COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 2440-01
Bill No.: Truly Agreed To and Finally Passed SB 514
Subject: Medicaid/MO HealthNet; Health Care
Type: Original
Date: June 17, 2019

Bill Summary: This proposal modifies provisions relating to health care.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND				
FUND AFFECTED	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
General Revenue	(Unknown - Greater than $15,794,348 to $21,364,307)	(Unknown - Greater than $15,583,938 to $33,405,642)	(Unknown - Greater than $18,510,098 to $43,544,771)	(Unknown - Greater than $21,487,611 to $53,908,342)
Total Estimated Net Effect on General Revenue	**(Unknown - Greater than $15,794,348 to $21,364,307)**	**(Unknown - Greater than $15,583,938 to $33,405,642)**	**(Unknown - Greater than $18,510,098 to $43,544,771)**	**(Unknown - Greater than $21,487,611 to $53,908,342)**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 66 pages.

ESTIMATED NET EFFECT ON OTHER STATE FUNDS				
FUND AFFECTED	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
Missouri Veterans' Health and Care*	$0	$0	$0	$0
Premium (0885)	$1,007,960	$1,209,552	$1,209,552	$1,209,552
Insurance Dedicated (0566)	Up to $22,500	$0	$0	$0
Other State	Greater than ($12,192)	Greater than ($14,630)	Greater than ($14,630)	Greater than ($14,630)
Total Estimated Net Effect on Other State Funds	**$1,018,268**	**Less than $1,194,922**	**Less than $1,194,922**	**Less than $1,194,922**

* Income and expenses Unknown, but net to $0.

ESTIMATED NET EFFECT ON FEDERAL FUNDS				
FUND AFFECTED	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
Federal	(Greater than $19,525)	(Greater than $23,430)	(Greater than $23,430)	(Greater than $23,430)
Total Estimated Net Effect on All Federal Funds	**(Greater than $19,525)**	**(Greater than $23,430)**	**(Greater than $23,430)**	**(Greater than $23,430)**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)				
FUND AFFECTED	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
General Revenue	1 to 5.46 FTE	1 to 5.5 FTE	1 to 5.5 FTE	1 to 5.5 FTE
Federal	0.34 FTE	0 FTE	0 FTE	0 FTE
Total Estimated Net Effect on FTE	**1.34 to 5.8 FTE**	**1 to 5.5 FTE**	**1 to 5.5 FTE**	**1 to 5.5 FTE**

☒ 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	Fully Implemented (FY 2023)
Local Government	**$0 to (Unknown)**	**$0 to (Unknown)**	**$0 to (Unknown)**	**$0 to (Unknown)**

FISCAL ANALYSIS

ASSUMPTION

§21.790 - Task Force on Substance Abuse Prevention and Treatment
Officials at the **Missouri Senate** assume there is no fiscal impact from this proposal.

In response to similar legislation (SCS HB 240), officials from the **Missouri Senate** stated there is no fiscal impact when task force meetings are held in Jefferson City during the legislative session. The legislation does not allow for reimbursement of travel to attend meetings. However, if meetings are held during the legislative interim there would be a negative fiscal impact to reimburse 6 senators for round trip mileage to attend meetings.

It will cost the Senate just under $600 per meeting, assuming the meetings are held in Jefferson City. This estimate is based the average of the total round trip miles for current sitting senators, 34 and current rate as set by the Office of Administration. (265 average miles * 0.37 per mile * 6 senators = $588.30, rounded up)

Officials from the **Missouri House of Representatives** assume the House will absorb any costs incurred by members serving on the task force.

Officials at the **Office of the Governor** assume there should be no added cost to the Governor's Office as a result of this measure.

Oversight notes this proposal would establish a Task Force made up of 6 members of the Senate, 6 members of the House of Representatives and 4 members of the public. This proposal indicates the Task Force meet at least once during the legislative session and any other time as called by the chairperson. The proposal does not indicate that members should be reimbursed expenses or receive a per diem.

Oversight notes that the SEN does not include the representatives or public members in their estimated costs. Therefore, Oversight will assume the average of the total round trip miles for current sitting Representatives and unknown mileage for public appointees. The current rate as set by the Office of Administration as reflected in table that follows:

EXPENSE	TOTAL AVERAGE MILES*	RATE PER MILE**	NUMBER OF APPOINTEES	EST TOTAL PER MEETING
Mileage - Representatives	268	0.37	6	594.96
Mileage - Public	Unknown	0.37	4	Unknown
TOTAL FISCAL IMPACT:				**594.96**

ASSUMPTION (continued)

Including the 4 public members (16 total), **Oversight** will assume a cost of approximately $1,500 per meeting held during the interim. Oversight will further assume three meetings per year for this task force, one during session and two during the interim. Therefore, Oversight will assume a cost of $3,000 per year for mileage reimbursement for committee members.

Oversight notes the proposal states the task force shall be assisted by legislative personnel as is deemed necessary to assist the task force in the performance of its duties. Oversight assumes staffing will be filled by existing legislative personnel; therefore, Oversight assumes no costs other than reimbursable expenses by the committee.

Officials from the **Department of Health and Senior Services, Division of Community and Public Health (DCPH)** state the proposed legislation would create a Task Force on Substance Abuse Prevention and Treatment. §21.790.4 would allow the task force to request assistance or information from state departments, agencies, board, commissions, and offices. DHSS assumes that it would receive requests to provide information to the task force, which would place a requirement on staff time to gather and disseminate such information. Such information gathering would exist within the normal ebb and flow of the department's responsibilities and, therefore, would have no fiscal impact.

§191.603, §191.605 and §191.607 - Adds psychiatrists to list of eligible persons for loan repayment

Officials at the **Department of Health and Senior Services** (**DHSS**) assume there is no fiscal impact from this proposal.

Oversight obtained information from the DHSS website and FY 2020 budget request regarding the Health Professional Student Loan Repayment Program (Program). The Program provides up to $50,000 in financial assistance to help professionals reduce educational debt and practice in a Health Professional Shortage Area for two years. In FY 2018, DHSS awarded loans to 16 individuals through the Program and anticipates providing 20 awards in each FY 2019 and FY 2020. This proposal expands eligibility for the Health Professional Student Loan Repayment Program to include psychiatrists. The proposal does not require the DHSS to fund any additional candidates; it only increases the number of applicants that may receive funds and, therefore, would have no fiscal impact for purposes of the fiscal note.

DHSS indicated that funding for the program is composed entirely of Federal grant monies and donations (no General Revenue) and assumes the program will continue to receive the same amount of funding each year. Therefore, DHSS assumes the proposal will have no fiscal impact.

ASSUMPTION (continued)

Oversight determined that in FY 2018, 16 applicants received funding through the Health Professional Student Loan Repayment Program. DHSS officials provided information stating candidates are chosen based on the area of the state they intend to work. Candidates planning on working in areas with the highest Health Professional Shortage Area (HPSA) scores receive funding first and funds are distributed from highest to lowest HPSA scores until funds run out.

§191.737 - Referral to children's division for infants affected by substance abuse
Officials from the **Department of Social Services (DSS)** assume the provisions of this section will have no fiscal impact on their organization.

§191.1164 - §191.1168 - Ensuring Access to High Quality Care for the Treatment of Substance Use Disorder Act"
Officials from the **Department of Corrections (DOC)** state the proposed legislation removes any reference to the DOC and adds drug courts and diversion programs. It is assumed that the language is intended to remove the DOC from the impact of this legislation. However, §191.1165.5 might still be interpreted to include the DOC. For purposes of this fiscal note the DOC assumes no fiscal impact.

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

Officials from the **Office of State Courts Administrator (OSCA)** stated the proposed legislation may result in some fiscal impact but there is no way to quantify the amount at the current time. Any significant changes will be reflected in future budget requests.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the costs for the OSCA as $0 to (Unknown) for fiscal note purposes.

In response to a previous version, officials from **Jefferson County** stated medication assisted treatment (MAT) will cost Jefferson County hundreds of thousands of dollars as they do not currently have a MAT program in place. Adjustments and bids would be required to update medical contracts.

Officials from the **City of Kansas City (Kansas City)** state this legislation would have a negative fiscal impact on Kansas City because §191.1165.7 requires "Drug courts or other diversion programs that provide for alternatives to jail or prison for persons with a substance use disorder shall be required to ensure all persons under their care are assessed for substance use disorders using standard diagnostic criteria by a licensed physician who actively treats patients

ASSUMPTION (continued)

with substance use disorders."

The above persons in Kansas City's drug court are treated by licensed clinicians or substance use counselors, but generally not physicians. If someone is on MAT (Medication Assisted Treatment), then they are treated by physicians. However, many in drug court are not MAT.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the costs provided by Jefferson County and the City of Kansas City as $0 to (Unknown) for Local Governments - Counties and Cities fiscal note purposes.

§§192.067 and 192.990 - Pregnancy-Associated Mortality Review Board
Officials from the **DHSS** assumes this legislation in §192.990.5(13) may require the promulgation of rules and regulations as necessary to implement the preventative strategies, evidence-based system changes, and policy recommendations of theses sections. This would include the following duties (but not all inclusive): establish guidelines, implement strategies, make evidence-based system changes, and create policy recommendations. DHSS, Office of General Counsel will need an additional .1 FTE for an attorney (salary of $64,500 per year) to perform the research necessary to ensure the new guidelines and information for this legislation has been properly vetted and implementation is completed quickly and with fiscal responsibility. This would need to be done on an ongoing basis. 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 the 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.

