COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 1272-03
Bill No.: SCS for HCS for HB 466 - Pending further review of impact of §208.225
Subject: Health Care
Type: Original
Date: May 1, 2019

Bill Summary: This proposal modifies provisions relating to medical public assistance.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
General Revenue	($14,355,866 to $16,698,341)	($13,224,715 to $18,805,909) or ($11,342,036 to $17,975,996)	($13,368,809 to $19,340,218) or ($11,461,654 to $18,499,517)
Total Estimated Net Effect on General Revenue	**($14,355,866 to $16,698,341)**	**($13,224,715 to $18,805,909) or ($11,342,036 to $17,975,996)**	**($13,368,809 to $19,340,218) or ($11,461,654 to $18,499,517)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
Premium (0885)	$1,007,960	$1,209,552	$1,209,552
Total Estimated Net Effect on Other State Funds	**$1,007,960**	**$1,209,552**	**$1,209,552**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 34 pages.

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

* Income, savings, costs and losses up to $17.6 million annually and net to $0.

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
General Revenue	7.5 to 8.26	7.5 to 8.5	7.5 to 8.5
Federal	7.84	7.5	7.5
Total Estimated Net Effect on FTE	**15.34 to 16.1**	**15 to 16**	**15 to 16**

☒ 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

Due to time constraints of less than 12 hours, **Oversight** was unable to receive some of the agency responses in a timely manner and performed limited analysis. Oversight has presented this fiscal note on the best current information that we have or on prior year information regarding a similar bill. Upon the receipt of agency responses, Oversight will review to determine if an updated fiscal note should be prepared and seek the necessary approval of the chairperson of the Joint Committee on Legislative Research to publish a new fiscal note.

§208.146 - Extends expiration date for Ticket-to-Work

In response to similar legislation (SB 232), officials from the **Department of Social Services (DSS)** stated they do not anticipate a fiscal impact as a result of this legislation. However, if the sunset is not extended, there would be a loss of revenue to the state. Individuals would no longer pay a premium for Ticket to Work which would result in a loss of revenue to the state of approximately $1.2 million per year (based on SFY 2018 premiums collected of $1,209,552; premiums go to the Premium Fund (#885)). Individuals no longer paying premiums would continue to be covered for Medicaid benefits through a different eligibility group or spenddown.

Oversight obtained additional information from DSS regarding costs associated with the Ticket to Work program. The Ticket to Work program costs the DSS approximately $35 million annually for the premium program and about $9 million annually for the non-premium program. Multiple programs have expenditures related to the Ticket to Work program including nursing facilities, hospitals, dental, pharmacy, physician services, in-home services, mental health services, state institutions and Early Periodic Screening Diagnosis and Treatment (EPSDT) services. Pharmacy and Managed Care programs receive the funds from the Ticket to Work premiums collected. During FY 2018, approximately 1,380 individuals participated in the premium program and 234 in the non-premium program.

Oversight assumes this bill will extend the sunset of the Ticket to Work program and will, therefore, will present premiums collected by the Ticket to Work program of $1,209,552 annually to the Premium Fund. Oversight assumes there may be costs associated with this program up to $44 million; however, Oversight is unable to determine whether the individuals would be covered through a different eligibility group or spenddown as stated by DSS above. Therefore, Oversight will reflect DSS' assumption of no fiscal impact from this proposal other than the continuation of collecting premiums.

In response to similar legislation (SB 232), officials from the **Office of Administration, Division of Budget & Planning (B&P)** stated this proposal has no direct fiscal impact on B&P. In addition, the proposal has no direct impact on general or total state revenues and will not impact the calculation pursuant to Article X, Sec. 18(e).

ASSUMPTION (continued)

§208.151 - MO HealthNet benefits for persons in foster care

In response to similar legislation (SB 514), officials from the **Department of Social Services (DSS), MO HealthNet Division (MHD)** stated §208.151.1(26) is amended to allow persons who were in foster care under the responsibility of another state for at least six months, are currently residing in Missouri, are at least eighteen years of age, are not eligible for coverage under another mandatory coverage group, and were covered by Medicaid while they were in foster care to also be eligible to receive MO HealthNet benefits.

Section 1902 (a)(10)(i)(IX) of the Social Security Act requires states to make medical assistance available to individuals who were in foster care under the responsibility of the State on the date of attaining eighteen years of age until the individual turns twenty-six years of age. However, the federal law does not require states to make medical assistance available to individuals who were in foster care under the responsibility of another state.

States have the option to apply for an 1115 demonstration waiver under 42 CFR 435.150 to provide medical assistance to former foster care youth who aged out in another state and were enrolled in Medicaid in another state at any time during the period of foster care.

In State Fiscal Year (SFY) 2018, there were 25 children, that were age 18 or older and placed in foster care in Missouri who were under the responsibility of another state for at least six months. For the purpose of this bill, the Family Support Division (FSD) is estimating that this is the number of children that would be eligible for this coverage per year. It is assumed that these individuals are eligible for a federally matched Medicaid program, under an 1115 demonstration waiver.

Because an 1115 waiver is required to implement the provisions of this bill, the DSS would have to apply for and be approved in order to receive a federal match on these individuals. Due to the amount of time estimated to apply and be approved for the waiver, the earliest this legislation could be implemented is expected to be January 1, 2020.

The FSD assumes existing staff will be able to complete necessary additional work as a result of this proposal.

The FSD assumes Office of Administration, Information Technology Services Division (OA,ITSD) will include the system programming costs for the system changes necessary to implement provisions of this bill.

ASSUMPTION (continued)

The Children's Division (CD) and FSD defer to MO HealthNet Division for costs to the program; therefore, there is no fiscal impact to the CD or to the FSD.

Oversight does not have any information to the contrary. Oversight assumes the CD and FSD have sufficient staff and resources to handle any increase in workload required under the provisions of this proposal and will reflect no fiscal impact for these divisions for fiscal note purposes.

MHD officials state per the new parameters of this legislation, the CD reports that a total of 25 children in FY 2018 were 18 or older and are currently residing in Missouri that had been under the responsibility of another state for at least 6 months. MO HealthNet Division found that a per member per month (PMPM) rate for foster care services is $604.11. Therefore, an annual cost for this new legislation is estimated to be $181,233 (25 newly eligible*$604.11 PMPM*12 months). A 2.4% inflation rate was used for FY21 and FY22.

FY20 (6 mos): Total: $90,617 (GR $31,183; FF $59,434);
FY21: Total: $185,583 (GR $63,863; FF $121,720; and,
FY22: Total: $190,037 (GR $65,396; FF $124,641).

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the costs provided by DSS, MHD for fiscal note purposes.

In response to similar legislation (SB 514), officials from the **Office of Administration, Information Technology Services Division (OA, ITSD)/DSS** stated system modifications will be required for the Missouri Eligibility Determination and Enrollment System (MEDES). System modifications will be executed via a Project Assessment Quotation under the existing Redmane contract (CT 170849002) for MEDES Maintenance and Operations as an enhancement. It is assumed the system modifications will require 4,043.52 IT consultant contract hours at $160 per hour for a total cost of $646,963 ($161,741 GR; $485,222 Federal funds) in FY 2020.

In addition, it is assumed the Family and Children Electronic Services (FACES) system will require modifications. IT consultants are estimated to require 648.00 hours at $75/hours to do the necessary modifications for a total of $48,600 ($32,076 General Revenue (GR); $16,524 Federal Funds) in FY 2020.

It is assumed that every new IT project/system will be bid out because all ITSD resources are at full capacity. Contracted IT consultant hours are estimated at a rate of $75 per hour.

ASSUMPTION (continued)

Oversight notes, based on information from OA, ITSD officials that changes to FACES are made using a mix of ITSD staff and a contractor. Generally changes are contracted out, especially if there are significant changes.

Oversight also notes ITSD assumes that every new IT project/system will be bid out because all their resources are at full capacity. For this proposal, ITSD assumes system changes will need to be made to the MEDES and FACES systems. The state has a contract with Redmane to perform system changes/enhancements to MEDES. However, since changes to FACES are made using a mix of ITSD staff and a contractor, Oversight assumes ITSD staff could make the required changes to FACES.

