.

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 for 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 core budget. However, the estimated $755 in additional annual expenses will be considered in calculating the anticipated license and renewal fees.

ASSUMPTION (continued)

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.

Officials from the **Department of Health and Senior Services (DHSS) - Division of Regulation and Licensure (DRL)** state the addition of another registrant type to the MOHWoRx system would require ITSD resources. A request for an estimate has been requested from ITSD but has not been received. Therefore, DHSS-DRL assumes an unknown, fiscal impact.

The number of assistant physicians that would be registered by the Bureau of Narcotics and Dangerous Drugs (BNDD) is unknown, but it is assumed the registrant fee revenue would be less than $100,000 annually.

Officials from the **Department of Social Services (DSS) - MO HealthNet Division (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 this will have no fiscal impact on MO HealthNet.

Officials from the **Department of Mental Health (DMH)** state the legislation proposes to consider an assistant physician providing primary care services as a physician assistant. The DMH does not provide primary care services; therefore, there is no fiscal impac to the DMH.

§§335.036, 335.038, 335.375 & 335.380 - Nursing Workforce

Officials from the **Department of Insurance, Financial Institutions and Professional Registration (DIFP)** state the proposal requires the Board of Nursing to contract with "Missouri Nurses Foundation Center for Advancing Health." This center may enter into a contractual agreement with a public institution of higher education to collect and analyze workforce data from its licensees. It creates the "Nursing Workforce Center Fund" and requires the board to collect a surcharge from licensees during the initial licensure and renewal to be deposited in that fund which is then to be used for expenditures authorized by sections 335.038, 335.375, and 335.380.

ASSUMPTION (continued)

The proposal requires the Board of Nursing to collect $5 per year on licenses and applicants for two professional groups - Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). This would be $10 per renewal cycle since both of theses professions renew biannually; on applicants the fee is a flat $5.

The DIFP estimates the number of new applications per year at 8,700; therefore, annual applicant revenues will be approximately $43,500 (8,700 applicants X $5 fee). The current number of LPNs that renew in even-numbered years is 25,570; therefore, additional licensing revenue for LPNs, in even numbered years is $255,700 (25,570 licenses X $10). The current number of RNs that renew in odd-numbered years is 96,989; therefore, additional licensing revenue for RNs, in odd-numbered years is $969,980 (96,989 licenses X $10). In total, DIFP estimates even numbered year revenue to be $299,200 [$43,500 applicant fees) + $255,700 LPN licenses]; odd numbered year revenue is estimated to be $1,013,390 [$43,500 applicant fees + $969,890 RN licenses].

DIFP assumes an unknown fiscal impact for the contractual agreement to analyze the workforce data. DIFP estimates it will collect the surcharge and would spend a correspondingly similar amount to contract with the Missouri Nurses' Foundation Center for Advancing Health. Therefore, no large net increase or decrease in cost is anticipated.

Oversight assumes contract analysis costs will equal the surcharge fees received from RN and LPN licenses and applicants for licensing and will net to $0.

§§354.535 and 376.387 - Prescription Copays

Officials from the **Department of Social Services (DSS) - MO HealthNet Division (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.

Officials from the **Department of Mental Health (DMH)** provides that this section of the legislation applies to insurance companies. There is no fiscal impact to the DMH.

Section 1 - Medical Clinics

Officials from the **Department of Health and Senior Services (DHSS)** state that while this legislation does not directly duplicate the Primary Care Resource Initiative for Missouri (PRIMO) program (Sections 191.411 and 191.500 - 191.614, RSMo), it is very similar. Also, the Missouri Healthcare Workforce Registry and Exchange (MoHWoRx) is an information system developed by DHSS to help health professionals meet state registration requirements to provide

ASSUMPTION (continued)

comprehensive and timely information on health care access statewide. The registry became operational at the beginning of 2012. It currently houses information for physicians, dentists, and nurses, maintaining a list of all persons and entities with the authority to conduct activities with controlled substances. It requests information from the three health professions at the time of license renewal to verify demographic information, practice location(s) and characteristics. The response rate for nurses was approximately 25 percent.