Oversight notes, to accomplish the duties of the board, §192.900.9 allows DHSS to request and receive data from health care providers, health care facilities, laboratories, medical examiners, coroners, law enforcement agencies and driver's license bureaus, and facilities licensed by the department. Oversight does not know if, or when, DHSS will request information (or what information would be requested) and assumes no fiscal impact for this provision.

ASSUMPTION (continued)

§192.667 - Infection Control Data Reporting

Officials at the **DSS** state 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.

Oversight contacted DHSS officials and asked whether the Centers for Medicare and Medicaid Services (CMS) already requires hospitals to submit health care-associated infection data. Officials indicated that although not required by CMS, most hospitals already provide the data to CMS. DHSS assumes there would be no savings for the department because they still have to collect health care-associated infection data from abortion facilities, ambulatory surgical centers (ASCs) and other facilities.

§193.015, §195.100, 334.037 - 334.749, 338.010, 630.175 and 630.875 - Physician assistants and collaborating physicians

Oversight notes that no agency indicated a fiscal impact from these provisions and therefore, Oversight will not reflect an impact from them.

§§195.060, 195.550, 196.100, 221.111, 338.015, 338.055 and 338.056 - Prescriptions to be issued electronically

Officials from the **DHSS, Division of Regulation and Licensure (DRL)** state §195.550 of the proposed legislation requires that all prescriptions, beginning January 1, 2021, be made electronically, unless certain exceptions are met. It is assumed that the DRL's Section for Health Standards and Licensure's (HSL) Bureau of Narcotics and Dangerous Drugs (BNDD) will assume the duties set forth in the proposed section. BNDD will require additional staff to implement the legislation (hired September 1, 2019).

One Health Program Representative II with an annual salary of $35,990 (salary is based on the average starting salary in the division with pay plan) will be needed to perform the following duties: provide education and communication regarding compliance with electronic prescriptions for controlled substances; assist in the receiving of applications for waivers, reviewing and making determinations, and issuing waivers.

ASSUMPTION (continued)

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

Officials from the **Office of Administration (OA), Information Technology Services Division (ITSD)/DHSS** state modification of the existing MOHWORX application enabling a prescribing practitioner to request a DHSS waiver or renewal of a waiver for the requirement of electronic prescribing will be required. Assuming receipt from DHSS of documented business process for requesting a waiver or renewal of a waiver, ITSD/DHSS would utilize a project team consisting of a Project Manager, Business Analyst, Architect, and Application Developer to analyze, design, develop, and implement modifications to the MOHWORX application. Assuming a full-time project team for four (4) months, no additional maintenance costs anticipated as it is modification to an existing system.

ITSD assumes that every new IT project/system will be bid out because all their resources are at full capacity. It is estimated IT consultants will be needed at a rate of $75 per hour for 820.8 hours for a total cost of $61,560 ($75 * 820.8) to the General Revenue (GR) Fund.

Oversight 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 modifications to the existing MOHWORX application will be required. ITSD estimates the project would take 820.8 hours at a contract rate of $75 per hour for a total cost to the state of $61,560 in GR 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 ($61,560 in FY 2020) to hiring 1 ($61,560 / $75 / 2,080 hours = 0.39 rounded up) additional FTE IT Specialists (at roughly $80,000 each, per year) to complete the system update. Oversight assumes the additional FTE would be permanent staff will range costs for FY 2021 and 2022 from $0 to the cost of an additional IT Specialist.

Officials at the **Department of Corrections** assumes this adds electronic prescriptions to the offense of possession of unlawful items in a correctional facility. Penalty provisions are already in place and therefore this is no impact.

§195.080 - Exceptions to prescription limitations for Sickle Cell
Oversight notes that no agency indicated a fiscal impact from this provision and therefore, Oversight will not reflect an impact.

ASSUMPTION (continued)

§195.820 - Administration/processing fee for Missouri Veterans' Health and Care Fund
Officials at the **Office of Administration Division of Budget and Planning** (**B&P**) assume this section allows DHSS to establish a new administration and processing fee if funds in the Missouri Veterans' Health and Care Fund are insufficient to cover the administration of the medical marijuana program. Therefore, this section could impact both Total State Revenue and the calculation pursuant to Art. X, Sec. 18(e) by an unknown amount if the fee is necessary. This section has no direct impact on B&P.

Officials from the **DHSS** state the proposed legislation allows DHSS to establish an administration and processing fee, exclusive of any application or licence fee established under article XIV of the Missouri Constitution, if the funds in the Missouri Veterans' Health and Care Fund are insufficient to provide for the administration of the program. It is unknown whether the DHSS will need to establish an administration and processing fee to sustain the Medical Marijuana Program. DHSS will only assess fees if they are needed to cover costs incurred by the program. The amount of uncovered costs and resulting fees are both unknown and assumed to be equal, so the impact on the Missouri Veterans' Health and Care Fund is zero.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the potential fees and costs to the Missouri Veterans' Health and Care Fund as $0 or Unknown netting to $0 as provided by the DHSS for fiscal note purposes.

Oversight notes the Missouri Veterans' Health and Care Fund was established upon passage of Constitutional Amendment 2 (Medical Marijuana) during the November, 2018 election. A state fund number has not been issued for the Missouri Veterans' Health and Care Fund as, to date, no funds have been credited to the fund.

§197.108 - Hospital Inspectors/Surveyors
Officials from the **DHSS** state §197.108 of this legislation prevents an individual from being an inspector or surveyor of a hospital if they were an employee of such hospital or another hospital within its organization in the preceding two years. It also requires newly hired inspectors or surveyors to disclose the name of every hospital they, or any immediate family member, had been employed by in the last ten years. Review and updates of conflict of interest policies and procedures are within the normal ebb and flow for the Division of Regulation and Licensure.

Oversight does not have any information to the contrary. Therefore, Oversight assumes the DHSS will be able to implement the provisions of this proposal with existing staff and resources and will indicate no fiscal impact to the DHSS for fiscal note purposes.

ASSUMPTION (continued)

§198.082 - Training requirements for certified nursing assistants
Officials from the **DHSS** state the required curriculum of the nurse aide training program is provided by CFR 483.152. DHSS is required to maintain the nurse aid registry and assessments of nurse aide training and competency evaluation programs.

This bill adds locations where a nurse aide training program can be placed (veteran's home or hospital). If these facilities establish training programs, the newly certified nurse aides will be added to the registry. These programs will increase the number of newly certified nurse aides who will be added to the registry. Since the Division of Regulation and Licensure (DRL) already maintains the certified nurse aide registry, passage of this proposal will not increase the workload of the staff in DRL, Therefore, DHSS assumes the proposal will have no fiscal impact.

Oversight notes provisions of §198.082.8 provide that the DHSS may offer additional training programs and certifications to students who are already certified as nursing assistants according to regulations promulgated by the department and curriculum approved by the board.

DHSS officials stated if they were to offer additional training programs and certifications as detailed in subsection 8, it is assumed 0.5 FTE of a Register Nurse Manager, 1.0 FTE Facility Advisory Nurse III, 0.1 FTE Attorney, and 1.0 FTE Senior Office Support Assistant would be needed. In addition, it is assumed there would be unknown Information Technology Services Division (ITSD) costs to develop and maintain an online test bank and automated test taking process. Therefore, the cost would be unknown greater than $206,094 to the General Revenue Fund (GR) for FY 2020; unknown greater than $210,845 to GR for FY 2021; and unknown greater than $213,070 to GR for FY 2022.

For purposes of this fiscal note, **Oversight** will range potential costs as $0 or the amount provided by the DHSS if they were to offer additional training programs and certifications to certified nurse aides.

§208.146 - Ticket to work
Officials from the **DSS** state 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 (0885)). 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.

ASSUMPTION (continued)

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 (0885). 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.

Officials from the **DHSS** defer to the Department of Social Services for response regarding the potential fiscal impact of this section.

§208.151 - MO HealthNet benefits for persons in foster care
Officials from the **DSS**, **MO HealthNet Division** (**MHD**) state §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.

DSS assumes for purposes of the fiscal note that Missouri Medicaid will cover health care benefits until age 26 for individuals aging out of another state's foster care system, in that other state's system for at least 6 months, and now living in Missouri.

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.

ASSUMPTION (continued)

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.

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.

ASSUMPTION (continued)

Officials from the **Office of Administration, Information Technology Services Division (OA, ITSD)/DSS** state 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 864.00 hours at $75/hours to do the necessary modifications for a total of $64,800 ($42,768 General Revenue (GR); $22,032 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.

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 864.00 hours at a contract rate of $75 per hour for a total cost to the state of $64,800 ($42,768 GR; $22,032 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 ($64,800 in FY 2020) to hiring 1 ($64,800 / $75 / 2,080 hours = 0.42 FTE, 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.

ASSUMPTION (continued)

Officials from the **Department of Mental Health (DMH)** state §208.151.1(26) provides Medicaid coverage to Missouri residents who are age 18 or over, but under age 26, and received foster care for at least 6 months in another state. The anticipated impact to DMH for Comprehensive Psychiatric Rehabilitation (CPR), Comprehensive Substance Treatment and Rehabilitation (CSTAR), and Developmental Disabilities (DD) waiver services for the additional individuals are included in the DSS estimate.