ITSD estimates the FACES project would take 648.00 hours at a contract rate of $75 per hour for a total cost to the state of $48,600 ($32,076 GR; $16,524 Federal funds). Oversight notes that an average salary for a current IT Specialist within ITSD is $51,618, which totals roughly $80,000 per year when fringe benefits are added. Assuming all ITSD resources are at full capacity, Oversight assumes ITSD may (instead of contracting out the programming) hire additional IT Specialists to perform the work required by this proposal. Therefore, Oversight will range the fiscal impact from the cost of contracting out the work for FACES updates ($48,600 in FY 2020) to hiring 1 ($48,600 / $75 / 2,080 hours = 0.31 rounded up) additional FTE IT Specialists (roughly $80,000 per year) to complete the FACES system changes in approximately the same time as contract IT consultants. For FY 2021 and 2022, Oversight cannot assume FTE costs would be split between GR and Federal funds and will present costs as 100% GR.

§208.225 - Capital expenditures by long-term care facilities - rebase

In response to similar legislation (SB 11), officials from the **Department of Health and Senior Services (DHSS)** stated the proposed changes to section 208.225 would modify the way the Nursing Facility per diem rate is calculated for MO HealthNet. DHSS assumes there will be a corresponding fiscal impact to Home- and Community-Based Services expenditures because reimbursement for these services is based on the Nursing Facility rates.

DHSS defers to the Department of Social Services (MoHealthNet) (DSS) to calculate the fiscal impact of altering long-term care facility (nursing home) provider rates.

In estimating the impact on DHSS home- and community-based programs, DHSS used the DSS (MoHealthNet) nursing home provider rate estimates. Any increase or decrease in the average monthly cost will equate to a corresponding increase or decrease to the monthly maximum allowable cost of home- and community-based services (HCBS) that eligible participants could potentially use. Currently, recipients of State Plan Basic Personal Care and Consumer-Directed

ASSUMPTION (continued)

Services HCBS are limited to a maximum monthly cost not to exceed 60 percent of the average monthly cost of nursing facilities for a participant, as calculated by DSS. Additionally, recipients of State Plan Advanced Personal Care, as well as Adult Day Care services, within both the Adult Day Care Waiver and the Aged and Disabled Waiver are limited to a maximum monthly cost not to exceed 100 percent of the average monthly cost of nursing facilities for a participant, as calculated by DSS.

DHSS used HCBS participant data for the last three fiscal years where the nursing facility rate increased, but the provider rate did not simultaneously increase (FY 14, FY 16, and FY 18). For the purposes of this fiscal note, only those participants that were authorized for services within the range of the previous fiscal years' 60 percent cap and the new fiscal years' 60 percent cap were considered to be those affected by the HCBS 60 percent cost cap increase in those specific years. By taking an average of the participants with increased authorization within this range from those years, DHSS estimates that the number of participants that will benefit from a new 60 percent cost cap increase would be 1,572 participants per year. DHSS used this participant count and the DSS (MHD) estimated rate calculations and ranges to estimate the HCBS cost cap ranging from $1,932 to $1,947 for FY 2020, $1,940 to $1,972 for FY 2021, and $1,948 to $1,998 for FY 2022. Subtracting the FY 2019 cost cap of $1,924 from these projections results in the increased cost cap range of $7.67 to $23.18, $15.69 to $47.63, and $23.91 to $73.55 per participant for FY 2020, FY 2021, and FY 2022, respectively. DHSS estimates additional total costs ranging from:

FY 2020 - $144,656 ($7.67*1,572*12) to $437,175 ($23.18*1,572*12);
FY 2021 - $295,913 ($15.69*1,572*12) to $898,302 ($47.63*1,572*12); and
FY 2022 - $450,943 ($23.91*1,572*12) to $1,387,153 ($73.55*1,572*12).

Additionally, those participants that were authorized for services within the range of the previous fiscal years' 100 percent cap and the new fiscal years' 100 percent cap were considered to be those affected by the 100 percent nursing facility cost cap increase in those specific years. By taking an average of the participants with increased authorization within this range from those years, DHSS assumed that the number of participants that will benefit from a new 100 percent cost cap increase would be 603 participants per year. DHSS used this participant count and the DSS (MHD) estimated rate calculations and ranges to estimate the average monthly nursing facility cost cap ranging from $3,220 to $3,246 for fiscal year 2020, $3,233 to $3,287 for fiscal year 2021, and $3,247 to $3,330 for fiscal year. Subtracting the FY 2019 cost cap of $3,207 from these projections results in the increased cost cap range of $12.78 to $38.63, $26.16 to $79.39, and $39.85 to $122.58 per participant for FY 2020, FY 2021, and FY 2022, respectively. DHSS estimates additional total costs ranging from:

ASSUMPTION (continued)

FY 2020 - $92,527 ($12.78*603*12) to $279,681 ($38.63*603*12);
FY 2021 - $189,398 ($26.16*603*12) to $574,784 ($79.39*603*12); and
FY 2022 - $288,514 ($39.85*603*12) to $887,479 ($122.58*603*12).

Accordingly, DHSS estimates total costs ranging from:
FY 2020 - $237,183 ($144,656 + $92,527) to $716,856 ($437,175 + $279,681);
FY 2021 - $485,312 ($295,913 + $189,398) to $1,473,086 ($898,302 + $574,784); and
FY 2022 - $739,457 ($450,943 + $288,514) to $2,274,632 ($1,387,153 + $887,479).

The current FMAP split for FY 2020 is 34.412 % GR and 65.588% Fed.

FY 2020: $81,620 - $246,684 (GR) and $155,564 - $470,172 (Fed)
FY 2021: $167,006 - $506,918 (GR) and $318,306 - $966,167 (Fed)
FY 2022: $254,462 - $782,746 (GR) and $484,995 - $1,491,886 (Fed).

Oversight determined from DHSS officials that the FY 2020 costs in the fiscal note are for a full year. Oversight will present FY 2020 costs for 10 months. Therefore, after applying the FMAP split, FY 2020 costs will be ranged from $68,017 - $205,570 (GR) and $129,637 - $391,810 (Fed).

In response to similar legislation (SB 11), officials from the **Department of Social Services (DSS), MO HealthNet Division (MHD)** stated 208.225.3 states any enrolled MHD intermediate care facility or skilled nursing facility that incurs total capital expenditures in excess of two thousand dollars per bed shall be entitled to obtain a recalculation of its Medicaid per diem reimbursement by MHD. The rate is based on its additional capital costs or all costs incurred during the facility fiscal year when the capital expenditures were made. Recalculations shall become effective and payable by MHD as the date of application for rate adjustment.

MHD estimates a vendor would be needed to audit/adjust rates for nursing homes. MHD estimates this will cost:

FY 2020 total: $136,383 (GR $68,191, FF $68,191);
FY 2021 total: $141,565 (GR $70,782, FF $70,782); and,
FY 2022 total: $146,945 (GR $73,472, FF $73,472).

Oversight does not have any information to the contrary. However, Oversight notes FY 2020 costs are for a full year. Oversight will reflect the vendor costs for FY 2020 for 10 months rather than 12 months for fiscal note purposes.

ASSUMPTION (continued)

MHD used the average rate increase for rate adjustments granted in 2002 for the impact of the "Adjust Capital Rate Only" scenario (adjusted for increase in nursing facility rates between 2002-2019 + 2.1% inflation for SFYs 20-22). MHD only used allowable nursing facility related capital expenditures to determine qualifying facilities (excludes capital expenditures for non-allowable items (construction in progress, vehicles, land, etc) or non-nursing facility related items (RCFs, apartments, etc). MHD assumes a range due to different rates recalculated for the capital costs vs all costs.

Costs associated with adjustment to Capital Rate only:

FY 2020 total: $3,666,401 (GR $1,261,682; FF $2,404,719) to $11,094,434 (GR $3,817,817; FF $7,276,617);
FY 2021 total: $7,465,126 (GR $2,568,899; FF $4,896,227) to $22,780,587 (GR $7,839,256; FF $14,941,331); and,
FY 2022 total: $11,399,319 (GR $3,922,734; FF $7,476,585) to $35,093,336 (GR $12,076,319; FF $23,017,018).

Oversight notes the DSS has provided "cumulative" costs for Capital Rate-only and costs incurred during the facility fiscal year for FY 2021 and FY 2022. For fiscal note purposes, Oversight will present estimated costs for each year. In addition, Oversight will present FY 2020 costs for 10 months rather than 12 months.

