COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 0350-01
Bill No.: HB 247
Subject: Medicaid/MO HealthNet; Health Care
Type: Original
Date: April 19, 2019

Bill Summary: This proposal changes the laws regarding managed care under the MO HealthNet program.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
General Revenue	($1,897,050)	($654,472)	($660,651)
Total Estimated Net Effect on General Revenue	**($1,897,050)**	**($654,472)**	**($660,651)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
Total Estimated Net Effect on Other State Funds	**$0**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 11 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
Federal funds*	$0	$0	$0
Total Estimated Net Effect on All Federal Funds	**$0**	**$0**	**$0**

* Income and expenditures exceed $1.8 million in FY 2020 and $600,000 annually thereafter and net to $0.

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
General Revenue	4	4	4
Federal Fund	3	3	3
Total Estimated Net Effect on FTE	**7**	**7**	**7**

☒ Estimated Net Effect (expenditures or reduced revenues) expected to exceed $100,000 in any of the three fiscal years after implementation of the act.

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

§§ 208.1100 and 208.1105 - MO Health Net managed care

Officials from the **Department of Social Services (DSS), MO HealthNet Division (MHD)** and **Division of Legal Services (DLS)** state this legislation adds new sections to Chapter 208 relative to MO HealthNet Managed Care.

§208.1100(1) Utilization review protocols: It is assumed that the requirements in the current Managed Care contract integrate guidelines prescribed by the Centers for Medicare and Medicaid Services (CMS). Given that health plans already must meet program standards for monitoring and evaluating systems to meet Federal and State regulations and implement components to improve utilization management, MO HealthNet assumes there will be no fiscal impact to the rates for this provision.

It is assumed the DSS will undergo a Request for Information (RFI) process or other process to meet the requirement for engagement with network health care providers. It will take approximately 10 hours of staff time each by a Social Services Manager (SSM), Program Development Specialist (PDS), and a clinical staff person (nurse or above) to write the Request for Information to obtain input from network health care providers. It will take approximately 10 hours of staff time each for a SSM, PDS, and clinical staff (nurse or above) to review the input from the RFI and write the standards and protocols. The total estimated costs for these staff would be $709 for the SSM ($35.45/hr*20 hrs), $436 for the PDS ($21.81/hr*20 hrs), and $453 for the clinical staff person ($22.64/hr*20 hrs). It is assumed existing staff can perform this requirement and costs would be absorbed.

Oversight does not have any information to the contrary and, therefore, assumes current resources are sufficient to perform the duties required under this paragraph of the proposal. Oversight will reflect a zero impact in the fiscal note for DSS for this section.

§208.1100(2) Timely utilization appeal: **DSS** notes the health plans already have member grievance systems in place which address the appeals process. Specifically, the current contract requires as part of the administrative services, a Complaint, Grievance, and Appeal Coordinator to manage and adjudicate member and provider complaints, grievances, and appeals in a timely manner. MHD assumes there would be no impact to the Managed Care rates for this provision.

§208.1100(3) Network adequacy standards: The current managed care contract requires the health plans' Primary Care, Specialty Care, Dental Service, and Behavioral Health networks to comply with travel distance standards as set forth by the Department of Insurance, Financial

ASSUMPTION (continued)

Institutions & Professional Registration (DIFP) in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards. MHD assumes there would be no impact to the Managed Care rates for this provision.

§208.1100(4) Administrative requirements: Health plans currently must have in place sufficient administrative personnel and an organizational structure to comply with all requirements of the contract, including data collection. MHD assumes there would be no impact to the Managed Care rates for this provision.

§208.1100(5) Supplemental payments: The intent of this provision is unclear.

§208.1100(6) Provider assessment pass-through: MHD interprets this provision to require a pass-through payment from the health plans to providers in the amount of any applicable provider tax. Additional discussion related to this requirement is needed to completely understand the intent and application within the Managed Care program. However, CMS may not allow this type of requirement in the health plan contract pursuant to the 2019 Managed Care Rate Development Guide. If this requirement is allowed by CMS, the requirement that contracts ensure compliance with this section will result in the need for an audit process. MHD will require additional staff in the Managed Care Rate Setting Unit, which could be the same staff as required to implement Section 208.1105 (see below).

§208.1100(7) Financial penalties: The current managed care rates already incorporate a Low-Acuity Non-Emergency (LANE) adjustment, which reduces the regional experience for low acuity, non-emergency visits. MHD assumes there would be no impact to the Managed Care rates for this provision. This section will require a new metric to be developed. It will take approximately 10 hours of staff time for a Managed Care Quality Oversight Manager to research and develop this metric. The total estimated cost for this staff would be $355 ($35.45/hr*10 hrs). It is assumed that existing staff would be able to absorb the work necessary to develop this new metric.