Officials from the **DHSS** defer to the Department of Social Services for response regarding the potential fiscal impact of this section.

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

Officials from the **DHSS** state 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 DSS' MHD 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 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

ASSUMPTION (continued)

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:

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).

ASSUMPTION (continued)

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).

It should be noted, that it is likely DHSS' estimated increases in HCBS service costs would be higher than projected. Therefore, for fiscal note purposes, Oversight will assume costs will "likely exceed" the costs provided by DHSS.

Officials from the **DSS' MHD** state §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.

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.

ASSUMPTION (continued)

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 obtained additional information from the DSS relating to potential Medicaid costs for capital expenditures by long-term care facilities (rebase). For fiscal note purposes, costs will be taken out to FY 2023.

DSS indicated there are approximately 510 Medicaid-certified long-term care facilities in Missouri. Reimbursement rates (effective July 1, 2018) ranged from $142.84 to $184.98 per bed per day. The average occupancy rate per facility is approximately 75%. FY 2019 projected bed days to be paid for by DSS are assumed to be approximately 8.7 million. DSS assumes bed days will increase by approximately 1.5% annually. Therefore, for fiscal note purposes, bed days are assumed to be as follows:

ASSUMPTION (continued)

Projected Medicaid Bed Days (1.5% growth factor)

FY 2019	8,700,000
FY 2020	8,830,500
FY 2021	8,962,978
FY 2022	9,097,402
FY 2023	9,233,863

Provisions of this proposal allow intermediate care or skilled nursing facilities that incur more than $2,000 per bed in capital improvements 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 (§208.225.3). Such recalculated reimbursement rate shall become effective and payable when granted by MO HealthNet as of the date of application for a rate adjustment. Once a facility's reimbursement rate is adjusted, the new rate continues indefinitely (or until a new rebasing occurs).

The last time facility rates were rebased by DSS was in 2002. DSS rebased facility rates based on capital improvements only, increased between $0.05 to $4.92 per bed, per day (with an average rate increase of $2.27).

At the 2002 average rate increase of $2.27 per bed, per day, it would take a 100-bed facility that invests $200,001 in capital improvements 3.22 years to "recoup" their investment with a 75% occupancy rate (100 beds * 75% = 75 beds *365 days = 27,375 bed days/year * $2.27 = $62,141.25 increase in reimbursement per year; $200,001 investment/$62,141.25 = 3.22 years).

As an example, Oversight assumes a facility with 100 beds would need to expend $200,001 in capital improvements to qualify for a rebasing of its per diem rate. Below is a table that provides possible rate increase scenarios depending on the return on investment (ROI) a facility might consider when determining whether or not to invest in additional capital improvements.

ASSUMPTION (continued)

ROI Years	Rate Increase Needed (per bed, per day)
2	$3.65
5	$1.46
10	$0.73
15	$0.49
20	$0.37

In supporting documentation received from DSS, using FY 2009 data, DSS assumed 56 facilities would qualify for and seek rate increases per year. Since rate increases would continue every year after a facility rebases, costs would "stack" on top of each other; therefore, if 56 facilities are rebased in FY 2020, those costs would continue each future fiscal year. DSS assumes a 2.40% increase for annual inflation in the 2002 rate adjustment of $2.27 to $3.48/bed/day for qualifying facilities for FY 2020.

Oversight notes it is difficult to predict the number of facilities that will be impacted by the rate increase created in the proposal as it depends on each facility's ROI, which include factors such as the age of the facility and current per diem rate. Additionally, Oversight assumes the proposal could allow a facility to receive a rate increase each year. This may result in some facilities being incentivized to invest in capital expenditures every year while other may not benefit from the proposal. For the purposes of the fiscal note, Oversight assumes up to 25% of the facilities would choose to upgrade each year until, or until all facilities are upgraded. Oversight will use the total bed days and the adjusted rate of $3.48/bed/day for fiscal note purposes.

ASSUMPTION (continued)

Projected Rebased Days

FY	Annual Projected Bed Days	Days for Facilities Rebasing (25%)
2020	8,830,500	2,207,625
2021	8,962,978	2,240,745
2022	9,097,402	2,274,350
2023	9,233,863	2,308,466

Capital Costs Rebasing

FY	Total Bed Days	Rate Increase per Bed Day	Increase in Costs	Total Costs	General Revenue (34.412%)	Federal Funds (65.588%)
2020	2,207,625	$3.48	$6,402,112	$6,402,112	$2,203,095	$4,199,017
2021	2,240,745	$3.56	$7,977,050	$15,659,585	$5,388,777	$10,270,809
2022	2,274,350	$3.65	$8,301,379	$23,960,965	$8,245,447	$15,715,518
2023	2,308,466	$3.74	$8,633,662	$32,594,627	$11,216,463	$21,378,164

However, provisions of the proposal also allow for facilities to rebase on all costs incurred during the facility fiscal year during which such capital expenditures were made rather than just capital costs, as long as the more than $2,000 investment per bed is made.

Under this assumption, DSS assumed that recalculated per diem rates could increase an average of $11.65/bed day with a 3.8% annual growth rate for future years. Using a 100-bed facility with 75% occupancy, that invests $200,001 in capital improvements, they could "recoup" their investment in less than 1 year (100 beds * 75% = 75 beds *365 days = 27,375 bed days/year * $11.65 = $318,919 increase in reimbursements per year; $200,001 investment/$318,919 = 0.63 years or 7.6 months).

Oversight notes that each facility's ROI will be different depending on the age of the facility and current per diem rate. This may result in some facilities being incentivized to invest in capital expenditures every year while other may not benefit from the proposal. Oversight assumes, under the "all cost" method, it is likely that most facilities would choose to invest over $2,000 capital improvements per bed to obtain a higher per diem rate. Oversight assumes one-fourth of

ASSUMPTION (continued)

all 510 facilities will choose to rebase each year and is presenting the estimated costs in the table below:

All Costs Rebasing

FY	Total Bed Days	Rate Increase per Bed Day	Increase in Costs	Total Costs	General Revenue (34.412%)	Federal Funds (65.588%)
2020	2,207,625	$11.65	$25,710,795	$21,425,662	$7,372,999	$14,052,663
2021	2,240,745	$12.09	$27,088,185	$52,798,980	$18,169,185	$34,629,795
2022	2,274,350	$12.55	$28,539,234	$81,338,214	$27,990,106	$53,348,108
2023	2,308,466	$13.03	$30,079,309	$111,417,523	$38,340,998	$73,076,525

Oversight notes the DSS has assumed there will be additional vendor costs associated with this provision of the proposal. Vendor costs are contracted auditors that go in and audit facility costs to determine the adjusted rates for facilities. Vendor costs for FY 2020 are estimated to be $136,383; FY 2021 costs are estimated to be $141,565; and FY 2022 vendor costs are estimated to be $146,945. Oversight will extrapolate vendor costs to FY 2023 and assumes costs of $152,323. These costs are reimbursed 50% GR/50% Federal.

§208.790 - Mo Rx Plan

Officials from the **DSS' MHD** state 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.

ASSUMPTION (continued)

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 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.

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.

Officials from the **DHSS** defer to the Department of Social Services for response regarding the potential fiscal impact of this section.

§208.896 - Structured family caregiving

Officials from the **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

ASSUMPTION (continued)

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 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.

ASSUMPTION (continued)

§208.896.2(8)
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).

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
DHSS 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
DHSS 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.

ASSUMPTION (continued)

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, DHSS 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.

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

ASSUMPTION (continued)

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%.

	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.

ASSUMPTION (continued)

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.

	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)

ASSUMPTION (continued)

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.

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.

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.

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. Due to the current workload being at maximum limits, these costs cannot be absorbed.

ASSUMPTION (continued)

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.

Officials from the **DSS' MHD** state 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.

ASSUMPTION (continued)

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.

§208.930 - Consumer-directed personal care assistance services
Officials at the **DHSS** state the proposal would not have a direct fiscal impact on their organization.

Oversight obtained addition information from the DHSS regarding the cost to continue personal care assistance services under this proposal. For FY 2018 and 2019, the DHSS stated funding for consumer-directed personal care assistance services totaled $505,140 annually. For FY 2017, funding was $740,140. Based on this information, Oversight will present on-going costs to fund consumer-directed personal care assistance services of $505,140 annually to the General Revenue Fund as a result of extending the expiration date for these provisions from June 30, 2019 to June 30, 2025.

§§217.930 and 221.125 - Suspension of MO HealthNet benefits when incarcerated
Officials from the **DSS' MHD** state that 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 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.

ASSUMPTION (continued)

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 eligibility determination systems FSD uses to determine and maintain coverage for MHD programs do not currently have the capability to suspend rather than terminate coverage. FSD defers to ITSD for any programmatic changes necessary to implement this legislation.

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 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.

ASSUMPTION (continued)

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.

Officials from the **DOC** defer 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.

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

ASSUMPTION (continued)

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.

§332.361 - Prescription of opioids by dentists
Oversight notes that no agency indicated a fiscal impact from this provision and therefore, Oversight will not reflect an impact.