Grand estimated total with Vendor Costs:

FY 2020 total: $3,802,784 (GR $1,329,873; FF $2,472,910) to $11,230,817 (GR $3,886,008; FF $7,344,809)
FY 2021 total: $7,606,691 (GR $2,639,682; FF $4,967,009) to $22,922,152 (GR $7,910,038; FF $15,012,114)
FY 2022 total: $11,546,264 (GR $3,996,206; FF $7,550,058) to $35,240,281 (GR $12,149,791; FF $23,090,490)

Oversight only reflects the responses that we have received from state agencies and political subdivisions; however, other nursing homes were requested to respond to this proposed legislation but did not. For a general listing of political subdivisions included in our database, please refer to www.legislativeoversight.mo.gov.

ASSUMPTION (continued)

§208.790 - Mo Rx Plan

In response to similar legislation (SB 78), officials from the **Department of Social Services (DSS) - MO HealthNet Division (MHD)** stated this legislation allows individuals whose income is less than one hundred eighty-five percent (185%) of the federal poverty level for the applicable family size to be eligible for the MO Rx plan. Currently the MO Rx program is available for dual-eligible (Medicare and Medicaid) participants only. Subject to appropriation, if this legislation is enacted, the program will be available for dual (Medicare and Medicaid eligible participants) and non-dual (Medicare-only) participants.

The federal budget recently passed by the United States Congress closes the coverage gap in Medicare Part D (known as the "Donut Hole"). In FY 2017, once an individual with Medicare Part D reached the coverage gap, they were responsible for 40% of the cost for brand drugs and 49% of the cost for generic drugs. For FY 2020, individuals will be responsible for 25% of all drug cost once they reach the coverage gap. When the MO Rx plan included coverage for non-dual members, the plan paid for 50% of the member cost once the member was in the coverage gap. As a result of the reduction in participant responsibility once in the coverage gap, the cost to add non-duals back into the MO Rx program would be reduced by $72,082 annually.

This amount was calculated assuming 31% of the FY 2020 projected number of qualifying recipients of 63,596 (Forbes: The Medicare Drug 'Donut Hole' is a Much Smaller Problem Than You Think) or 19,715 of non-duals, could be affected by the donut hole. Of the 19,715 recipients, it is assumed 6% or 1,183 (19,715 x .06) would reach the coverage gap. The coverage gap is $1,250 but only a small percentage of Medicare Part D participants spend the full gap amount. For the purposes of this fiscal note, the coverage gap is estimated to be $625 ($1,250/2). Assuming a member responsibility of 44.5% (average of 40% brand and 49% generic), the member responsibility in the gap would be $278 (625 x 0.445). MO Rx would pay 50% or $139 ($278 / 2) for a total gap coverage cost of $164,494 (1,183 x $139). In FY 2020 the Medicare Part D member responsibility drops to 25% for an estimated member coverage gap cost of $156 ($625 x 0.25). MO Rx would pay 50% or $78 for a total FY 2020 estimated coverage gap cost of $92,412 (1,183 x $78). The annual savings applied to the cost of this fiscal note for donut hole closing is $72,082 ($164,494 - $92,412).

The projected average number of non-duals in FY 2020 is 63,596. Using a per member per year cost of $281, the projected FY 2020 10-month cost would be $14,909,543 ((63,596 x $281= $17,891,452) /12 x10 = $14,909,543). The estimated FY 2020 start-up and administrative cost include contractor, mailings, and enrollment fees would be $492,253 for a total cost of $15,401,797. Estimated FY 2020 rebate revenue of $3,260,312 would offset the cost and it is

ASSUMPTION (continued)

assumed MO Rx rebates are paid 6 months in arrears. FY 2020 savings related to the donut hole would be $72,082. FY 2020 net cost would be $12,069,403. Full year FY 2021 and FY 2022 net cost are $11,062,189. Until the FY 2020 budget is final, the department cannot identify specific funding sources.

Oversight notes, based on information from DSS officials, the donut hole savings for FY 2020 should be $60,068 (10 months) rather than $72,082. Annual donut hole savings for FY 2021 and 2022 is $72,082.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the costs, savings, and rebate income as provided by DSS for fiscal note purposes.

In response to similar legislation (SB 78), officials from the **Office of Administration, Division of Budget & Planning (B&P)** stated the proposal will have no direct impact on B&P. In addition, there is no impact to Total State Revenue (TSR) or the calculation pursuant to Article X, Section 18(e).

Oversight does not have any information to the contrary. Therefore, Oversight will reflect no fiscal impact for B&P for fiscal note purposes.

§§208.896 - Structured family caregiving

In response to the previous version of this proposal, officials from the **Department of Health and Senior Services (DHSS)** stated §208.896 provides that upon submission of a waiver application by the Department of Social Services (DSS) and approval by the Centers for Medicare and Medicaid Services (CMS), the Structured Family Caregiver waiver would be created as a new home- and community-based (HCBS) service under Missouri's Medicaid program, which the Division of Senior and Disability Services (DSDS) would administer. The bill would cap the number of slots in the waiver at 300 in the first year with the number available in each subsequent year subject to appropriation. If waiver slots are added it would represent an additional cost.

Currently, service cost caps are calculated on a percentage of the average monthly cost of nursing facility services, which is currently $3,207.12 per month or $105.44 per day. Costs for the basic agency model and consumer-directed state plan personal care are capped at 60 percent of the cost cap; advanced personal care and adult day care are capped at 100 percent of the cost cap; and all other current waiver services are capped in aggregate at 100 percent of the cost cap. The proposed legislation would cap the cost of the Structured Family Caregiver waiver service at 60

ASSUMPTION (continued)

percent of the average monthly cost of nursing home services. DSDS estimated an annual increase of 1.31 percent, based on the five-year average cost cap increase in state fiscal years 2014 to 2018 and the number of unduplicated participants having paid claims in these waivers in FY 2018.

The proposed legislation specifies that the DSS shall request a waiver from CMS to provide structured family caregiving as an HCBS under Missouri's Medicaid program. DSDS assumes that any individual currently eligible for HCBS, and who has been diagnosed with Alzheimer's or related disorders as defined in section 172.800, would be eligible to apply for services under the newly created waiver. Additionally, individuals who are not currently accessing services, but meet the criteria would be eligible.

§208.896.1
For fiscal note purposes DSDS assumes structured family caregiving would be available to all of the individuals listed above.

Changes will be required to the HCBS web tool system in which HCBS assessments are completed and HCBS authorizations are approved. Using a similar recent change, where an HCBS waiver was added, DSDS estimates the cost to be at least $400,000, paid at the administrative match rate of 50 percent General Revenue (GR) and 50 percent Federal. The changes would be completed in FY2020 in preparation for implementation on July 2, 2020.

Oversight determined that DHSS' current contractor for the Webtool system is Conduent. Therefore, Oversight will reflect the costs provided by DHSS for the Webtool system updates for fiscal note purposes.

§208.896.2(9)
For fiscal note purposes, **DHSS** calculated the daily rate for structured family caregiving as no more than 60 percent of the daily nursing home cost cap.

DHSS calculated the daily rate for structured family caregiving based on the cost cap amount for HCBS, which is $3,207 per month, or $105.44 per day ($3,207.12 X 12 ÷ 365 = $105.44). An annual increase in the cost cap rate of 1.3 percent is estimated based on the previous five-year average resulting in a daily rate at implementation in FY 2021 of $108.20 ($105.44 X 1.013 (FY20) X 1.013 (FY19) = $108.20). DHSS calculated the daily rate for structured family caregiving at 60 percent of the cost cap resulting in a daily rate at implementation in FY 2021 of $64.92 ($108.2 x 0.60 = $64.92).

ASSUMPTION (continued)

The estimated daily rate for FY 2022 is $109.61 ($108.20 X 1.013 = $109.61). DHSS calculated the daily rate for structured family caregiving at 60 percent of the cost cap resulting in a daily rate at implementation in FY 2022 of $65.77 ($109.61 x 0.60 = $65.77).

Cost of Services
For the purposes of this fiscal note, DHSS officials assume the cap of 300 participants will be served.

FY 2021
DSDS estimates the cost of structured family caregiver in FY 2021 to be $0 to $7,108,740 (300 x 365 x $64.92).