Oversight does not have any information to the contrary and, therefore, assumes current resources are sufficient to perform the duties required under this paragraph of the proposal. Oversight will reflect a zero impact in the fiscal note for DSS for this section.

§208.1100(8) Medical Loss Ratios (MLR): **DSS** notes no definitions are included of which services are eligible to be included in the calculation of the MLR. The MLR in the SFY 2019 capitation rate is 85%, so this provision may suggest the administrative component of the rates be reduced by about 2% depending on the definition of services to be included in the MLR; however, this provision may not support actuarially sound rates.

ASSUMPTION (continued)

§208.1100(9) Provide monthly data for monitoring: Under the current Managed Care contract, the state does not interfere with the health plans' contractual agreements with providers. Data may be necessary to ensure required reimbursement, e.g. Federally Qualified Health Centers (FQHCs), is provided. MHD assumes there would be no impact to the Managed Care rates for this provision. However, it is assumed that there would be additional auditing for the three health plans.

It is anticipated that it will take a total of 10 hours of staff time by a Social Service Manager (SSM) (3.33 hours) and two Program Development Specialist (PDS) (3.33 hours per specialist) to plan the audits and prepare the audit materials. In addition, it will take 8 hours of staff time each for a SSM and two PDSs to perform an on-site audit for each health plan (one staff member per health plan). Therefore, it would take a total of 34 hours for an audit of all three health plans (3.33+8=11.33 hrs for a SSM, 3.33+3.33+8+8=22.67 hrs for the PDSs, 34 hours total). It would take another 10 hours total for a SSM (3.33 hours) and PDS (3.33 hours per specialist) to evaluate findings and provide written feedback. Assuming there would be three different audits per year, the total amount of hours would be 132 (34 hours + 10 hours = 44*3). The total costs associated with these audits would be $520 ($35.45/hr*14.67 (11.33+3.33) hrs) for a SSM per audit, and $640 ($21.81/hr*29.33 (22.67+6.67) hrs) for the PDS's per audit, for a total of $3,479 ($520.05*3 audits/yr + $639.69*3 audits/yr). Since the auditing is permissive, it is assumed that any additional auditing would be handled by existing staff; therefore, there is no fiscal impact to MO HealthNet.

Oversight does not have any information to the contrary and, therefore, assumes current resources are sufficient to perform the duties required under this paragraph of the proposal as the additional auditing is permissive. Oversight will reflect a zero impact in the fiscal note for DSS for this section.

§208.1100(10) Shared savings: **DSS** notes health plans are already competitively negotiating contracts with providers and this provision would allow them to take part in value-based purchasing arrangements with providers. Managed Care rates could be impacted for this provision depending on the Shared savings model that is implemented. More analysis is needed.

§208.1100(11) Coercion: MHD assumes there would be no impact to the Managed Care rates for this provision.

§208.1100(12) Timely payment: Managed Care contracts already require the health plans to follow state law for timely payment and allows the health plans to contractually require more stringent requirements. MHD assumes there would be no impact to the Managed Care rates for this provision.

ASSUMPTION (continued)

§208.1105 Regional Plan Proposals from Coordinated Care Organizations (CCO): MHD assumes this section requires the DSS to award contracts to provider-sponsored care management organizations to provide health care services as an option for MO HealthNet beneficiaries to choose instead of choosing a health plan that is available under the MO HealthNet Managed Care Program. It is assumed the intent is to cover only Managed Care-like populations and not the aged, blind and disabled population. It is not clear if the intent is for the CCO to provide services to all Managed Care-like members in a region or to targeted populations, e.g., children only. As written, it is unclear if CCO enrollment would be limited to MO HealthNet participants or if it could include the commercial market.

Currently, the health plans that are contracted in the MO HealthNet Managed Care program operate as health maintenance organizations (HMO). These HMOs must be appropriately licensed and able to meet adequate access requirements as regulated by the DIFP. CCOs are regional, comprised of health care providers and provide services to a defined group of people. Since they are regional, CCOs would not be able to reach the network adequacy standards set by the DIFP. Therefore, a new procurement would be needed to solicit proposals for this program.

Currently, health plans are required to bid on contracts statewide to provide services in all regions. This statewide requirement combines the financially attractive urban areas with the more difficult and less lucrative rural areas. Limiting the number of health plans supports the business viability of the health plans. If additional entities were awarded contracts, the distribution of the members would be spread over more entities and it is possible that some may not have sufficient business to be successful.