§335.175 - Telehealth by nurses program
Oversight notes that no agency indicated a fiscal impact from this provision and therefore, Oversight will not reflect an impact.

Oversight notes the "Utilization of Telehealth by Nurses" allows an advanced practice registered nurse (APRN) providing nursing services under a collaborative practice arrangement to provide agreed-upon services outside the geographic proximity requirements of section 334.104 if the collaborating physician and APRN utilize telehealth in the care of the patient and if the services are provided in a rural area of need.

The State Board of Healing Arts and the Board of Nursing implemented an emergency rule on April 26, 2018 increasing the mileage restrictions in section 334.104 to 75 miles between collaborating professionals (physicians and APRNs) because the current regulations required APRNs to be no more than 30 or 50 miles from their collaborating physician. If the "Utilization of Telehealth by Nurses" program is allowed to expire, APRNs providing services via telehealth to patients in rural areas of need would have to meet the 75 mile proximity requirement. The provisions of section 335.175 do not require collaborating professionals to be within a certain proximity to each other if the services are provided by an APRN in a rural area of need via telehealth.

§337.712 - Suicide assessment training
Oversight notes that no agency indicated a fiscal impact from this provision and therefore, Oversight will not reflect an impact.

§338.140 - Pharmacist compliance agreements
Oversight notes that no agency indicated a fiscal impact from this provision and therefore, Oversight will not reflect an impact.

ASSUMPTION (continued)

§338.143 - Pharmacy pilot projects
Oversight notes that no agency indicated a fiscal impact from this provision and therefore, Oversight will not reflect an impact.

§§338.010 and 338.665 - Pharmacists prescribing and dispensing tobacco cessation products
Officials from the **DSS' MHD** state §338.800 allows pharmacists to prescribe and dispense any tobacco cessation products. Nicotine replacement therapy products are defined as any drug approved by the federal Food and Drug Administration for use as an aid to tobacco cessation. The board of pharmacy shall adopt regulations.

Based on FY 2018 data, MO HealthNet had 111,948 participants with a diagnosis of nicotine dependence. 19,491 of those participants utilized tobacco cessation products in the last year, leaving 92,457 participants who could potentially seek prescriptions directly from a pharmacist in lieu of a physician. On average participants utilizing tobacco cessation products get 2.5 prescriptions per year. The average cost of a tobacco cessation product prescription is $124.16.

MO HealthNet also assumes some savings as a result of increased tobacco cessation product use. An article published on Medicaid.Gov (https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/tobacco/index.html) indicates a savings of $2-$3 for every dollar invested in tobacco cessation.

The number of individuals that will utilize a pharmacist to receive tobacco cessation products instead of a physician is unknown and the total amount of associated savings related to tobacco cessation in unknown; therefore, the fiscal impact is presented as a range from $0 - Unknown.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the fiscal impact of this proposal as Unknown savings to Unknown costs.

§374.500 - Prior authorization reviews
Oversight notes that no agency indicated a fiscal impact from this provision and therefore, Oversight will not reflect an impact.

§376.690 - Unanticipated out-of-network care
Officials from the **DSS** assume this legislation revises Chapter 376, which pertains to Health Maintenance Organizations (HMO). The health plans that contract with the state to provide health services in the MO HealthNet Managed Care Program are licensed as HMOs, therefore without a specific exemption, this legislation could pertain to these health plans.

ASSUMPTION (continued)

This legislation revises legislation passed in FY 2018 that outlines reimbursement requirements and an arbitration system for reimbursement disputes for out-of-network providers providing "unanticipated out-of-network care" defined as services received in an in-network facility from an out-of-network provider when the patient presents with an emergency medical condition.

The legislation passed in FY 2018 was permissive and allowed for this reimbursement and arbitration system, and required an effective date of January 1, 2019. The current bill requires this reimbursement, the arbitration process and removes the January 1, 2019 effective date.

Currently, the MO HealthNet Managed Care contract requires that non-participating providers be reimbursed at 90% of the Fee-for-Service fee schedule. There are exceptions to this requirement including emergency services and "other non-participating reimbursement rates required by law or in the contract". Currently, emergency services provided by an out-of-network provider must be paid at no lower than the current MO HealthNet program rates in effect at the time of service.

If the proposed legislation passes and the MO HealthNet Managed Care contract would need to be amended to align non-participating reimbursement with the legislation, it would be assumed that unanticipated out-of-network care would be reimbursed at a rate higher than the current FFS fee schedule reimbursement. Given the negotiation process outlined and the connection of "reasonable" reimbursement to commercial levels, the "reasonable" level of reimbursement in Medicaid is not aligned with the negotiation benchmarks. This is true whether the MCO Medicaid contract required reimbursement at 90% of Medicaid FFS for non-participating providers or if the Medicaid FFS was required. It is assumed that the Managed Care capitation rates would increase at least $100,000 for this change. We estimate the actuarial cost to evaluate this program change to the Managed Care capitation rates to be no more than $50,000. Below splits are based on FMAP rate with a 2.10% medical inflation rate for FY21 and FY22.

FY20: ($150,000) -- GR: ($59,412); FF: ($90,588)
FY21: ($102,100) - GR: ($35,135); FF: ($66,965)
FY22: ($104,244.10) - GR: ($35,872); FF: ($68,372)

Oversight notes that costs for capitation rate increases would be split 35.412% state funds and 65.588% federal funds. Costs for actuarial studies are split equally between state and federal funds.

ASSUMPTION (continued)

§376.1040 and §376.1042 - Solicitation and marketing of multiple-employer self-insured health plans
Oversight notes that no agency indicated a fiscal impact from these provisions and therefore, Oversight will not reflect an impact.

§376.1224 - Health care for persons with disabilities
In response to similar legislation (SS SCS HCS HB 399), officials from the **Department of Insurance, Financial Institutions and Professional Registration (DIFP)** state this legislation impacts group major medical policies only. Companies may choose to file a rider under the "other" code to impact multiple lines in one filing. Therefore, it is unknown how many filings the DIFP will receive.

The DIFP estimates up to 150 companies will file one policy amendment each for a total of 150 filings submitted to the department for review along with a $150 filing fee. Additional revenues to the Insurance Dedicated Fund are estimated to be up to $22,500 (150 X $150 = $22,500).

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

Oversight does not have any information contrary to the information provided by DIFP and will reflect one-time revenues up to $22,500 to the Insurance Dedicated Fund for FY 2020.

§376.1345 - Prohibits health carriers from requiring health care providers to use methods of reimbursement that require providers pay a fee
Oversight notes that no agency indicated a fiscal impact from this provision and therefore, Oversight will not reflect an impact.

§376.1350, §376.1356, §376.1363, §376.1364, §376.1372, and §376.1385 -Utilization Reviews
Officials from the **Missouri Consolidated Health Care Plan (MCHCP)** assume this proposal enacts provisions relating to payments for health care services.

MCHCP consulted with its contracted third party administrators (TPA) and pharmacy benefit manager (PBM) to provide input on the financial impact of this proposed legislation.

The language in this proposed legislation adds a definition of prior authorization to be an affirmative determination of coverage made pursuant to a prior authorization review. MCHCP's

ASSUMPTION (continued)

definition of preauthorization is "A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. . . . . Preauthorization is not a promise the plan will cover the cost. . . . " The proposed language significantly expands the prior authorization definition from a review of medical necessity to a determination of coverage which expands the scope of the review to include not only a review of medical necessity to include a claim processing review. The provider will have to provide a proposed claim in addition to any clinical data to clear the potential claim for payment. Claims processing include, in summary, an automated review of edits that check for issues such as member status, provider status, benefit accumulators, correct coding edits to detect potential fraud and abuse, and other issues. This significant additional scope of review will add time to the review for medical necessity. In addition the definition of certification includes a requirement that a determination by a health carrier or a utilization review entity will include a determination that payment will be made for that health care service. Similar to the prior authorization, that expands the scope of the certification process to include a claims processing component to determine claims payment. The provider will have to provide additional billing information for that determination to be complete. Any deviation the provider makes to the final bill after services are complete, could result in a change to the payment determination.

The fiscal impact of this proposed legislation is unknown, but greater than $100,000 annually, based on increased administrative cost associated with revised authorization protocols.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect an annual cost of "Greater than" $61,940 to the General Revenue Fund, $14,630 to Other State Funds and $23,430 to Federal funds based on the following MCHCP fund splits provided by the Office of Administration:

General Revenue	61.94%;
Federal	23.43%; and
Other	14.63%

MCHCP also notes that §376.1385 changes the process of second level reviews of grievances; however, MCHCP is a non-federal governmental plan which must follow the federal review process, not state. Therefore, there is no fiscal impact from that provision.

Officials from the **Department of Social Services (DSS)** state that in order to comply with this §376.1364 of the legislation, the Managed Care Organizations may need to make changes to their current system or, if the current systems utilized do not meet the requirements of this legislation, obtain a system that does. It is assumed this legislation would have a fiscal impact as the

ASSUMPTION (continued)

capitation rates would increase at least $100,000 due to electronic requirements for prior authorization for medical and behavioral health services. A 2.4% inflation rate was used for FY21 and FY22.