FY 2022
DSDS estimates the cost of structured family caregiver in FY 2022 to be $0 to $ 7,201,815 (300 x 365x $65.77).

MO HealthNet covered services are reimbursed at the Federal Medical Assistance Percentage (FMAP). For this estimate, DSDS is using the FY 2020 blended rate of 34.412 percent GR and 65.588 percent Federal. The estimated reimbursement amounts for structured family caregiver calculated for FY 2021 and FY 2022 were multiplied by the estimated number of participants for the Adult Disabled Waiver (ADW) in FY 2018 and the FY 2020 blended FMAP rate applied.

Cost of Family Caregiver Services for HCBS Daily Rates					
	Unduplicated Participants	FY2021 Family Caregiver Daily Rate	FY2021 Estimated Annual Cost	FY2022 Family Caregiver Daily Rate	FY2022 Estimated Annual Cost
ADW/FSC	300	$64.92	$7,108,740	$65.77	$7,201,815
GR			$2,446,260		$2,478,289
FED			$4,662,480		$4,723,526

Offsetting Savings

For the purposes of this fiscal note, DSDS assumes that all 300 waiver slots would be filled by existing HCBS participants. Any slot that is filled by a participant not currently receiving HCBS services would not have an offsetting HCBS cost savings. In addition, DSDS cannot estimate the cost savings for other Medicaid services that a participant might replace with structured family caregiving.

ASSUMPTION (continued)

DSDS assumes that half of the 300 participants that would opt for Structured Family Caregiving would come from those currently in the ADW and half would come from those currently receiving State Plan Personal Care services. DSDS has assumed a range for the potential savings offset. As it is uncertain if the participants that choose to utilize the Structured Family Caregiver option (thus replacing all other HCBS) will be those currently capped at 60% of the nursing facility rate or will be those participants utilizing waiver services or advanced personal care above the 60% threshold, the range for potential savings includes the average participant cost for those capped at 60% and the overall average cost of a participant in both the ADW and the Personal Care program potentially receiving 100% of the cost cap. DSDS bases this assumption on the potential for a participant who is currently receiving services above 60% through waiver services or Advanced Personal Care to choose the Structured Family Caregiver Option simply as it may be preferable to have a family member to provide the care.

Offsetting Savings for claims paid up to 60%

The FY 2018 paid claims expenditures for the ADW Waiver for those participants that do not exceed the nursing home cost cap was $86,522,064 for claims paid up to 60%. That cost was then multiplied by the average annual growth in the cost cap of 1.3 percent for FY 2020, FY 2021, and FY 2022. The annual costs were divided by the number of participants with paid claims (10,485 unduplicated) to get the average participant cost and then multiplied by the 150 participants. The estimated savings would be:

FY 2021 = $1,286,703
FY 2022 = $1,303,430

The FY 2018 paid claims expenditures for the State Plan Personal Care services for those participants that do not exceed the nursing home cost cap was $114,933,430 for claims paid up to 60%. That cost was then multiplied by the average annual growth in the cost cap of 1.3 percent for FY 2020, FY 2021, and FY 2022. The annual costs were divided by the number of participants with paid claims (15,930 unduplicated) to get the average participant cost and then multiplied by the 150 participants. The estimated savings would be:

FY 2021 = $1,124,993
FY 2022 = $1,139,618

The FY2020 blended rate of 34.412 percent General Revenue and 65.588 percent Federal was applied to the total estimated cost waiver services for FY2021 and FY2022. This is the amount of the maximum estimated savings for claims paid up to 60%.

ASSUMPTION (continued)

	FY2021 Estimated Waiver Savings	FY2022 Estimated Waiver Savings
Total	$ 2,411,696	$ 2,443,047
GR	$ 829,913	$ 840,701
FED	$ 1,581,783	$ 1,602,346

Offsetting Savings for overall ADW and State Plan Personal Care participant claims

The FY 2018 paid claims expenditures for the ADW Waiver for those participants that do not exceed the nursing home cost cap was $232,578,899. That cost was then multiplied by the average annual growth in the cost cap of 1.3 percent for FY 2020, FY 2021, and FY 2022. The annual costs were divided by the number of participants with paid claims (17,415 unduplicated) to get the average participant cost and then multiplied by the 150 participants. The estimated savings would be:

FY2021 = $2,082,411
FY2022 = $2,109,483

The FY 2018 paid claims expenditures for the State Plan Personal Care services for those participants that do not exceed the nursing home cost cap was $565,791,352. That cost was then multiplied by the average annual growth in the cost cap of 1.3 percent for FY 2020, FY 2021, and FY 2022. The annual costs were divided by the number of participants with paid claims (26,035 unduplicated) to get the average participant cost and then multiplied by the 150 limit.

The estimated savings would be:

FY2021 = $3,388,586
FY2022 = $3,432,638

The FY2020 blended rate of 34.412 percent General Revenue and 65.588 percent Federal was applied to the total estimated cost waiver services for FY2021 and FY2022. This is the amount of the maximum estimated savings for overall paid claims in the ADW waiver and State Plan Personal Care services.

ASSUMPTION (continued)

	FY2021 Estimated Waiver Savings	FY2022 Estimated Waiver Savings
Total	5,470,997	5,542,121
GR	1,882,679	1,907,155
FED	3,588,317	3,634,966

Net Effect

Federal matching funds would be utilized as offset for 65.588 percent of the costs. For the purposes of this estimate, the number of unduplicated participants authorized has no caseload growth factor applied.

For paid claims up to 60%, DSDS assumes the following net effect on GR.

	FY2021			FY2022		
	GR	FED	TOTAL	GR	FED	TOTAL
Estimated Cost	$ (2,446,260)	$ (4,662,480)	$ (7,108,740)	$ (2,478,289)	$ (4,723,526)	$ (7,201,815)
Maximum Savings	$ 829,913	$ 1,581,783	$ 2,411,696	$ 840,701	$ 1,602,346	$ 2,443,047
Subtotal	$ (1,616,347)	$ (3,080,698)	$ (4,697,045)	$ (1,637,587)	$ (3,121,181)	$ (4,758,768)
Federal Match	$ -	$ 3,080,698	$ 3,080,698	$ -	$ 3,121,181	$ 3,121,181
Net Effect	$ (1,616,347)	$ -	$ (1,616,347)	$ (1,637,587)	$ -	$ (1,637,587)

For the average of overall paid claims, DSDS assumes the following net effect on GR.

	FY2021			FY2022		
	GR	FED	TOTAL	GR	FED	TOTAL
Estimated Cost	$ (2,446,260)	$ (4,662,480)	$ (7,108,740)	$ (2,478,289)	$ (4,723,526)	$ (7,201,815)
Maximum Savings	$ 1,882,679	$ 3,588,317	$ 5,470,997	$ 1,907,155	$ 3,634,966	$ 5,542,121
Subtotal	$ (563,580)	$ (1,074,163)	$ (1,637,744)	$ (571,134)	$ (1,088,560)	$ (1,659,695)
Federal Match	$ -	$ 1,074,163	$ 1,074,163	$ -	$ 1,088,560	$ 1,088,560
Net Effect	$ (563,580)	$ -	$ (563,580)	$ (571,134)	$ -	$ (571,134)

TOTAL COST

DSDS is unable to determine the exact cost of the proposal due to the following unknown factors:

- if CMS would approve the waiver to add structured family caregiver;
- the number of participants who would opt for structured family caregiver;
- the potential savings based on current participant expenditure levels; and
- the number of providers who would participate as structured family caregiver agencies.

ASSUMPTION (continued)

Therefore, the estimated total fiscal impact of this fiscal note is ($200,000) GR and ($200,000) Federal in FY 2020; ($563,580 to $1,616,347) GR and ($1,074,163 to $3,080,698) Federal in FY 2021; and ($571,134 to $1,637,587) GR and ($1,088,560 to $3,121,181) Federal in FY 2022.

Section 208.896.3(1):
Submission and approval of a waiver would be required by the Centers for Medicare and Medicaid (CMS) prior to implementation, no later than July 2, 2020. These duties would be absorbed by existing DHSS staff. The department anticipates being able to absorb these costs. However, until the FY20 budget is final, the department cannot identify specific funding sources.

Section 208.896.3(2) ;
DHSS would be required to develop criteria, regulations, and policies for structured family caregiver agencies for staffing, quality, qualification, and training standards.

