COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 5485-02
Bill No.: SB 1245
Subject: Certificate of Need; Health Care; Health Care Professionals; Health Department; Health, Public; Hospitals; Physicians; Social Services Department; Employees-Employers
Type: Original
Date: March 28, 2006

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2007	FY 2008	FY 2009
General Revenue	(Greater than $1,544,322)	(Greater than $1,570,985)	(Greater than $1,599,055)
Total Estimated Net Effect on General Revenue Fund	**(Greater than $1,544,322)**	**(Greater than $1,570,985)**	**(Greater than $1,599,055)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2007	FY 2008	FY 2009
Ambulatory Surgical Center Federal Reimbursement Allowance Fund*	$0	$0	$0
Total Estimated Net Effect on Other State Funds	**$0**	**$0**	**$0**

*Unknown income and costs would net to $0.
Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 14 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2007	FY 2008	FY 2009
Federal*	$0	$0	$0
Total Estimated Net Effect on All Federal Funds	**$0**	**$0**	**$0**

*Income and costs of greater than $150,000 would net to $0.

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2007	FY 2008	FY 2009
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Department of Mental Health**, the **Department of Economic Development**, and the **Office of Administration - Administrative Hearing Commission** assume this proposal would not fiscally impact their agencies.

Officials from the **Department of Social Services - Division of Medical Services (DMS)** state Section 197.241 - Section 197.247 requires licensed ambulatory surgical centers in this state to pay a reimbursement allowance for the privilege of engaging in the business of providing ambulatory surgical center services in Missouri. All amounts remitted shall be deposited in the Ambulatory Surgical Center Federal Reimbursement Allowance Fund for the sole purpose of providing payment to ambulatory surgical centers. DMS states similar provider tax assessments are currently imposed on hospitals, nursing homes, pharmacies and managed care organizations.

To determine the federal reimbursement allowance assessment for each Ambulatory Surgical Center (ASC), the Division of Medical Services (DMS) will need currently unavailable data such

ASSUMPTION (continued)

as revenues, expenses, total utilization, and Medicaid utilization. This information is included in the annual Medicaid cost reports submitted by hospitals and nursing facilities. Ambulatory surgical centers, on the other hand, do not currently submit cost reports. DMS states without cost reports, DMS lacks the data necessary to calculate both assessments from ASCs and additional Medicaid payments from the Ambulatory Surgical Center Federal Reimbursement Allowance Fund to the providers. An annual cost report filing requirement, however, would be a new burden on ASCs.

Prior to preparing a cost report, an ambulatory surgical center will also need to have an independent audit performed. The independent audit provides assurance that the provider's "books" - the source of financial information for the Medicaid cost report - accurately reflect the results of the provider's operations. Data from the ASC owner's income tax return may not provide sufficient information for assessment and payment calculations, because revenues and expenses may be reported differently for tax purposes than they would be under generally accepted accounting principles.

The DMS uses at least 2 full time employees (FTE) to maintain each of the federal reimbursement allowance programs under operation. Such a minimum staffing requirement will also apply to the proposed ambulatory surgical center federal reimbursement allowance program. Additional staff will need to: promulgate rules for the new program as set forth in Section 197.244.1; develop cost reporting formats to be used by ASCs; review and audit the cost reports from ASCs for accuracy and adherence to Medicaid regulations; compile finalized data from audited ASC cost reports; calculate assessments every state fiscal year for all ASCs and monitor all ASCs to verify that their assessments are paid in a timely manner; determine the methodology for reimbursement of ASC federal reimbursement allowance funds to the providers and calculate the amounts of such reimbursement to the ASCs every state fiscal year; and prepare the fiscal period reports in the manner required for the other federal reimbursement allowance programs. The additional staff will also have frequent correspondence and communication with the ASCs regarding their cost report audits, assessments, payments, and other ASC-related inquiries.

The DMS must obtain approval from the federal Centers for Medicare and Medicaid Services for the proposed ASC federal reimbursement allowance. At a minimum, DMS must submit for CMS's review and approval a Medicaid state plan amendment for the ASC program. CMS will demand voluminous supporting documentation for this state plan amendment as part of its review. While DMS cannot arrive at an actual dollar increase to Medicaid, DMS assumes there will be a fiscal impact exceeding $150,000 annually.