FY 2020 GR $34,412; Fed $65,588 Total: $100,000
FY 2021 GR $35,238; Fed $67,162 Total: $102,400
FY 2022 GR $36,084; Fed $68,774 Total: $104,858

Bill as a whole

Officials at the **Department of Insurance, Financial Institutions and Professional Registration** stated the proposal is not anticipated to have a direct fiscal impact on their organization. However, should the extent of the work be more than anticipated, the Department would request additional appropriation and/or FTE through the budget process.

Officials at the **Missouri Department of Transportation**, **Missouri Highway Patrol**, **Office of the State Auditor**, **Office of the State Public Defenders** and the **Department of Conservation** each assume there is no fiscal impact from this proposal.

Oversight notes that the above mentioned agencies have 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 on the fiscal note.

Officials at the **Office of Administration** defer to Missouri Consolidated Health Care Plan for any fiscal impact.

Officials at the **Administrative Hearing Commission** does not anticipate this legislation will significantly alter its caseload. If similar bills pass, resulting in more cases, there will be a fiscal impact.

Officials at the **City of Columbia**, **St. Louis County**, **St. Louis County Department of Justice Services** and the **St. Louis County Public Health** all assume there is no fiscal impact from this proposal.

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

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

ASSUMPTION (continued)

Officials from the **Office of the Secretary of State (SOS)** state many bills considered by the General Assembly include provisions allowing or requiring agencies to submit rules and regulations to implement the act. The 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.

Oversight only reflects the responses that we have received from state agencies and political subdivisions; however, other Cities, Counties, Sheriffs and Police Departments, Nursing Homes, Hospitals, Local Public Health Departments, and Colleges and Universities 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.

FISCAL IMPACT - State Government	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
GENERAL REVENUE FUND				
Costs - (§21.790) SEN- Joint Contingency Expenses - Mileage reimbursement for task force members p .5	($3,000)	($3,000)	($3,000)	($3,000)
Costs - OSCA p. 6 (§191.1165)	$0 to (Unknown)	$0 to (Unknown)	$0 to (Unknown)	$0 to (Unknown)
Costs - DHSS (§192.990) p. 7	$0 to...			
Personal service	($5,375)	$0	$0	$0
Fringe benefits	($411)	$0	$0	$0
Equipment and expense	($3,657)	$0	$0	$0
Total Costs - DHSS	$0 to ($9,443)	$0	$0	$0
FTE Change - DHSS	0 to 0.1 FTE	0 FTE	0 FTE	0 FTE
Costs - DHSS (§§195.060, 195.550, 196.100, 221.111, 338.015, 338.055 and 338.056) p. 8				
Personal service	($29,992)	($36,350)	($36,713)	($37,080)
Fringe benefits	($19,649)	($23,688)	($23,798)	($23,910)
Equipment and expense	($19,033)	($13,611)	($13,950)	($14,299)
Total Costs - DHSS	($68,674)	($73,649)	($74,461)	($75,289)
FTE Change - DHSS	1 FTE	1 FTE	1 FTE	1 FTE

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
GENERAL REVENUE (continued)				
Costs - OA, ITSD (§§195.060, 195.550, 196.100, 221.111, 338.015, 338.055 and 338.056) System updates (ranged from contracting out the programming ($61,560) to hiring an additional 1 FTE IT Specialist) p. 9	($61,560 to $66,667)	$0 or ($80,800)	$0 or ($81,608)	$0 or ($82,424)
FTE Change - OA, ITSD	0 or 1 FTE	0 or 1 FTE	0 or 1 FTE	0 or 1 FTE
Costs - DHSS (§198.082) p. 11	$0 to...	$0 to...	$0 to...	$0 to...
Personal service	($100,576)	($115,383)	($116,537)	($118,880)
Fringe benefits	($57,972)	($66,687)	($67,039)	($67,753)
Equipment and expense	(Greater than $47,546)	(Greater than $28,775)	(Greater than $29,494)	(Greater than $30,987)
Total Costs - DHSS	$0 or (Greater than $206,094)	$0 or (Greater than $210,845)	$0 or (Greater than $213,070)	$0 or (Greater than $217,620)
FTE Change - DHSS	0 or 2.6 FTE	0 or 2.5 FTE	0 or 2.5 FTE	0 or 2.5 FTE
Costs - DSS (§208.151) p. 13 Increase in state share of MO HealthNet benefits for foster children	($31,183)	($63,863)	($65,396)	($66,900)

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
GENERAL REVENUE (continued)				
Costs - OA, ITSD (§208.151) p. 14				
FACES system modifications (ranged from contracting out the programming ($42,768) to hiring additional 1 FTE IT Specialist)	($42,768 to $44,000)	$0 or ($80,800)	$0 or ($81,608)	$0 or ($82,424)
MEDES modifications	($161,741)	$0	$0	$0
Total Costs - OA, ITSD	($204,509 or $205,741)	$0 or ($80,800)	$0 or ($81,608)	$0 or ($82,424)
FTE Change - OA, ITSD	0 or 0.66 FTE	0 or 1 FTE	0 or 1 FTE	0 or 1 FTE
Costs - DHSS (§208.225) Increase in HCBS cap rates p.16	Could exceed ($68,017 to $205,570)	Could exceed ($167,006 to $506,918)	Could exceed ($254,462 to $782,746)	Expected to exceed ($254,462 to $782,746)
Costs - DSS (§208.225) p. 22 Contractor costs	($56,826)	($70,783)	($73,472)	($76,161)
Costs - DSS (§208.225) p. 22 Increase in capital expenditures	Could exceed ($2,203,095 to $7,372,999)	Could exceed ($5,388,777 to $18,169,185)	Could exceed ($8,245,447 to $27,990,106)	Could exceed ($11,216,463 to $38,340,998)
Income - DSS (§208.790) p. 23 Increase in rebate revenue	$3,260,312	$6,962,649	$6,962,649	$6,962,649

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
GENERAL REVENUE (continued)				
Savings - DSS (§208.790) p. 23 Reduction in costs due to "donut hole"	$60,068	$72,082	$72,082	$72,082
Costs - DSS (§208.790) p. 23 Contractor, mailings and enrollment	($492,253)	($205,468)	($205,468)	($205,468)
Costs - DSS (§208.790) p. 23 Program expenditures to expand coverage to non-dual (Medicare - only) recipients	($14,897,530)	($17,891,452)	($17,891,452)	($17,891,452)
Savings - DHSS (§208.896) p. 28 Reduction in HCBS waiver services	$0	$0 or $829,913 to $1,882,679	$0 or $840,701 to $1,907,155	$0 or Could exceed $840,701 to $1,907,155
Costs - DHSS (§208.896) p. 30	$0 to...	$0 to...	$0 to...	$0 to...
Personal service	($5,375)	$0	$0	$0
Fringe benefits	($411)	$0	$0	$0
Equipment and expense	($3,657)	$0	$0	$0
Total Costs - DHSS	($9,443)	$0	$0	$0
FTE Change - DHSS	0 or 0.1 FTE	0 FTE	0 FTE	0 FTE

FISCAL IMPACT - State Government (continued) **GENERAL REVENUE (continued)**	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
Costs - DHSS (§208.896) p. 24 Webtool changes	($200,000)	$0	$0	$0
Costs - DHSS (§208.896) p. 31 Structured family caregiver services p.	$0	($2,446,260)	($2,478,289)	Likely to exceed ($2,478,289)
Costs - DSS (§208.896) p.33 MMIS system changes/Wipro	($52,500)	$0	$0	$0
Costs - DHSS (§208.930) p. 35 Personal care assistance service costs	($505,140)	($505,140)	($505,140)	($505,140)
Costs - DSS (§§217.930 and 221.125) p. 33 MMIS system modifications	($125,000)	$0	$0	$0

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
GENERAL REVENUE (continued)				
Savings - DSS (§§338.010 and 338.665) p. 35 Reduction in Medicaid expenditures as a result of decreased tobacco use	Unknown	Unknown	Unknown	Unknown
Costs - DSS (§§338.010 and 338.665) p.35 Pharmacy costs from tobacco sensation	(Unknown)	(Unknown)	(Unknown)	(Unknown)
Costs - DSS (§376.690) p. 36 Actuarial & Increase in managed care capitation rates	($59,412)	($35,135)	($35,873)	($36,611)
Costs - MCHCP (§376.1350) p.38 Prior authorization protocols	Greater than ($51,617)	Greater than ($61,940)	Greater than ($61,940)	Greater than ($61,940)

FISCAL IMPACT - State Government (continued) **GENERAL REVENUE (continued)**	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
Costs - DSS (§376.1364) p. 39 Increase in managed care capitation rates	($34,412)	($35,135)	($35,873)	($36,611)
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**(Unknown - Greater than $15,794,348 to $21,364,307)**	**(Unknown - Greater than $15,583,938 to $33,405,642)**	**(Unknown- Greater than $18,510,098 to $43,544,771)**	**(Unknown - Greater than $21,487,611 to $53,908,342)**
Estimated Net FTE Change on the General Revenue Fund	1 to 5.46 FTE	1 to 5.5 FTE	1 to 5.5 FTE	1 to 5.5 FTE

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
MISSOURI VETERANS' HEALTH AND CARE FUND				
Income - DHSS §195.820 p. 10 Administration/ processing fees	$0 or Unknown	$0 or Unknown	$0 or Unknown	$0 or Unknown
Costs - DHSS §195.820 p. Administration costs p. 10	$0 or (Unknown)	$0 or (Unknown)	$0 or (Unknown)	$0 or (Unknown)
ESTIMATED NET EFFECT ON THE MISSOURI VETERANS' HEALTH AND CARE FUND*	**$0**	**$0**	**$0**	**$0**

* Additional administration/processing fees assessed equal additional administration expenses.