General Counsel - Attorney ($64,500)
The proposed legislation requires the promulgation of rules and regulations, which include the following duties (but not all inclusive): establish guidelines, implement strategies, make evidence-based system changes, and create policy recommendations. The DHSS, Office of General Counsel will need an additional 0.10 FTE for an attorney (salary of $64,500 per year) to perform the research necessary to ensure the new guidelines and information for this proposed legislation has been properly vetted and implementation is completed.

Oversight assumes 0.1 FTE would not be provided fringe benefits and the state would only pay Social Security and Medicare benefits of 7.65 percent. In addition, Oversight assumes the DHSS would not need additional rental space for 0.1 FTE. However, if multiple proposals pass during the legislative session requiring additional FTE, cumulatively the effect of all proposals passed may result in the DHSS needing additional rental space.

Oversight assumes since DHSS states their responsibility to perform the research necessary to ensure the new guidelines and information for this proposed legislation has been properly vetted and implementation is completed quickly and with fiscal responsibility, Oversight will range the cost of the partial FTE from $0 to DHSS' estimate less fringe benefits over 7.65% and rental space costs.

Based on information from DHSS officials, **Oversight** notes the range of $0 to $7.1 million (FY 2021: $2.45 million GR; $4.66 million Federal) and $7.2 million (FY 2022: $2.48 million GR; $4.72 million Federal) costs provided by DHSS. The only way structured family caregiving costs would be $0, is if no participants take advantage of the program. In addition, there would also be no savings. Savings will only occur to the existing waiver programs if the structured family caregiving program is used and then the costs will exceed the savings. Therefore, Oversight will range costs for fiscal note purposes from $0 (no participants) to the costs provided by DHSS.

ASSUMPTION (continued)

In response to the previous version of this proposal, officials from the **Department of Social Services (DSS), MO HealthNet Division (MHD)** stated HCS for HB 466 amends §208.896, RSMo, to include structured family care giving as a MO HealthNet covered service, subject to federal waiver approval.

§208.896.1: Allows participants diagnosed with Alzheimer's or related disorders to live at home in the community of their choice and receive support from the caregivers of their choice. This section directs the DSS to apply to the U. S. Health and Human Services (HHS) Secretary for a 'structured family caregiver' waiver under Section 1915(c) of the Social Security Act and requires federal approval of the waiver before provisions of this section are implemented. This section also provides that 'structured family caregiving' is to be considered an agency-directed model and no financial management services shall be required.

§208.896.2: Describes what must be included in a 'structured family caregiver' waiver:

- Qualified and credentialed caregivers, including family caregivers, for the participant to choose from;
- Community settings for the participant to choose from where the participant will receive the structured family caregiving, including the caregiver's home or the participant's home as long as the caregiver is a full time resident in the same home as the participant;
- Caregivers must be added to the family care safety registry and comply with the provisions of 210.900 to 210.936;
- Caregivers are required to obtain liability insurance;
- No more than 300 participants can receive structured family caregiving;
- Organizations serving as structured family caregiving agencies are considered in-home service providers and, therefore, must maintain documentation of services delivered ads required of in-home service providers; caregivers must meet the same qualification and requalification of caregivers and homes and caregiver training; a case manager or registered nurse must create a service plan tailored to each participant's needs; professional staff support must be available for those eligible; ongoing monitoring and support must occur through monthly home visits; electronic daily notes are to be used; and the ability to remotely consult with the participant's family must be available;
- Caregivers are responsible for providing for the participant's personal care needs, including, at a minimum, laundry, housekeeping, shopping, transportation, and assisting with activities of daily living;
- The daily payment rate for services must be enough to pay the caregiver's salary and to pay provider agencies for the cost of providing professional staff support as required under this section and administrative functions required of in home services provider agencies. Payments to the provider agency cannot exceed 35% of the daily reimbursement rate; and
- Daily payment rates for structured family caregiving services cannot be more than 60% of the daily nursing home cost cap established by the state each year.

ASSUMPTION (continued)

§208.896.3: Requires the DSS to apply to the U.S. HHS Secretary for a structured family caregiver waiver within 90 days of the effective date of this section if necessary to implement the provisions of this section. This section also requires DSS to request an effective date before July 2, 2020, and to take all administrative actions necessary to ensure timely and equitable availability of structured family caregiving services for home- and community-based care participants by that date. This section also requires the Department of Health and Senior Services (DHSS) to promulgate rules to implement the family caregiving services program once approval is received from HHS.

Services in the Aged and Disabled Waiver are paid via the DHSS budget. The MO HealthNet Division (MHD) assumes structured family caregiving services will be paid via DHSS budget as well. It is also assumed that DHSS will be the operating agency for the service/program. The staffing for the program, evaluation, assessment, and policy and procedure development will be DHSS.

This bill requires MHD to seek amendments to a HCBS waiver to allow structured family caregiving to become a covered service. MHD assumes new provider types will need to be added in order to properly track and report this new service. This will be completed by Medicaid Management Information Systems (MMIS) and Wipro. This is an estimated 500 hours of work. Other costs include adding the new service to Cognos (data reporting tool), finance reports and CMS reports which accounts for 100 hours of work. There will also need to be a System Task Request (STR) completed through Wipro in order for system changes to occur which is an additional 100 hours of work. The total hours to perform these duties is estimated to be 700 hours. MHD uses $100/hour to account for the changes and updates. This will cost MHD $70,000 with a 75/25 GR/Federal funds split. There are no ongoing costs for MHD.

MHD assumes all cost reports would be submitted to the DHSS as noted in the bill or MMAC which currently receives all required Consumer Directed Services reports.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the costs provided by DSS for fiscal note purposes. Oversight assumes changes to the MMIS would be completed prior to the approval of the waiver amendments rather than waiting to perform system changes until after amendments are approved; waiting until after approval of the amendments would further delay implementation of structured family care giving services.

In response to the previous version of this proposal, officials from the **Office of the Secretary of State (SOS)** stated many bills considered by the General Assembly include provisions allowing or requiring agencies to submit rules and regulations to implement the act. The SOS 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 $5,000. The SOS recognizes that this is a small amount and does not expect that

ASSUMPTION (continued)

additional funding would be required to meet these costs. However, the SOS also recognizes 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 with the 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.

Oversight assumes the SOS could absorb the costs of printing and distributing regulations related to this proposal. If multiple bills pass which require the printing and distribution of regulations at substantial costs, the SOS could require additional resources.

In response to the previous version of this proposal, officials from the **Joint Committee on Administrative Rules (JCAR)** stated the legislation is not anticipated to cause a fiscal impact to JCAR beyond its current appropriation.

Oversight assumes JCAR will be able to administer any rules resulting from this proposal with existing resources.

Oversight notes, in response to the previous version of this proposal, the **Department of Insurance, Financial Institutions and Professional Registration** stated the proposal would not have a direct fiscal impact on their organization. Oversight does not have any information to the contrary. Therefore, Oversight will reflect a zero impact in the fiscal note for this organization.

§§208.909, 208.918, and 208.924 - Consumer directed services

In response to similar legislation (SCS SB 70 & 128), officials from the **Department of Health and Senior Services (DHSS)** stated the DHSS would promulgate by rule a consumer-directed services division provider certification manager course; however, it is assumed that Missouri Medicaid Audit and Compliance (MMAC) in the Department of Social Services (DSS) would enforce the rule. Therefore, any fiscal costs outside of rule-making would impact MMAC rather than DHSS.

§208.918.2(4)(a): DHSS interprets this to mean that DHSS would promulgate a rule to define the elements and frequency of the consumer-directed division provider certification manager course, and MMAC would maintain responsibility for provisions of the course and administering the exam. This would be similar to the current certified manager course required of agency model in-home services providers and would follow the delineation of authorities granted through executive order to MMAC, specifically related to the responsibilities of provider education and oversight.

ASSUMPTION (continued)

Director's Office
§208.918.2(3)(a) provides that the department of health and senior services shall promulgate by rule a consumer-directed division provider certification manager course for the implementation of this section.

General Counsel ($64,500)
§208.918.2.(3).(a) of the proposed legislation requires the promulgation of rules and regulations, which include the following duties (but not all inclusive): establish guidelines, implement strategies, make evidence-based system changes, and create policy recommendations. The DHSS, Office of General Counsel will need an additional .10 FTE for an attorney (salary of $64,500 per year) to perform the research necessary to ensure the new guidelines and information for this proposed legislation has been properly vetted and implementation is completed quickly and with fiscal responsibility. Due to current workload being at maximum limits, these costs cannot be absorbed.

