

COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 0350-02
Bill No.: HCS for HB 247
Subject: Medicaid/MO HealthNet; Health Care
Type: Original
Date: May 2, 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	More than (\$1,812,638)	More than (\$569,234)	More than (\$569,234)
Total Estimated Net Effect on General Revenue	More than (\$1,812,638)	More than (\$569,234)	More than (\$569,234)

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
Total Estimated Net Effect on <u>Other</u> State Funds	\$0	\$0	\$0

Numbers within parentheses: () indicate costs or losses.

This fiscal note contains 12 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 <u>All</u> 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 Centers for Medicaid and Medicare Services (CMS). The 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. Requiring a vendor of services to use the same set of utilization protocols and standards in determining medical necessity for services and for authorizing payment for services delivered, and administration pursuant to the contract, would require major system changes for the vendor. The vendor would need to change payment policy solely for this state. There would be an increase in fixed administrative costs for management and oversight. The vendor would also assume an increase in licensing and one-time technical implementation costs. MHD assumes capitation rates will increase an unknown amount based on these costs.

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 \$709.00 for the SSM (\$35.45/hr*20 hrs), \$436.20 for the PDS (\$21.81/hr*20 hrs), and \$452.80 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.

ASSUMPTION (continued)

§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. The vendors of service currently meet state and federal regulations for this provision; however, the bill states standards shall be established by DSS and each vendor shall use the same set of standards in Missouri. Under this provision the managed care companies will need to modify their current systems to comply with the standards set forth in Missouri that may differ from how the company operates in other areas. The vendors of services assume cost increases associated with protocol licensing, technical implementation, and administrative staff due to the change in systems, processes and review tools. MHD assumes capitation rates will increase an unknown amount based on these costs.

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

§208.1100(4) Administrative requirements: This section states that each vendor shall be standardize and uniformly applied and include collection of financial, care delivery, and quality of care data. 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. The vendor of services would require additional staff to manage changes as well as increased technology needs. MHD assumes capitation rates will increase an unknown amount based on these costs

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

§208.1100(6) Provider assessment pass-through: MO HealthNet 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, requiring that contracts comply with this section will result in the need for an audit process. MO HealthNet will require additional staff in the Managed Care Rate Setting Unit, which could be the same staff as required

ASSUMPTION (continued)

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-emergent visits. MO HealthNet 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 \$354.50 (\$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 a minimum 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.

§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. MO HealthNet 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 PDS's, 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 \$520.05 (\$35.45/hr*14.67 (11.33+3.33) hrs) for a SSM per

ASSUMPTION (continued)

audit, and \$639.69 ($\$21.81/\text{hr} \times 29.33$ ($22.67 + 6.67$) hrs) for the PDS's per audit, for a total of \$3,479.22 ($\520.05×3 audits/yr + $\$639.69 \times 3$ 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 the 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. Further 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. MO HealthNet assumes there would be no impact to the Managed Care rates for this provision.

§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 Department of Insurance and Professional Registration (DIFP). CCOs are regional, comprised of health care

ASSUMPTION (continued)

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.

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 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.

ASSUMPTION (continued)

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.

MHD states MO HealthNet will incur costs for the needed system changes 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, MO HealthNet 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.

The actuarial cost to evaluate this program change to the HMO Managed Care capitation rates would be a one-time cost of \$50,000.

ASSUMPTION (continued)

Oversight note most costs provided by DSS, MHD are split 50/50 between GR and Federal funds. Only the increase in the managed care capitation 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.

Due to the plans having such large costs to implement these legislative changes, Managed Care assumes that the capitation rates will increase resulting in an unknown fiscal impact. The total cost to the state is \$3,541,664 (\$1,770,832 GR/\$1,770,832 FED) to unknown.

§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.

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.

ASSUMPTION (continued)

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.

<u>FISCAL IMPACT - State Government</u>	FY 2020 (10 Mo.)	FY 2021	FY 2022
GENERAL REVENUE FUND			
<u>Costs - DSS (§208.1105) p. 7</u>			
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 p. 9	(Unknown)	(Unknown)	(Unknown)
CCO rates	\$0	\$0	\$0
One-time actuarial costs p. 8	(\$25,000)	\$0	\$0
MMIS system changes p. 8	<u>(\$1,500,000)</u>	<u>(\$250,000)</u>	<u>(\$250,000)</u>
Total <u>Costs</u> - DSS	<u>More than</u> <u>(\$1,756,745)</u>	<u>More than</u> <u>(\$505,942)</u>	<u>More than</u> <u>(\$508,346)</u>
FTE Change - DSS	3 FTE	3 FTE	3 FTE
<u>Costs - SAO (§210.1110) p. 9</u>			
Personal service	(\$33,685)	(\$40,826)	(\$41,234)
Fringe benefits	(\$18,621)	(\$22,466)	(\$22,587)
Equipment and expense	<u>(\$3,587)</u>	<u>\$0</u>	<u>\$0</u>
Total <u>Costs</u> - SAO	<u>(\$55,893)</u>	<u>(\$63,292)</u>	<u>(\$63,821)</u>
FTE Change - SAO	1 FTE	1 FTE	1 FTE
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	<u><u>More than</u></u> <u><u>(\$1,812,638)</u></u>	<u><u>More than</u></u> <u><u>(\$569,234)</u></u>	<u><u>More than</u></u> <u><u>(\$572,167)</u></u>
Estimated Net FTE Change on the General Revenue Fund	4 FTE	4 FTE	4 FTE

<u>FISCAL IMPACT - State Government</u>	FY 2020 (10 Mo.)	FY 2021	FY 2022
FEDERAL FUNDS			
<u>Income - DSS (\$208.1105)</u>			
Increase in MO HealthNet expenditures	More than \$1,756,745	More than \$505,942	More than \$508,346
<u>Costs - DSS (\$208.1105)</u>			
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	(Unknown)	(Unknown)	(Unknown)
CCO rates	\$0	\$0	\$0
One-time actuarial costs	(\$25,000)	\$0	\$0
MMIS system changes	<u>(\$1,500,000)</u>	<u>(\$250,000)</u>	<u>(\$250,000)</u>
Total <u>Costs</u> - DSS	<u>More than</u> <u>(\$1,756,745)</u>	<u>More than</u> <u>(\$505,942)</u>	<u>More than</u> <u>(\$508,346)</u>
FTE Change - DSS	3 FTE	3 FTE	3 FTE

ESTIMATED NET EFFECT ON FEDERAL FUNDS	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
Estimated Net FTE Change for Federal Funds	3 FTE	3 FTE	3 FTE

<u>FISCAL IMPACT - Local Government</u>	FY 2020 (10 Mo.)	FY 2021	FY 2022
	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>

FISCAL IMPACT - Small Business

This proposal may impact small business health care providers.

FISCAL DESCRIPTION

This bill modifies provisions relating to Mo HealthNet managed care.

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



Kyle Rieman
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May 2, 2019

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Assistant Director
May 2, 2019