PREMIUM FUND (0885)				
Income - DSS (§208.146) p. 12 Ticket to work premiums	$1,007,960	$1,209,552	$1,209,552	$1,209,552
ESTIMATED NET EFFECT ON THE PREMIUM FUND	**$1,007,960**	**$1,209,552**	**$1,209,552**	**$1,209,552**

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
INSURANCE DEDICATED FUND (0566)				
Income - DIFP §376.1224 p. 37				
Form filing fees	Up to $22,500	$0	$0	$0
ESTIMATED NET EFFECT ON THE INSURANCE DEDICATED FUND	**Up to $22,500**	**$0**	**$0**	**$0**
OTHER STATE FUNDS				
Costs - MCHCP §376.1350 p. 38				
Prior authorization protocols	Greater than ($12,192)	Greater than ($14,630)	Greater than ($14,630)	Greater than ($14,630)
ESTIMATED NET EFFECT ON OTHER STATE FUNDS	**Greater than ($12,192)**	**Greater than ($14,630)**	**Greater than ($14,630)**	**Greater than ($14,630)**

FISCAL IMPACT - State Government	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
FEDERAL FUNDS				
Savings - DSS (§§338.010 and 338.665) p. 35 Reduction in Medicaid expenditures as a result of decreased smoking	Unknown	Unknown	Unknown	Unknown
Income - DSS (§208.151) p. 13 Increase in program reimbursements	$59,434	$121,720	$124,641	$127,508
Income - OA, ITSD (§208.151) p. 14 Reimbursement for MEDES and FACES system updates	$501,746 or $507,889	$0	$0	$0
Income - DHSS (§208.225) p. 16 Increase in HCBS program reimbursements	Could exceed $129,637 to $391,810	Could exceed $318,306 to $966,167	Could exceed $484,995 to $1,491,886	Likely to exceed $484,995 to $1,491,886
Income - DSS §208.225 p. 22 Reimbursement for contractor costs	$56,826	$70,783	$73,472	$76,162

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
FEDERAL FUNDS (continued)				
Income - DSS §208.225 p. 22 Reimbursement for increase in capital expenditures	Could exceed $4,199,018 to $14,052,664	Could exceed $10,270,809 to $34,629,795	Could exceed $15,715,518 to $53,348,108	Could exceed $21,378,164 to $73,076,525
Income - DHSS §208.896 p. 24 Webtool update reimbursement	$200,000	$0	$0	$0
Income - DHSS §208.896 p. 24 Structured family caregiver service reimbursement	$0	$0 to $4,662,480	$0 to $4,723,526	$0 to Likely to exceed $4,723,526
Income - DSS §§208.896 p. 30 Increase in program reimbursements for MMIS changes	$17,500	$0	$0	$0
Income - DSS §§217.930 and 221.125 p. 33 Program reimbursements for MMIS modifications	$375,000	$0	$0	$0
Income - DSS §§338.010 and 338.665 p. 35 Increase in program reimbursements	Unknown	Unknown	Unknown	Unknown

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
FEDERAL FUNDS (continued)				
Income - DSS §376.690 p. 36 Increase in managed care capitation rates	$65,588	$66,965	$68,371	$69,777
Income - DSS (§376.690) p. 36 Actuarial study	$25,000	$0	$0	$0
Income - DSS §376.1364 p. 39 Increase in managed care capitation rates	$65,588	$66,965	$68,371	$69,777
Savings - DHSS §208.896 p. 28	$0 or...	$0 or...	$0 or...	$0 or...
Reduction in HCBS waiver expenditures	$0	$1,581,783 to $3,588,317	$1,602,346 to $3,634,966	Could exceed $1,602,346 to $3,634,966
Costs -DSS §208.151 p. 13 Increase in program costs for children in foster care	($59,434)	($121,720)	($124,641)	($127,508)
Costs - OA, ITSD §208.151 p. 14 FACES system modifications (ranged from contracting out the programming to hiring additional 1 FTE IT Specialist)	($16,524 or $22,667)	$0	$0	$0
MEDES modifications	($485,222)	$0	$0	$0
Total Costs - DSS	($501,746 or $507,889)	$0	$0	$0
FTE Change - OA, ITSD	0.34 FTE	0 FTE	0 FTE	0 FTE

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
FEDERAL FUNDS (continued)				
Costs - DHSS §208.225 p. 16 Increase in HCBS cap rates	Could exceed ($129,637 to $391,810)	Could exceed ($318,306 to $966,167)	Could exceed ($484,995 to $1,491,886)	Likely to exceed ($484,995 to $1,491,886)
Costs - DSS §208.225 p. 22 Contractor costs	($56,826)	($70,783)	($73,472)	($76,162)
Costs - DSS (§208.225) p. 22 Increase in capital expenditures	Could exceed ($4,199,018 to $14,052,664)	Could exceed ($10,270,809 to $34,629,795)	Could exceed ($15,715,518 to $53,348,108)	Could exceed ($21,378,164 to $73,076,525)
Costs - DHSS (§208.896) Webtool update p. 24	($200,000)	$0	$0	$0
Costs - DHSS (§208.896) Structured family caregiver services p. 24	$0	$0 to ($4,662,480)	$0 to ($4,723,526)	$0 to Likely to exceed ($4,723,526)
Costs - DSS §208.896 p. 30 MMIS system changes/Wipro	($17,500)	$0	$0	$0
Costs - DSS §217.930 and §221.125 p. 33 MMIS system modifications	($375,000)	$0	$0	$0

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
FEDERAL FUNDS (continued)				
Costs - DSS §338.010 and §338.665 p. 35 Pharmacy expenditures	(Unknown)	(Unknown)	(Unknown)	(Unknown)
Costs - DSS §376.690 p. 36 Increase in managed care capitation rates	($65,588)	($66,965)	($68,371)	($69,777)
Costs - DSS §376.690 p. 36 Actuarial study	($25,000)	$0	$0	$0
Costs - MCHCP §376.1350 p. 38 Prior authorization protocols	Greater than ($19,525)	Greater than ($23,430)	Greater than ($23,430)	Greater than ($23,430)
Costs - DSS §376.1364 p. 39 Increase in managed care capitation rates	($65,588)	($66,965)	($68,371)	($69,777)
Loss - DHSS (§208.896) p. 28 Reduction in HCBS waiver reimbursements	$0	$0 or... ($1,581,783 to $3,588,317)	$0 or... ($1,602,346 to $3,634,966)	$0 or... Could exceed ($1,602,346 to $3,634,966)

FISCAL IMPACT - State Government (continued)	FY 2020	FY 2021	FY 2022	Fully Implemented (FY 2023)
FEDERAL FUNDS (continued)				
Loss - DSS §338.010 and §338.665 p. 35 Reduction in reimbursements as a result of decreased smoking	(Unknown)	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**Greater than ($19,525)**	**Greater than ($23,430)**	**Greater than ($23,430)**	**Greater than ($23,430)**
Estimated Net FTE Change on Federal Funds	0.34 FTE	0 FTE	0 FTE	0 FTE

FISCAL IMPACT - Local Government	FY 2020 (10 Mo.)	FY 2021	FY 2022	Fully Implemented (FY 2023)
LOCAL GOVERNMENTS				
Costs - counties & cities - §376.1224 - increase in health care plan expenditures to cover treatment of symptoms and behaviors for individuals with physical or developmental disabilities p. 37	$0 to (Unknown)	$0 to (Unknown)	$0 to (Unknown)	$0 to (Unknown)
Costs - Counties and Cities §191.1164 - §191.1168 p. 7 Substance use treatment	$0 to (Unknown)	$0 to (Unknown)	$0 to (Unknown)	$0 to (Unknown)
ESTIMATE NET EFFECT ON LOCAL GOVERNMENTS	**$0 to (Unknown)**	**$0 to (Unknown)**	**$0 to (Unknown)**	**$0 to (Unknown)**

FISCAL IMPACT - Small Business

This will directly impact small businesses that provide insurance to their employees if the cost of the insurance increases. (§191.1165)

This proposal could have a negative fiscal impact on small business pharmacies and individual practitioners dispensing prescriptions if they incur costs to obtain computer hardware and software. In addition, there may be additional costs related to entering and transmitting prescriptions electronically. (§§195.060, 195.550, 196.100, 221.111, 338.015, 338.055 and 338.056)

FISCAL IMPACT - Small Business (continued)

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)

Not extending the expiration date for the provision of personals care assistance services could directly impact small businesses that provide these services. (§208.930)

If this proposal does not pass, there could be a negative impact to small business physicians that collaborate with APRNs located further than 75 miles from them. The physicians would no longer be able to collaborate with the APRNs and the APRNs would not be able provide services via telehealth in rural areas of need. (§335.175)

The proposal may have a minor impact to some small business marital and family therapists. (§337.712)

This proposal could have a positive fiscal impact on small business pharmacies. (§§338.010 and 338.665)

This proposal could impact small businesses that provide insurance coverage to their employees if the cost of the insurance increases upon passage of this proposal. (§376.1224)

FISCAL DESCRIPTION

This act modifies several provisions relating to health care, including: (1) the "Task Force on Substance Abuse Prevention and Treatment; (2) the Health Professional Student Loan Repayment Program; (3) physician referrals of infants affected by substance abuse; (4) medication-assisted treatment; (5) pregnancy-associated mortality; (6) infection data reporting; (7) physician assistants; (8) electronic prescribing; (9) opioid prescriptions for sickle cell patients; (10) medical marijuana; (11) hospital inspections; (12) certified nursing assistants; (13) Ticket to Work Health Assurance Program; (14) MO HealthNet benefits for former foster youth; (15) MO HealthNet per diem reimbursement rates; (16) the Missouri RX Plan; (17) suspension of MO HealthNet benefits of offenders in correctional facilities and jails; (18) structured family caregiving; (19) consumer-directed services for non-MO HealthNet eligible participants; (20) the prescribing of long-acting or extended-release opioids by dentists; (21) telehealth; (22) family and marital therapist training; (23) tobacco cessation; (24) pharmacist voluntary compliance agreements; (25) pharmacy pilot projects; (26) utilization reviews; (27) unanticipated out-of-network health care services; (28) multiple employer self-insured health plans; (29) health insurance for persons with disabilities; and (30) health insurance reimbursement.