Oversight assumes 0.1 FTE would not be provided fringe benefits and the state would only pay Social Security and Medicare benefits of 7.65 percent. In addition, Oversight assumes the DHSS would not need additional rental space for 0.1 FTE. However, if multiple proposals pass during the legislative session requiring additional FTE, cumulatively the effect of all proposals passed may result in the DHSS needing additional rental space.

Oversight assumes since DHSS states their responsibility to perform the research necessary to ensure the new guidelines and information for this proposed legislation has been properly vetted and implementation is completed quickly and with fiscal responsibility, Oversight will range the cost of the partial FTE from $0 to DHSS' estimate less fringe benefits over 7.65% and rental space costs.

In response to similar legislation (SCS SB 70 & 128), officials from the **Department of Social Services (DSS), Missouri Medicaid Audit Compliance (MMAC)** stated §208.918 is part of the state statutes pertaining to Personal Care Assistance Services, more commonly known as Consumer Directed Services (CDS) which allow a physically-disabled Medicaid consumer to remain in his or her home and hire a personal care attendant to perform routine tasks for the consumer including, but not limited to, such tasks as dressing and undressing, moving into and out of bed, bathing and grooming, and meal preparation. Federal law (42 U.S.C. § 455.432) requires MMAC to conduct pre-enrollment and post-enrollment site visits of vendors that are designated as "moderate" risks to the Medicaid program. CDS vendors are considered "moderate" risks.

ASSUMPTION (continued)

The Centers for Medicare and Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services that oversees many federal healthcare programs, including Medicaid. In a sub-regulatory guidance document, CMS told states that visits required by §455.432 could be combined as long as the verification activity for screening and enrollment was documented separately. MMAC has been able to take advantage of this directive from CMS by using site visits performed by either the Missouri Department of Health and Senior Services or the Missouri Department of Mental Health, thereby consolidating the work of the state agencies and staff positions necessary to perform site visits. If MMAC is made solely responsible for verifying vendors' compliance with §208.918.2(5), it will result in an increase in the number of Full Time Employees (FTEs) that MMAC will have to hire and train to carry out this work.

§208.918.2(5) is added to require vendors to maintain a proper business location that complies with all applicable city, county, state, and federal regulations and is verified by Missouri Medicaid Audit and Compliance (MMAC). MMAC will need 15 FTE (Medicaid Specialists). The Department of Health and Senior Services (DHSS) interprets the statute to mean that DHSS will promulgate the rule and MMAC will provide the course.

Until the FY 20 budget is final, the Department cannot identify specific appropriations.

The Grand Total for the DSS is:
FY 2019 (10 mo.): $1,015,436 (GR: $507,718; FF: $507,718);
FY 2020: $1,107,317 (GR: $553,657; FF: $553,657); and,
FY 2021: $1,118,912 (GR: $559,456; FF: $559,456).

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the costs provided by DSS for fiscal note purposes.

Oversight has inquired with DSS if there would be some amount of offsetting savings to DHSS and DMH, but have received information yet. Upon the receipt of their response, Oversight will review to determine if an updated fiscal note should be prepared and seek the necessary approval of the chairperson of the Joint Committee on Legislative Research to publish a new fiscal note.

Oversight notes, in response to similar legislation (SCS SB 70 & 128), the **Department of Mental Health** has stated the proposal would not have a direct fiscal impact on their organization. Oversight does not have any information to the contrary. Therefore, Oversight will reflect a zero impact in the fiscal note for DMH.

ASSUMPTION (continued)

In response to similar legislation (SCS SB 70 & 128), officials from the **Joint Committee on Administrative Rules (JCAR)** stated the legislation is not anticipated to cause a fiscal impact to JCAR beyond its current appropriation.

Oversight assumes JCAR will be able to administer any rules resulting from this proposal with existing resources.

In response to similar legislation (SCS SB 70 & 128), officials from the **Office of the Secretary of State (SOS)** stated many bills considered by the General Assembly include provisions allowing or requiring agencies to submit rules and regulations to implement the act. The SOS 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 $5,000. The SOS recognizes that this is a small amount and does not expect that additional funding would be required to meet these costs. However, the SOS also recognizes 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 with the 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.

Oversight assumes the SOS could absorb the costs of printing and distributing regulations related to this proposal. If multiple bills pass which require the printing and distribution of regulations at substantial costs, the SOS could require additional resources.

§§217.930 and 221.125 - Suspension of MO HealthNet benefits when incarcerated

In response to similar legislation (SB 393), officials from the **Department of Social Services (DSS), MO HealthNet Division (MHD)** stated SB 393 amends chapters 217 and 221, RSMo. This legislation requires MHD benefits of offenders in correctional facilities and jails to be suspended rather than terminated. These benefits shall be restored upon release until such time as the person is determined to no longer be eligible for the program.

Currently, when the Family Support Division (FSD) is notified that an individual has become incarcerated, MHD eligibility is closed and a new application is required upon release. The FSD has a Memorandum of Understanding (MOU) in place with the Missouri Department of Corrections (DOC) to accept applications facilitated by the DOC when an individual is temporarily released to receive inpatient treatment for twenty-four hours or longer and when an inmate is expected to be permanently released. The DOC facilitates the application process on

ASSUMPTION (continued)

behalf of FSD for certain inmates within its custody who would appear to meet all factors for eligibility and coverage for MHD and assists in completing the necessary forms for application. FSD notifies the inmate in writing when the eligibility determination is complete of its decision regarding eligibility for MHD benefits.

In State Fiscal Year (SFY) 2018, the FSD closed MHD eligibility for 1,124 individuals due to incarceration and determined 461 individuals eligible for MHD benefits upon release. Of the 461 individuals determined eligible upon release, 155 were due to a temporary release of at least twenty-four hours for inpatient treatment and 306 were due to permanent release.

The proposed changes do not change MHD eligibility criteria established by Centers for Medicare & Medicaid Services (CMS) and participants will still need to meet all program eligibility requirements in order to keep active and/or suspended MHD benefits. To ensure the proper eligibility is determined, the FSD completes a review when there is a change in circumstances. An individual becoming incarcerated is a change in circumstance and when a participant with active or suspended coverage no longer meets the criteria for his or her current program benefits, FSD will explore an ex parte review to determine if the participant qualifies for coverage under another MHD program. If the individual does not qualify for coverage under another MHD program, their coverage will be closed. If the individual qualifies for coverage under another MHD program, they will be moved to the proper program. Therefore, "restored" coverage refers to the activation of coverage. However, this may not be at the same level as when the individual became incarcerated due to a change in circumstances. The FSD will continue to work with the DOC and will also work with county, city, and private jails to facilitate applications and eligibility reviews of incarcerated individuals to determine eligibility.

The provisions of this bill do not affect any provisions relating to eligibility for any benefits from any program FSD administers. Therefore, there is no fiscal impact to FSD. Because FSD only determines eligibility for covered services, FSD defers to MHD regarding any services or medical expenses the participant may incur during periods of suspended coverage.

Currently, MHD has a process for persons that are incarcerated, but it involves starting and stopping their eligibility. In order to add a process to suspend eligibility, new system work would need to be created. This system work would include creating lock in segments for all incarcerated members. MHD does not pay for services while individuals are incarcerated. When they are admitted into the hospital or when they are released from prison, the lock in would have to be ended and a new lock in created for the date when/if they return to prison. Also, MHD would have to update the eligibility verification responses sent to providers to reflect the lock in to prison. This would require Medicaid Management Information System (MMIS) system modifications costing up to $500K to MHD. This would be calculated at a 75/25 split. Plus, additional staff time would be needed to manually add and close the lock-ins described

ASSUMPTION (continued)

above. This is estimated to be approximately 4 extra hours a month. These duties could be handled by a Management Analysis Specialist II (MAS II). At approximately $22/hr for a MAS II, the total administrative costs associated with this legislation would be $1,056 ($22/hr*4 hrs*12 months) per year. It is assumed that MHD could absorb these costs with a MAS II already on staff.