This new program will create additional administrative, operational, monitoring and reporting duties for the Managed Care Unit. A new contract will need to be written; a procurement process will need to be managed; policies and procedures will need to be developed to establish standards to ensure comparable levels of benefits, quality and protection to enrollees for this program. Contracts and waivers would need to be revised and approved by CMS. Additional staff will be needed to participate in the new required audits with the State Auditor and to develop and maintain data for reporting requirements. Additional staff will be needed to operationalize, implement and monitor the new CCOs. New staff will have new daily duties to coordinate program requirements and ensure compliance. Ongoing marketing and member education from the CCO to their members would need to be reviewed and approved by the state for the CCO. If performance incentive payments were used, the performance incentive program would need to be developed, implemented and monitored. Eligibility and payment systems will also need to be revised.

ASSUMPTION (continued)

Since it is not known what number or combination of health plans and CCOs would be awarded contracts, the cost of this provision is unknown. However, it is anticipated that at least one (1) FTE Social Service Manager, one (1) FTE Program Development Specialist, and two (2) FTE Management Analysis Specialists II will be needed in the Managed Care Unit.

With the addition of CCOs, a separate global payment methodology would need to be determined apart from the current HMO rates. MHD estimates two (2) new fiscal staff would be needed in the Managed Care Rate Setting Unit at the level of a (1 FTE) Management Analysis Specialist II and a (1 FTE) Social Services Manager. These fiscal staff would also be responsible for the payments related to performance incentives.

Oversight notes CCOs are community-based, integrated care organizations created by states (original legislative establishment by Oregon HB 3650 (2011) and implementation requirements established by SB 1580 (2012)). CCOs work with health care providers, hospitals and local community groups to integrate healthcare services and contain cost increases through improved quality of care. Although having some basic similarities to accountable care organizations (ACOs), the Affordable Care Act made no provisions for CCOs and there is no structured framework for them. Developed by states, CCOs may function as either a single organization or as a network of providers and have a different financial risk structure than ACOs (CCOs may have a global budget with shared savings vs. ACOs sharing savings and losses depending on performance compared to a benchmark).

Oversight contacted officials at the Oregon Health Authority (OHA) to obtain information regarding implementation costs and potential savings associated with CCOs. The 2012 Fiscal Impact statement assumed savings of $239 million to the General Revenue Fund in the second year of the 2011-2013 biennium. At the time of this fiscal note, OHA officials indicated that it was unlikely they would be able to provide Oversight with implementation costs and that it would be difficult to determine actual savings for the CCO program.

Oversight is unable to evaluate the information on CCOs or the assumptions provided by DSS, MHD and therefore, will present the estimated costs proposed by DSS in the fiscal note. Additional FTE and related expenses are split 50/50 between GR and Federal funds.

Oversight notes DSS assumes it will need a total of 6 new FTE as a result of the provisions of this proposal. Based on discussions with DSS officials, it is assumed the additional FTE can be housed within current DSS locations. However, if multiple proposals pass during the legislative session requiring additional FTE, cumulatively the effect of all proposals passed may result in the DSS needing additional rental space.

ASSUMPTION (continued)

MHD states MO HealthNet will incur costs for needed system changes to the Medicaid Management Information System (MMIS) to accommodate the new CCO model. It is difficult to determine exactly what this new CCO program would look like with the information available in this bill; however, MHD assumes this would require setting up an entirely new "managed-care-like" system. The effort needed would be very high and is estimated to be $3,000,000 for system changes in the first year (i.e. updated managed care logic, new rate cells, etc.), with an additional $500,000 per year to add operational staff to the fiscal agent contract to support this new program.

MHD assumes the Managed Care capitation rates would increase by at least $100,000 each year as a result of these changes. The actuarial cost to evaluate this program change to the HMO Managed Care capitation rates would be a one-time cost of $50,000. MHD estimates an ongoing increase to the actuarial contract to determine actuarial sound rates for each CCO. While the actual contract increase would depend on the number of CCOs, MHD estimates an increase of $100,000 per year for this purpose.

Oversight note most costs provided by DSS, MHD are split 50/50 between GR and Federal funds. Only the increase in the managed care captitation payment rates is split approximately 34% GR/66% Federal funds.

§208.1110 Annual Audits: **DSS** assumes that the State Auditor's Office will not invoice DSS for the cost of the annual evaluations; however, if this is not the intent of the proposed legislation DSS may incur additional costs due to the requirement for annual evaluations. MHD assumes there would be no impact to the Managed Care rates for this provision.

Until the FY 2020 budget is finalized, DSS cannot identify specific funding sources.

§208.1110 - SAO annual evaluation

Officials from the **Office of State Auditor (SAO)** state the SAO would need to hire additional staff equivalent to a half FTE Senior Auditor III and a half FTE Staff Auditor II to meet the requirements of evaluating the costs and savings attributable to the implementation of prepaid capitated services. Annual costs to the General Revenue Fund are estimated to be $55,893 for FY 2020; $63,292 for FY 2021; and $63,821 for FY 2022.