FISCAL DESCRIPTION (continued)

THE "TASK FORCE ON SUBSTANCE ABUSE PREVENTION AND TREATMENT"
This act establishes the "Task Force on Substance Abuse Prevention and Treatment". The task force shall be comprised of sixteen members, including six from the House of Representatives, six from the Senate, and four appointed by the Governor, as specified in the act. The task force shall conduct hearings on current and future drug and substance use and abuse in Missouri, explore solutions to such issues, and draft or modify legislation as necessary to effectuate the goals of finding and funding education and treatment solutions. The task force shall report annually to the General Assembly and Governor with recommendations for legislation pertaining to substance abuse prevention and treatment. (§21.790)

HEALTH PROFESSIONAL STUDENT LOAN REPAYMENT PROGRAM - This act adds psychiatrists to the Health Professional Student Loan Repayment Program. The Department of Health and Senior Services shall designate areas of need for psychiatric services when such areas have been designated as mental health care professional shortage areas by the federal Department of Health and Human Services or when the Director of the Department of Health and Senior Services has determined such areas to have an extraordinary need. (§191.603, §191.605, and §191.607)

PHYSICIAN REFERRALS OF INFANTS AFFECTED BY SUBSTANCE ABUSE - Under this act, any physician or health care provider shall refer to the Children's Division families in which infants are born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder. (§191.737)

MEDICATION-ASSISTED TREATMENT - This act establishes the "Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act". These provisions specify that medication-assisted treatment (MAT) services shall include, but not be limited to, pharmacologic and behavioral therapies. Formularies used by a health insurer or managed by a pharmacy benefits manager, and medical benefit coverage in the case of medications dispensed through an opioid treatment program, shall include all certain specified medications. All MAT medications required for compliance with these provisions shall be placed on the lowest cost-sharing tier of the formulary.

MAT services provided for under these provisions shall not be subject to: annual or lifetime dollar limits; limits to predesignated facilities, specific numbers of visits, days of coverage, days in a waiting period, scope or duration of treatment, or other similar limits; financial requirements and quantitative treatment limitations that do not comply with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA); step therapy or other similar strategies when it interferes with a prescribed or recommended course of treatment from a licensed health care professional; or prior authorization.

FISCAL DESCRIPTION (continued)

These provisions shall apply to all health insurance plans delivered in the state. (§191.1164, §191.1165, §191.1167, and §191.1168)

PREGNANCY-ASSOCIATED MORTALITY - This act establishes the "Pregnancy-Associated Mortality Review Board" within the Department of Health and Senior Services to improve data collection and reporting regarding maternal mortality and to develop initiatives that support at-risk populations. The Board shall consist of no more than 18 members appointed by the Director of the Department, as specified in the act, with diverse racial, ethnic, and geographic membership. Before June 30, 2020, and each year thereafter, the Board shall submit a report on maternal mortality in the state and proposed recommendations to the Director of the Centers for Disease Control and Prevention, the Director of the Department, the Governor, and the General Assembly.

The Department shall have the authority to request and receive data for maternal deaths from specified entities. All individually identifiable or potentially identifiable information and other records shall be kept confidential as described in the act. (§192.067 and §192.990)

INFECTION DATA REPORTING - Under this act, hospitals and the Department of Health and Senior Services shall not be required to comply with infection data reporting requirements of current law applying to hospitals if the Centers for Medicare and Medicaid Services (CMS) also requires the submission of such data, except that the Department shall post a link on its website to the publicly reported data on CMS's website. Additionally, hospitals that have established antimicrobial stewardship programs, as required under current law, shall meet the National Healthcare Safety Network requirements for reporting antimicrobial usage or resistance when CMS's conditions of participation requiring such reporting become effective. Nothing shall prohibit a hospital from voluntarily reporting the data prior to the effective date of the conditions of participation. (§192.667)

PHYSICIAN ASSISTANTS - This act modifies provisions of current law relating to supervision agreements between physicians assistants and supervising physicians by changing such agreements to collaborative practice arrangements with collaborating physicians. Collaborative practice arrangements shall delegate to the physician assistant the authority to prescribe, administer, or dispense drugs, including certain controlled substances, and provide treatment to patients. Geographic proximity requirements shall be determined by the Board of Registration for the Healing Arts. Further requirements of collaborative practice arrangements are specified in the act. No collaborative practice arrangement shall supercede existing hospital licensing regulations governing hospital medication orders for inpatient or emergency care.

Additionally, the physician assistant program accrediting entity is changed under this act to include other accreditation programs. (Sections 193.015, 195.100, 334.037, 334.104, 334.108, 334.735, 334.736, 334.747, 334.749, 338.010, 630.175, and 630.875)

FISCAL DESCRIPTION (continued)

ELECTRONIC PRESCRIBING - Under this act and beginning January 1, 2021, no person shall issue a prescription for any Schedule II, III, or IV controlled substance unless the prescription is electronic and made to a pharmacy, excluding prescriptions issued in circumstances specified in the act. Pharmacists receiving a written, oral, or faxed prescription shall not be required to verify that the prescription falls into one of the exceptions and may continue to dispense medication from an otherwise valid non-electronic prescription. An individual who violates this provision may be subject to disciplinary action by his or her professional licensing board.(§195.060, §195.550, §196.100, §221.111, §338.015, §338.055, and §338.056)

OPIOID PRESCRIPTIONS FOR SICKLE CELL PATIENTS - This act excludes patients undergoing treatment for sickle cell disease from the initial opioid prescription limitations in current law. (§195.080)

MEDICAL MARIJUANA - This act authorizes the Department of Health and Senior Services to establish through rule promulgation an administration and processing fee, as specified in the amendment, to cover the costs of administering the medical marijuana program if the funds in the Missouri Veterans' Health and Care Fund are insufficient to cover such administration costs. (§195.820)

HOSPITAL INSPECTIONS - This act prohibits the Department of Health and Senior Services from assigning an individual to inspect or survey a hospital if the inspector or surveyor was an employee of such hospital or another hospital within its organization or a competing hospital within 50 miles of the hospital to be inspected or surveyed within the previous 2 years. The Department shall require inspectors or surveyors to disclose the name of every hospital in which he or she was employed in the previous 10 years, the length of service, and the job title held, as well as the same information for any immediate family member employed at a hospital. Such information shall be considered a public record.

If any person has reason to believe that an inspector or surveyor has any personal or business affiliation that would result in a conflict of interest, he or she may notify the Department. If the Department has reason to believe the information to be true, the Department shall not assign the inspector or surveyor to the hospital or any hospital within its organization. (§197.108)

CERTIFIED NURSING ASSISTANTS - This act requires certified nursing assistant training programs to be offered at skilled nursing or intermediate care facility units in Missouri veterans homes and hospitals. Certified nursing assistants shall include certain employees at such units and hospitals who have completed the training and passed the certification examination. Training shall include on-the-job training at certain locations and the act repeals language pertaining to continuing in-service training. Persons who have completed the required hours of classroom

FISCAL DESCRIPTION (continued)

instruction and clinical practicum for unlicensed assistive personnel under state regulations shall be allowed to take the certified nursing assistant examination and shall be deemed to have fulfilled the classroom and clinical standards requirements for designation as a certified nursing assistant. Finally, the Department of Health and Senior Services may offer additional training programs and certifications to students already certified as nursing assistants as specified in the act. (§198.082)

TICKET TO WORK HEALTH ASSURANCE PROGRAM - This act changes the Ticket to Work Health Assurance Program's expiration date from August 28, 2019, to August 28, 2025. (§208.146)

MO HEALTHNET BENEFITS FOR FORMER FOSTER YOUTH - 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)

MEDICAID PER DIEM REIMBURSEMENT RATES - 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)

MISSOURI RX PLAN - 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)

SUSPENSION OF MO HEALTHNET BENEFITS OF OFFENDERS IN CORRECTIONAL FACILITIES AND JAILS - 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 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 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

FISCAL DESCRIPTION (continued)

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)

STRUCTURED FAMILY CAREGIVING - This act requires the Department of Social Services to seek a waiver from the U.S. Secretary of Health and Human Services to add structured family caregiving as a covered home and community based service for certain MO HealthNet participants. Structured family caregiving shall include: (1) a choice for participants of qualified and credentialed caregivers; (2) a choice for participants of the community settings in which they receive care; (3) a requirement that caregivers be added to the Family Care Safety Registry; (4) a requirement that caregivers be required to carry liability insurance; (5) a cap of 300 participants to receive services; (6) a requirement that structured family caregiving agencies are accountable for quality care; (7) a requirement that caregivers provide for participants' personal needs; (8) a daily, adequate payment rate; and (9) that such payment rate be capped at 60% of the daily nursing home cost cap established by the state each year. (§208.896)

CONSUMER DIRECTED SERVICES FOR NON-MO HEALTHNET ELIGIBLE PARTICIPANTS - This act extends the consumer directed services program for non-MO HealthNet eligible participants from June 30, 2019, to June 30, 2025. (§208.930)

This provision has an emergency clause.