Oversight contacted DSS staff regarding the $500,000 in system modifications that would be needed. DSS assumes it would have to issue a request for proposal and get bids for the modifications that would be needed. Oversight contacted officials with the Office of Administration, Division of Purchasing and Materials Management (DPMM). DPMM officials indicated that a request for proposal would have to be submitted and bids received for these system modifications.

In addition, Oversight contacted DSS officials regarding any potential savings as a result of not having to process Medicaid applications for offenders being released from prison because benefits were suspended rather than terminated. Officials indicated the DSS would still need to go through a re-verification process to determine whether an individual would be eligible for benefits upon release. Any savings would be very small and there is no way to track the potential savings. Re-verification would still have to be performed manually for each offender being released from prison/jail to determine eligibility.

Oversight does not have any information to the contrary. Oversight assumes the MHD has sufficient staff and resources to absorb the additional duties required by this proposal to manually add and close the lock-ins described in their response. However, Oversight will reflect the costs for MMIS modifications provided by DSS for fiscal note purposes.

In response to similar legislation (SB 393), officials from the **Department of Corrections (DOC)** deferred to the DSS for any impact related to this proposal.

Oversight notes this legislation appears to require the DOC to notify DSS within 20 days of an offender on Medicaid coming to prison and to notify them within 45 days of the offender leaving prison. This will be less burdensome than the current process. This bill should provide qualifying offenders access to the medical and mental health care they need immediately upon release which may increase their probability of success in the community. This bill could immensely aid re-entry purposes and continuation of care.

The bill does not specify how the DOC determines if a person is receiving benefits under MO HealthNet. Therefore, it is unclear how this practice will be implemented.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect no fiscal impact as provided by the DOC for fiscal note purposes.

ASSUMPTION (continued)

Oversight notes, in response to similar legislation (SB 393), the **City of Kansas City,** the **Joplin Police Department**, the **Springfield Police Department**, the **St. Louis County Police Department**, and the **St. Louis County Department of Justice Services** 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.

Oversight only reflects the responses that we have received from state agencies and political subdivisions; however, other Sheriffs' Offices, Police Departments, and the City of Columbia were requested to respond to this proposed legislation but did not. For a general listing of political subdivisions included in our database, please refer to www.legislativeoversight.mo.gov.

Oversight notes this proposal could have positive benefits to the state (including savings related to not having to process MoHealthnet applications once prisoners are released from prison and the potential reduced recidivism rates if newly-released inmates have access to health insurance immediately upon release) and to certain persons recently released from confinement in a prison or jail. Oversight assumes these benefits are indirect impacts and will not reflect them in the fiscal note.

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
GENERAL REVENUE FUND			
Income - DSS (§208.790)			
Increase in rebate revenue p. 10 & 11	$3,260,312	$6,962,649	$6,962,649
Savings - DSS (§208.790) p. 10 & 11			
Reduction in costs due to "donut hole"	$60,068	$72,082	$72,082
Savings - DHSS (§208.896)		$0 or...	$0 or...
Reduction in HCBS waiver services p. 15	$0	$829,913 to $1,882,679	$840,701 to $1,907,155
Total Income and Savings	$3,320,380	$7,034,731 or $7,864,644 to $8,917,410	$7,034,731 or $7,875,432 to $8,941,886

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
GENERAL REVENUE FUND (continued)			
Costs - DSS (§208.151) p.5			
Increase in state share of MO HealthNet benefits for foster children	($31,183)	($63,863)	($65,396)
Costs - OA, ITSD (§208.151) p. 5 & 6			
FACES system modifications (ranged from contracting out the programming ($32,076) to hiring additional 1 FTE IT Specialist)	($32,076 to $44,000)	$0 or ($80,800)	$0 or ($81,608)
MEDES modifications	($161,741)	$0	$0
Total Costs - OA, ITSD	($193,817 or $205,741))	$0 or ($80,800)	$0 or ($81,608)
FTE Change - OA, ITSD	0 or 0.66 FTE	0 or 1 FTE	0 or 1 FTE
Costs - DHSS (§208.225) p. 8			
Increase in HCBS cap rates	($68,017 to $205,570)	($167,006 to $506,918)	($254,462 to $782,746)
Costs - DSS (§208.225) p. 8 & 9			
Contractor costs	($56,826)	($70,783)	($73,472)
Increase in capital expenditures	($1,051,402 to $3,181,514)	($1,307,217 to $4,021,439)	($1,353,835 to $4,237,063)
Total Costs - DSS	($1,108,228 to $3,238,340)	($1,378,000 to $4,092,222)	($1,427,307 to $4,310,535)
Costs - DSS (§208.790) p. 10 & 11			
Contractor, mailings and enrollment	($492,253)	($205,468)	($205,468)
Program expenditures to expand coverage to non-dual (Medicare - only) recipients	($14,897,530)	($17,891,452)	($17,891,452)
Total Costs - DSS	($15,389,783)	($18,096,920)	($18,096,920)

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
GENERAL REVENUE FUND (continued)			
Costs - DHSS (§208.896)	$0 to...	$0 to...	$0 to...
Personal service p. 17	($5,375)	$0	$0
Fringe benefits	($411)	$0	$0
Equipment and expense	($3,657)	$0	$0
Webtool changes p. 12	($200,000)	$0	$0
Structured family caregiver services p. 13 or 16	$0	($2,446,260)	($2,478,289)
Total Costs - DHSS	($200,000 to $209,443)	$0 to ($2,446,260)	$0 to ($2,478,289)
Costs - DSS (§208.896)			
MMIS system changes/Wipro p. 19	($52,500)	$0	$0
Costs - DHSS (§208.918) p. 21			
Personal service	($5,375)	$0	$0
Fringe benefits	($411)	$0	$0
Equipment and expense	($3,657)	$0	$0
Total Costs - DHSS	$0 to ($9,443)	$0	$0
FTE Change - DHSS	0 to 0.1 FTE	0 FTE	0 FTE
Costs - DSS (§208.918) p. 22			
Personal service	($239,400)	($290,153)	($293,054)
Fringe benefits	($151,770)	($183,000)	($183,884)
Equipment and expense	($116,548)	($80,504)	($82,517)
Total Costs - DSS	($507,718)	($553,657)	($559,455)
FTE Change - DSS	7.5 FTE	7.5 FTE	7.5 FTE
Costs - DSS (§§217.930 and 221.125) p. 24 &25			
MMIS system modifications	($125,000)	$0	$0
Total All Costs	($17,676,246 to $20,018,721)	($20,259,446 to $25,840,640)	($20,403,540 to $26,374,949)
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**($14,355,866 to $16,698,341)**	**($13,224,715 to $18,805,909) or ($11,342,036 to $17,975,996)**	**($13,368,809 to $19,340,218) or ($11,461,654 to $18,499,517)**
Estimated Net FTE Change on the General Revenue Fund	7.5 to 8.26 FTE	7.5 to 8.5 FTE	7.5 to 8.5 FTE

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
PREMIUM FUND (0885)			
Income - DSS (§208.146) p. 3			
Ticket to work premiums	$1,007,960	$1,209,552	$1,209,552
ESTIMATED NET EFFECT ON THE PREMIUM FUND	**$1,007,960**	**$1,209,552**	**$1,209,552**
FEDERAL FUNDS			
Income - DSS (§208.151) p.5			
Increase in program reimbursements	$59,434	$121,720	$124,641
Income - OA, ITSD (§208.151) p. 5&6			
Reimbursement for MEDES and FACES system updates	$501,746 or $507,889	$0	$0
Income - DHSS (§208.225) p.8			
Increase in HCBS program reimbursements	$129,637 to $391,810	$318,306 to $966,167	$484,995 to $1,491,886
Income - DSS (§208.225) p. 8 & 9			
Reimbursement for contractor costs	$56,826	$70,783	$73,472
Reimbursement for increase in capital expenditures	$2,003,933 to $6,063,848	$2,491,508 to $7,664,714	$2,580,359 to $8,075,686
Total Income - DSS	$2,060,759 to $6,120,674	$2,562,291 to $7,735,497	$2,653,831 to $8,149,158
Income - DHSS (§208.896)		$0 to...	$0 to..
Webtool update reimbursement p. 12	$200,000	$0	$0
Structured family caregiver service reimbursement p. 13 or 16	$0	$4,662,480	$4,723,526
Total Income - DHSS	$200,000	$0 to $4,662,480	$0 to $4,723,526
Income - DSS (§§208.896)			
Increase in program reimbursements p. 19	$17,500	$0	$0
Income - DSS (§208.918) p. 22			
Program reimbursements	$507,718	$553,657	$559,455