Oversight notes that in 2018, the SAO completed 140 audits with approximately 100 auditors (all positions). The SAO is responsible for auditing all state agencies, boards, commissions, judicial circuits, public and charter schools, counties that do not have a county auditor, and political subdivisions when requested by petition or the governor. As Oversight does not have any information to the contrary, FTE and associated costs provided by the SAO will be reflected in the fiscal note.

ASSUMPTION (continued)

Officials from the **Department of Mental Health (DMH)** assume the State Auditor's Office will not invoice DMH for the cost of the annual evaluations required under this proposal. However, if this is not the intent of the proposed legislation, DMH may incur additional costs due to the requirement for annual evaluations.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect a zero impact in the fiscal note for this organization.

Oversight notes that the **Department of Insurance, Financial Institutions and Professional Registration** and the **Office of Administration, Division of Purchasing and Materials Management** have stated the proposal would not have a direct fiscal impact on their organizations. Oversight does not have any information to the contrary. Therefore, Oversight will reflect a zero impact in the fiscal note for these organizations.

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
GENERAL REVENUE FUND			
Costs - DSS (§208.1105)			
Personal service	($128,522)	($155,768)	($157,326)
Fringe benefits	($70,691)	($85,299)	($85,773)
Equipment and expense	($32,532)	($14,875)	($15,247)
MC increase in cap rate	($34,412)	($35,238)	($38,484)
CCO rates	($50,000)	($50,000)	($50,000)
One-time actuarial costs	($25,000)	$0	$0
MMIS system changes	($1,500,000)	($250,000)	($250,000)
Total Costs - DSS	($1,841,157)	($591,180)	($596,830)
FTE Change - DSS	3 FTE	3 FTE	3 FTE
Costs - SAO (§210.1110)			
Personal service	($33,685)	($40,826)	($41,234)
Fringe benefits	($18,621)	($22,466)	($22,587)
Equipment and expense	($3,587)	$0	$0
Total Costs - SAO	($55,893)	($63,292)	($63,821)
FTE Change - SAO	1 FTE	1 FTE	1 FTE
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**($1,897,050)**	**($654,472)**	**($660,651)**
Estimated Net FTE Change on the General Revenue Fund	4 FTE	4 FTE	4 FTE

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
FEDERAL FUNDS			
Income - DSS (§208.1105)			
Increase in MO HealthNet expenditures	$1,872,333	$623,104	$627,120
Costs - DSS (§208.1105)			
Personal service	($128,522)	($155,768)	($157,326)
Fringe benefits	($70,691)	($85,299)	($85,773)
Equipment and expense	($32,532)	($14,875)	($15,247)
MC increase in cap rate	($65,588)	($67,162)	($68,774)
CCO rates	($50,000)	($50,000)	($50,000)
One-time actuarial costs	($25,000)	$0	$0
MMIS system changes	($1,500,000)	($250,000)	($250,000)
Total Costs - DSS	($1,872,333)	($623,104)	($627,120)
FTE Change - DSS	3 FTE	3 FTE	3 FTE
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**
Estimated Net FTE Change for Federal Funds	3 FTE	3 FTE	3 FTE

FISCAL IMPACT - Local Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

This proposal may impact small business health care providers.

FISCAL DESCRIPTION

This bill requires any contract between the state and a vendor of prepaid capitated health services issued, reauthorized, or renewed after August 28, 2019, must incorporate the standards specified in the bill.

HWC:LR:OD

FISCAL DESCRIPTION (continued)

The Department of Social Services must accept regional plan proposals from provider-sponsored care management organizations as an option for coverage of beneficiaries. Such regional proposals may be submitted by coordinated care organizations (CCOs), which are organizations that are accountable for the quality, cost, coordination, and overall care of a defined group of MO HealthNet participants. The regional or statewide CCOs must use a shared savings-shared risk model, and the department must reimburse the CCOs through a global payment methodology, which may utilize a population-based mechanism based on a per-member, per-month calculation with risk-adjustment, risk sharing, and aligned payment incentives. The department may develop performance incentive payments designed to reward increased quality and decreased cost of care.

The State Auditor must conduct an annual evaluation of the savings and costs attributable to state government, political subdivisions, health care providers, and MO HealthNet participants following the expansion of MO HealthNet managed care on or after May 1, 2019.

The annual evaluations must include an assessment of the financial implications attributable to the use of subcontractors by prepaid capitated health services to administer the delivery of health services, including behavioral health services, to MO HealthNet participants.

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

SOURCES OF INFORMATION

Department of Insurance, Financial Institutions and Professional Registration
Department of Mental Health
Department of Social Services
Office of Administration -
Division of Purchasing and Materials Management
Office of State Auditor

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April 19, 2019

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HWC:LR:OD