Officials from the **Department of Health and Senior Services (DHSS) - Office of Primary Care and Rural Health (OPRCH)** provide for Section 1 the following assumptions:

For fiscal note purposes, DHSS estimate is based on the total number of counties designated as Health Professional Shortage Areas (HPSA) and assumes a range of zero to 100 percent participation in the program. Missouri has 106 counties which are designated as primary care HPSAs. Therefore, the range for matching funds from the Medical Clinics in Medically Underserved Area Fund (MCMUAF) could be $0 to $10,600,000 (106 counties X $100,000), as the legislation directs DHSS to prioritize based on need.

DHSS estimates the following staff would be required to administer the program:

One (1) FTE Program Manager ($50,000 annually) to direct the overall planning, development, and administration of assigned health programs, assist in the identification of program priorities and the development and implementation of new programs and services, and develop and coordinate a comprehensive public health system for a large geographic area related to the expansion of medical clinics.

One (1) FTE Health Program Representative III ($38,040 annually) to assume responsibility as delegated by the program manager, for the planning, promotion, implementation, and evaluation of the public health program; maintaining liaison with other administrative units of the department, local governments, community groups, and others interested in program activities; developing program goals, objectives, policies, and procedures; monitoring program activities; managing program resources; assisting in budget development; tracking and monitoring expenditures; preparing assigned program fiscal reports, contracts, and grants; and assessing program effectiveness through program evaluation and data analysis and modifying program delivery to improve implementation and/or outcome.

Oversight assumes that contributions/grants to start up medical clinics in medically underserved areas will equal the expenditures/grants to counties and municipalities that provide matching funds and the net impact to the MCMUAF will be $0.

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ASSUMPTION (continued)

Oversight notes the provisions of the proposal regarding counties and municipalities establishing medical clinics is permissive. Oversight assumes that counties/municipalities would not establish medical clinics unless they could absorb the start-up funds necessary to obtain matching funds from the DHSS/Medical Clinics in Medically Underserved Area Fund. Therefore, Oversight assumes the proposal will have no fiscal impact on local governments.

Officials from the **Department of Mental Health (DMH)** state this section requires the Department of Health and Senior Services to establish and administer a program to increase the number of medical clinics in medically underserved areas. DMH anticipates no fiscal impact.

Bill as a Whole

Officials from the **University of Missouri Health Care** state the proposal, as written, will cost the University more than $100,000 annually to comply with the provisions.

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 **Office of State Courts Administrator (CTS)** state the proposed changes to various health care and MO HealthNet program provisions may have some impact, but there is no way to quantify the amount currently. Any significant changes will be reflected in future budget requests.

Officials from the **Office of Prosecution Services (OPS)** assume the proposal will have no measurable fiscal impact on the OPS. The creation of a new crime creates additional responsibilities for county prosecutors which may, in turn, result in additional costs, which are difficult to determine.

Oversight assumes the potential responsibilities imposed on county prosecutors as a result of this proposal, will be absorbable within current funding and staffing levels.

HWC:LR:OD

ASSUMPTION (continued)

Officials from the **Office of Attorney General** assume any potential costs arising from this proposal can be absorbed with existing resources.

Officials from the **Missouri Senate (SEN)** state the proposal will have no fiscal impact on their organization beyond existing appropriations.

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 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 **Office of Administration (OA)** state the proposal will have no fiscal impact on the following divisions: **Division of Accounting**, **General Services Division** and the **Division of Purchasing and Materials Management**.

Officials from the **Department of Higher Education**, the **Missouri Consolidated Health Care Plan**, the **Missouri Department of Transportation**, the **Office the Governor**, the **Missouri Department of Conservation**, and the **Office of State Treasurer** each assume the proposal would not fiscally impact their respective agencies.