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
FEDERAL FUNDS (continued)			
Income - DSS (§§217.930 and 221.125) p. 24 & 25			
Program reimbursements for MMIS modifications	$375,000	$0	$0
Savings - DHSS (§208.896) p. 15 & 16		$0 or...	$0 or...
Reduction in HCBS waiver expenditures	$0	$1,581,783 to $3,588,317	$1,602,346 to $3,634,966
Total All Income and Savings	$3,851,794 to $8,180,025	$3,555,974 to $14,039,521 or $5,137,757 to $17,627,838	$3,822,922 to $15,048,666 or $5,425,268 to $18,683,632
Costs -DSS (§208.151) p.5			
Increase in program costs for children in foster care	($59,434)	($121,720)	($124,641)
Costs - OA, ITSD (§208.151) p.5 & 6			
FACES system modifications (ranged from contracting out the programming to hiring additional 1 FTE IT Specialist)	($16,524 or $22,667)	$0	$0
MEDES modifications	($485,222)	$0	$0
Total Costs - OA, ITSD	($501,746 or $507,889)	$0	$0
FTE Change - OA, ITSD	0.34 FTE	0 FTE	0 FTE
Costs - DHSS (§208.225) p. 8			
Increase in HCBS cap rates	($129,637 to $391,810)	($318,306 to $966,167)	($484,995 to $1,491,886)
Costs - DSS (§208.225) p. 8 & 9			
Contractor costs	($56,826)	($70,783)	($73,472)
Increase in capital expenditures	($2,003,933 to $6,063,848)	($2,491,508 to $7,664,714)	($2,580,359 to $8,075,686)
Total Costs - DSS	($2,060,759 to $6,120,674)	($2,562,291 to $7,735,497)	($2,653,831 to $8,149,158)

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
FEDERAL FUNDS (continued)			
Costs - DHSS (§208.896)		$0 to...	$0 to...
Webtool update p. 12	($200,000)	$0	$0
Structured family caregiver services p. 13 or 16	$0	($4,662,480)	($4,723,526)
Total Costs - DHSS	($200,000)	$0 to ($4,662,480)	$0 to ($4,723,526)
Costs - DSS (§§208.896)			
MMIS system changes/Wipro p. 19	($17,500)	$0	$0
Costs - DSS (§208.918) p. 22			
Personal service	($239,400)	($290,153)	($293,054)
Fringe benefits	($151,770)	($183,000)	($183,884)
Equipment and expense	($116,548)	($80,504)	($82,517)
Total Costs - DSS	($507,718)	($553,657)	($559,455)
FTE Change - DSS	7.5 FTE	7.5 FTE	7.5 FTE
Costs - DSS (§§217.930 and 221.125) p. 24 & 25			
MMIS system modifications	($375,000)	$0	$0
Loss - DHSS (§208.896) p. 15 & 16		$0 or...	$0 or...
Reduction in HCBS waiver reimbursements	$0	($1,581,783 to $3,588,317)	($1,602,346 to $3,634,966)
Total All Costs and Losses	($3,851,794 to $8,180,025)	($3,555,974 to $14,039,521) or ($5,137,757 to $17,627,838)	($3,822,922 to $15,048,666) or ($5,425,268 to $18,683,632)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**
Estimated Net FTE Change on Federal Funds	7.84 FTE	7.5 FTE	7.5 FTE

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

FISCAL IMPACT - Small Business

This proposal could have a direct fiscal impact on small businesses that could provide structured family caregiving or personal care assistance to clients. (§208.896)

This proposal could have a direct, negative fiscal impact on small business consumer-directed services programs as they will be required to have an annual audit or financial statement review performed by a Certified Public Accountant. (§§208.909, 208.918 and 208.924)

FISCAL DESCRIPTION

This act changes the Ticket to Work Health Assurance Program's expiration date from August 28, 2019, to August 28, 2025. (§208.146)

Under this act, persons who reside in Missouri, are at least 18 years of age and under 26, and who have received foster care for at least six months in another state shall be eligible for MO HealthNet benefits. (§208.151)

Under this act, any intermediate care facility or skilled nursing facility participating in MO HealthNet that incurs total capital expenditures in excess of $2,000 per bed shall be entitled to obtain a recalculation of its Medicaid per diem reimbursement rate based on its additional capital costs or all costs incurred during the facility fiscal year during which such capital expenditures were made. (§208.225)

Under current law, only Medicaid dual-eligible individuals meeting certain income limitations are eligible to participate in the Missouri RX Plan. This act removes the Medicaid dual eligible requirement, while retaining the income limitations. (§208.790)

This bill adds structured family caregiving as an agency-directed model to the MO HealthNet Program to ensure the availability of comprehensive and cost-effective choices for a MO HealthNet participant who has been diagnosed with Alzheimer's or a related disorder to live at home in the community of his or her choice and to receive support from a caregiver of his or her choice.

FISCAL DESCRIPTION (continued)

The bill specifies that the structured family caregiving waiver must include a cap of 300 participants. Within 90 days of the effective date of these provisions, the Department of Social Services must, if necessary to implement the provisions of this section, apply to the United States Secretary of Health and Human Services for a structured family caregiver waiver under Section 1915(c) of the Federal Social Security Act. The department must request an effective date of not later than July 1, 2020, and must take all administrative actions necessary to ensure time and equitable availability of structured family caregiving services for any home- and community-based care participant. (§208.896)

Under current law, vendors of consumer-directed services shall monitor the performance of personal care assistance service plans. This act requires the consumer to permit the vendor to comply with its quality assurance and supervision process, including bi-annual face-to-face home visits and monthly case management activities. During the home visits, the vendor shall document if the attendant was present and providing services as set forth in the plan of care and report the Department if the attendant is not present or providing services, which may result in a suspension of services to the consumer.

This act repeals language permitting the Department of Health and Senior Services to establish certain pilot projects for telephone tracking systems.

This act also requires vendors to notify consumers during orientation that falsification of personal care attendant time sheets shall be considered and reported to the Department as fraud.

Under this act, a vendor shall submit an annual financial statement audit or annual financial statement review performed by a certified public accountant to the Department. The Department shall require the vendor to maintain a business location in compliance with any and all city, county, state, and federal requirements. Additionally, this act requires the Department to create a consumer-directed services division provider certification manager course. No state or federal funds shall be authorized or expended if the owner, primary operator, certified manager, or any direct employee of the consumer-directed services vendor is also the personal care attendant, unless such person provides services solely on a temporary basis.

Currently, a consumer's services may be discontinued if the consumer has falsified records. This act adds language to include providing false information of his or her condition, functional capacity, or level of care needs. (§§208.909, 208.918 and 208.924)

Under this act, MO HealthNet benefits shall be suspended, rather than cancelled or terminated, for offenders entering into a correctional facility or jail if the Department of Social Services is notified of the person's entry into the correctional center or jail, the person was currently enrolled

FISCAL DESCRIPTION (continued)

in MO HealthNet, and the person is otherwise eligible for MO HealthNet benefits but for his or her incarcerated status. Upon release from incarceration, the suspension shall end and the person shall continue to be eligible for MO HealthNet benefits until such time as he or she is otherwise ineligible.

The Department of Corrections shall notify the Department of Social Services within 20 days of receiving information that a person receiving MO HealthNet benefits is or will become an offender in a correctional center or jail and within 45 days prior to the release of such person whose benefits have been suspended under this act. City, county, and private jails shall notify the Department of Social Services within 10 days of receiving information that person receiving MO HealthNet benefits is or will become an offender in the jail. (§§217.930 and 221.125)

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

SOURCES OF INFORMATION

Department of Health and Senior Services
Department of Insurance, Financial Institutions and Professional Registration
Department of Mental Health
Department of Corrections
Department of Social Services
Joint Committee on Administrative Rules
Office of Administration -
Office of Secretary of State
City of Kansas City
Joplin Police Department
Springfield Police Department
St. Louis County Police Department
St. Louis County Department of Justice Services

Kyle Rieman
Director
May 1, 2019

Ross Strope
Assistant Director
May 1, 2019

HWC:LR:OD