PRESCRIBING OF LONG-ACTING OR EXTENDED RELEASE OPIOIDS BY DENTISTS - Under this act, long-acting or extended-release opioids shall not be used to treat acute pain in dentistry. If the dentist, in his or her professional judgment, believes a long-acting or extended-release opioid is necessary to treat the patient, the dentist shall document and explain in the patient's dental record the reason for the necessity for the long-acting or extended-release opioid.

Dentists shall avoid prescribing doses greater than 50 morphine milligram equivalents (MME) per day for treatment of acute pain. If the dentist believes doses greater than 50 MME are necessary to treat the patient, the dentist shall document and explain the reason for the dose greater than 50 MME.

The Missouri Dental Board is required, under this act, to maintain an MME conversion chart and instructions for calculating MMEs on its website. (§332.361)

TELEHEALTH - This act removes the sunset provision on the utilization of telehealth for advanced practice registered nurses in rural areas of need. (§335.175)

FAMILY AND MARITAL THERAPIST TRAINING - This act requires marital and family therapists to complete two hours of suicide assessment, referral, treatment, and management training as a condition of initial licensure and as a condition of license renewal. (§337.712)

FISCAL DESCRIPTION (continued)

TOBACCO CESSATION - Under this act, the practice of pharmacy shall include the prescribing and dispensing of any nicotine replacement therapy product. A nicotine replacement therapy product is defined as any drug, regardless of whether it is available over-the-counter, that delivers small doses of nicotine to a person and that is approved by the Food and Drug Administration (FDA) for the sole purpose of aiding in tobacco or smoking cessation. The Board of Pharmacy and the Board of Healing Arts shall, under this act, jointly adopt regulations governing a pharmacist's authority to prescribe and dispense nicotine replacement therapy products. Neither Board shall separately promulgate rules governing a pharmacist's authority to prescribe and dispense such products. (§338.010 and §338.665)

PHARMACIST VOLUNTARY COMPLIANCE AGREEMENTS - Under current law, the Board of Pharmacy may issue letters of reprimand, censure, or warning to any pharmacist licensed, registered, or with a permit in the state for any violations that could result in disciplinary action. Under this act, the Board may enter into a voluntary compliance agreement with a pharmacist to ensure or promote compliance with current law and the rules of the Board, in lieu of disciplinary action. The agreement shall be a public record, and the time limitation set forth under current law for commencing a disciplinary proceeding shall be tolled while an agreement authorized under this act is in effect. (§338.140)

UTILIZATION REVIEWS - This act replaces "utilization review organization" with "utilization review entity", and "prospective review" with "prior authorization review" throughout the statutes relating to utilization reviews. Additionally, this act adds health care services that are denied under a utilization review to the definition of "adverse determination", including with regard to the reconsideration process. The definitions of "adverse determination" and "certification" are modified to refer to decisions made by "a utilization review entity" rather than a health carrier's "designee utilization review entity". "Certification" is also modified to require a guarantee of payment, provided the patient is still an enrollee at the time the certified health care service is provided. "Clinical review criteria" is modified to include several specific policies and rules, as well as any other criteria or rationale used by a health carrier or utilization review entity to determine appropriateness or necessity of health care services. "Health care service" is modified to specifically include the provision of drugs or durable medical equipment.

The act replaces references to "initial certification" with "certification" and "initial determination" with "determination". Currently, notice of an adverse determination is required to include instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. T his act repeals this requirement, specifies that the adverse determination notice shall include a written statement of the clinical rationale, requires notice to the health care provider, and repeals the requirement that notice of the adverse determination must be requested. Written procedures to address a failure or inability of a provider or enrollee to provide all information necessary to make a decision shall be made available on the health carrier's website or provider portal. Provided the patient is an enrollee of the health benefit

FISCAL DESCRIPTION (continued)

plan, no utilization review entity shall revoke, limit, condition, or otherwise restrict a prior authorization within 45 working days of its receipt by a health care provider. Provided the patient is an enrollee of the health benefit plan at the time the service is provided, no health carrier, utilization review entity, or health care provider shall bill an enrollee for any health care service for which a prior authorization was in effect at the time the service was provided, except as consistent with cost-sharing requirements applicable to covered benefits.

Under the act, any utilization review entity performing prior authorization review shall provide a unique confirmation number to a provider upon receipt from that provider of a request for prior authorization. Confirmation numbers shall be transmitted or otherwise communicated through the same medium through which the requests for prior authorization were made.

No later than January 1, 2021, utilization review entities shall accept and respond to requests for prior authorization of drug benefits through a secure electronic transmission using the National Council for Prescription Drugs SCRIPT Standard Version 2017071 or a backwards-compatible successor adopted by the United States Department of Health and Human Services.

No later than January 1, 2021, utilization review entities shall accept and respond to requests for prior authorization of health care services and mental health services electronically, which shall not include facsimile, proprietary payer portals, and electronic forms.

No later than January 1, 2021, utilization review entities shall develop a single secure prior authorization cover page for all its health benefit plans utilizing prior authorization review, which the carrier or its utilization review entity shall use to accept and respond to, and providers shall use to submit, requests for prior authorization. The cover page shall include, but not be limited to, fields for certain information as specified in the act.

The act requires health carriers and utilization review entities to make available on its website or provider portal any current prior authorization requirements or restrictions, including written clinical criteria. Requirements and restrictions, including step therapy protocols, shall be described in detail. No health carrier or utilization review entity shall amend or implement a new prior authorization requirement or restriction prior to the change being reflected on the carrier or review entity's website or provider portal. Health carriers and utilization review entities shall provide in-network health care providers with written or electronic notice of the new or amended requirement not less than 60 days prior to implementing the requirement or restriction.

The act specifies that when an enrollee's grievance with a health carrier involves an adverse utilization review determination and the panel upholds the adverse determination, the carrier shall

FISCAL DESCRIPTION (continued)

submit the grievance for review to 2 independent clinical peers in the same or similar specialty as would typically manage the case being reviewed.

If both independent reviewers agree with the panel's decision, the decision stands. If both reviewers disagree with the panel, the decision is overturned. If one disagrees with the panel, the panel shall reconvene and use its discretion to make a final decision. (§374.500, §376.1350, §376.1356, §376.1363, §376.1364, §376.1372, and §376.1385)

UNANTICIPATED OUT-OF-NETWORK HEALTH CARE SERVICES - This act specifies that health care professionals shall, rather than may, utilize the process outlined in statute for claims for unanticipated out-of-network care. (§376.690)

HEALTH INSURANCE FOR PERSONS WITH DISABILITIES - This act adds therapeutic care for "developmental or physical disabilities", as such term is defined in the act, to the insurance coverage mandate for autism spectrum disorders, and makes the mandate applicable to policies issued or renewed on or after January 1, 2020, rather than to group policies only. The act specifies that autism spectrum disorder shall not be subject to any limits on the number of visits an individual may make to an autism service provider. Coverage for therapeutic care provided under the act for developmental and physical disabilities may be limited to a number of visits per calendar year, provided that additional visits shall be covered if approved and deemed medically necessary by the health benefit plan. Provisions requiring coverage for autism spectrum disorders and developmental or physical disabilities shall not apply to certain grandfathered, pre-empted, or supplemental plans as described in the act.

This act repeals a provision of law directing the Department of Insurance, Financial Institutions, and Professional Registration to grant small employers waivers from the coverage requirements under certain circumstances. The act also repeals a provision requiring the Department to submit annual reports to the legislature and requiring health carriers to supply certain diagnosis and coverage information for the report.

These provisions apply to policies issued, delivered, or renewed on or after January 1, 2020. (§376.1224)

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

City of Columbia
City of Kansas City
Department of Conservation
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
Jefferson County
Joint Committee on Administrative Rules
Missouri Consolidated Health Care Plan
Missouri House of Representatives
Missouri Department of Transportation
Missouri Highway Patrol
Missouri Senate
Office of Administration -
Office of the Governor
Office of the State Auditor
Office of State Courts Administrator
Office of the State Public Defenders
Office of Secretary of State
St. Louis County
St. Louis County Public Health
St. Louis County Department of Justice Services

Kyle Rieman
Director
June 17, 2019

Ross Strope
Assistant Director
June 17, 2019