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			
Income - DHSS-DRL			
Registrant fee revenue	Unknown, less than $100,000	Unknown, less than $100,000	Unknown, less than $100,000
Costs - DHSS-DCPH (§191.875)			
Personal service	($33,320)	($40,384)	($40,788)
Fringe benefits	($16,995)	($20,598)	($20,804)
Equipment and expense	(Unknown, greater than $113,087)	(Unknown, greater than $108,269)	(Unknown, greater than $108,473)
Total Costs - DHSS	(Unknown, greater than $163,402)	(Unknown, greater than $169,251)	(Unknown, greater than $170,065)
FTE Change - DHSS	1 FTE	1 FTE	1 FTE
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
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 - OA-ITSD/DSS			
System changes (§208.010)	($1,229)	$0	$0
System changes and pilot project system contract (§208.187)	(Unknown, greater than $78,170)	$0	$0
System changes (§208.325)	($1,229)	$0	$0
Total Costs - OA-ITSD	(Unknown, greater than $80,628)	$0	$0

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	($5,300,000 to $17,800,000)	(Unknown, greater than $300,000)	(Unknown, greater than $300,000)
Costs - DMH (§208.187)			
Increase in CPR and CSTAR provider costs	(Unknown, greater than $33,333)	(Unknown, greater than $40,000)	(Unknown, greater than $40,000)
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 - 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 - DHSS-OPRCH (Section 1)			
Personal service	($73,367)	($88,920)	($89,810)
Fringe benefits	($37,421)	($45,354)	($45,808)
Equipment and expense	($35,691)	($33,482)	($37,319)
Total Costs - DHSS	($146,479)	($167,756)	($172,937)
FTE Change - DHSS	2 FTE	2 FTE	2 FTE
Total All Costs	(Unkown, greater than $37,105,435)	(Unknown, greater than $39,260,535)	(Unknown, greater than $40,871,486)
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**(Unknown, greater than $37,005,435)**	**(Unknown, greater than $39,160,535)**	**(Unknown, greater than $40,771,486)**
Estimated Net FTE Change on the General Revenue Fund	5 FTE	5 FTE	5 FTE

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
NURSING WORKFORCE CENTER FUND			
Income - DIFP (§§335.036, 335.038, 335.375, & 335.380)			
License surcharge fees	$299,200	$1,013,390	$299,200
Costs - DIFP			
Contract costs for analysis of workforce data	($299,200)	($1,013,390)	($299,200)
ESTIMATED NET EFFECT ON THE NURSING WORKFORCE CENTER FUND	**$0**	**$0**	**$0**
MEDICAL CLINICS IN MEDICALLY UNDERSERVED AREAS FUND			
Income - DHSS (Section 1)			
Grants and other contributions	$0 to $10,600,000	$0 to $10,600,000	$0 to $10,600,000
Costs - DHSS (Section 1)			
Clinic start-up costs	($0 to $10,600,000)	($0 to $10,600,000)	($0 to $10,600,000)
ESTIMATED NET EFFECT ON THE MEDICAL CLINICS IN MEDICALLY UNDERSERVED AREAS FUND	**$0**	**$0**	**$0**
UNIVERSITY FUNDS			
Costs - University of Missouri Health Care			
Various healthcare provision	(Greater than $83,333)	(Greater than $100,000)	(Greater than $100,000)
ESTIMATED NET EFFECT ON UNIVERSITY FUNDS	**(Greater than $83,333)**	**(Greater than $100,000)**	**(Greater than $100,000)**

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)
ESTIMATED NET EFFECT ON VARIOUS OTHER STATE FUNDS	**($15,733,059)**	**($19,672,617)**	**($20,498,867)**
FEDERAL FUNDS			
Income - OA-ITSD/DSS			
Reimbursement for system changes (§208.010)	$1,230	$0	$0
Reimbursement for system changes and pilot project system contract (§208.187)	Unknown, greater than $78,170	$0	$0
Reimbursement for system changes (§208.325)	$1,230	$0	$0
Total Income - OA-ITSD	Unknown, greater than $80,630	$0	$0
Income - DHSS-DSDS (§208.010.2(4))			
Increase in program reimbursements	$59,495	$68,349	$69,132
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- DSS-MHD (§208.187)			
Patient-centered care/HSAs reimbursement	$15,300,000 to $52,800,000	Unknown, greater than $300,000	Unknown, greater than $300,000
Income - DMH (§208.187)			
Program reimbursements	Unknown, greater than $50,000	Unknown, greater than $60,000	Unknown, greater than $60,000

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Income - DSS-FSD (§208.188)			
Increase in program reimbursements	Unknown, greater than $750,000	Unknown, greater than $300,000	Unknown, greater than $300,000
Total All Income	Unknown, greater than $95,352,421	Unknown, greater than $99,650,364	Unknown, greater than $103,805,872
Costs- OA-ITSD/DSS			
System changes (§208.010)	($1,230)	$0	$0
System changes and pilot project system contract (§208.187)	(Unknown, greater than $78,170)	$0	$0
System changes (§208.325)	($1,230)	$0	$0
Total Costs - OA-ITSD	(Unknown, greater than $80,630)	$0	$0
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-MHD (§208.010.2(4))			
Increase in program expenditures due to increasing asset limits	($79,112,296)	($98,922,015)	($103,076,740)
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 - DMH (§208.187)			
Increase in provider reimbursement costs	(Unknown, greater than $50,000)	(Unknown, greater than $60,000)	(Unknown, greater than $60,000)

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Costs - DSS-MHD (§208.187) Patient-centered care/HSAs reimbursement	($15,300,000 to $52,800,000)	(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)
Total All Costs	(Unknown, greater than $95,858,109)	(Unknown, greater than $100,257,432)	(Unknown, greater than $104,412,940)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**(Up to $505,688)**	**(Up to $607,068)**	**(Up to $607,068)**
Estimated Net FTE Change on Federal Funds	1 FTE	1 FTE	1 FTE

FISCAL IMPACT - Local Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

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

FISCAL DESCRIPTION

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.

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.

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

FISCAL DESCRIPTION (continued)

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.

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.

NURSING WORKFORCE CENTER (SECTIONS 335.375, 335.380)

This proposal authorizes the State Board of Nursing within the Department of Insurance, Financial Institutions and Professional Registration to enter into a contractual agreement for the purpose of collecting and analyzing workforce data from its licensees for future workforce planning.

The proposal creates the Nursing Workforce Analysis Fund to be managed by the state board. The board must collect at the time of licensure or licensure renewal a $5 per year surcharge from each registered professional nurse and licensed practical nurse that must be deposited in the fund in addition to appropriated moneys, contributions, grants, and federal funds to pay all administrative costs and expenses incurred from the implementation of the provisions of the proposal.

MEDICAL CLINICS (SECTION 1)

The proposed legislation establishes the Medical Clinics in Medically Underserved Areas Fund which could include moneys from state moneys appropriated, gifts, grants, and donations. The department of health and senior services is to establish and administer the program to increase the number of medical clinics in medically underserved areas. A county or municipality which includes a medically underserved area may establish a medical clinic by contributing start-up money for the clinic and having such contribution, up to $100,000, matched wholly or partly by grant monies. The department is to seek all available moneys from any source. Start-up moneys from the county or municipality may be provided over a two-year period.

This legislation is not federally mandated, would not duplicate any other program and 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 Social Services -
- Family Support Division
- Mo HealthNet Division
- Division of Legal Services

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
Office of Administration -
- Division of Accounting
- General Services Division
- Division of Purchasing and Materials Management
- Information Technology Services Division/DSS

Office of Prosecution Services
Missouri Senate
Office of Secretary of State
Office of State Treasurer
University of Missouri Health Care

Mickey Wilson, CPA
Director
April 11, 2014

Ross Strope
Assistant Director

HWC:LR:OD

April 11, 2014

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