ASSUMPTION (continued)

Section 197.305 - Section 197.357:
DMS states without the CON approval process additional new hospitals would be built and other new health services will be generated. The new hospital and services would increase the cost to the Medicaid program. Any increase that may result due to this legislation is not expected to occur until SFY 11.

The cost impact would be to the hospital program and is unknown. Hospitals are paid on a per diem rate for each day that the recipient is in the hospital. A new facility is paid either the Medicare per diem rate or 90% of the weighted average statewide per diem rate for the first three (3) years of operation. The fourth year of operation they are given a prospective per diem rate based on their fourth year prior cost report. With the addition of new hospitals, existing hospitals would lose patient days as individuals may go to the new hospital instead of the existing hospitals. The cost to the state could either be more or less depending on the rate the new hospital is receiving versus the rate the existing hospital is receiving.

The cost increase for capital would not be reflected until the hospital receives their prospective per diem rate using their fourth prior year cost report which would not be expected to happen until SFY 11.

Officials from 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 proposal. SOS is provided with core funding to handle a certain amount of normal activity resulting from each years legislative session. The fiscal impact for Administrative Rules is less than $1,500. The SOS recognizes that this is a small amount and does not expect that additional funding would be required to meet these costs. However, 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 our office can sustain with our core budget. Therefore, SOS reserves the right to request funding for the cost of supporting administrative rules requirements should the need arise based on a review of the finally approved bills signed by the governor.

Officials from the **Department of Health and Senior Services (DOH)** state the following:

Health Care Consumer Website
Since the long-range plan specified in this proposal has not been developed and DOH has not determined which medical conditions and procedures, quality outcomes, and patient charge data to disclose, staffing projections are based on current technology efforts for data being collected by DOH.

ASSUMPTION (continued)

In order to complete the plan and implement a web portal, additional funding must be secured. The following information technology items have been identified as necessary to develop and support such a portal.

3 FTE for development and on-going support:
GIS Specialist (one) – This position will be responsible for designing, developing, administering and maintaining the GIS applications created in support of this project. This will require advanced work with GIS applications with emphasis on web/geodatabase design, implementation and reporting.

Web Developer (CIT Spec II) (one) –This position will provide web development, customer service, support and assistance. This person will provide technical expertise in web site analysis, design and programming as well as troubleshoot web hardware/software problems.

Data Manager (CIT Spec I) (one) – This position will be responsible for determining the data needs for the project and for establishing, building, protecting and maintaining on-going data services support. They will also assist with the on-going reporting requirements and assist with enhancement implementations and maintenance releases.

3 Contractors for the Development Effort:
One Design Analyst will be responsible for communicating and documenting the requirements of the project. This person serves as the primary requirements contact for the project and is responsible for change management and ensuring requirement compliance.

One Developer/Coder will be responsible for translating the requirements into the Application Design. This includes the technical specifications for the database and programming deliverables. This person participates in analysis, documents requirements, designs the prototypes, identifies interfaces to other program areas, document security and reporting requirements.

One Data Support Manager will be responsible determining the data needs for the project and establishing, building, protecting and maintaining the data for the project. They will also work with the team to gain an understanding of the report requirements and assist with project implementations.

Patient Abstract Data Reporting:
Both the number of ASCs and the volume of reported patient abstract records has been increasing in recent years. In 2003, licensed ASCs reported 135,505 patient abstract records, compared to

ASSUMPTION (continued)

107,954 records the previous year--an increase of 25 percent. More than half of the ASCs elect to report their patient abstract data directly to the DOH, on a quarterly basis, rather than submit their data through the Health Industry Data Institute (HIDI). The volume of directly reported records increased nearly 30 percent between 2002 and 2003 (i.e., at a higher rate than for all ASCs). The number of direct reporting ASCs during that same reporting period climbed from 24 to 34. In 2004, 40 ASCs directly reported their patient abstract data. In 2005, 70 ASC's were reporting directly. Currently, DOH is averaging one new ASC per week.

The direct reporting ASCs tend to be those that are small business operations that have elected not to purchase the services of a third party business associate (vendor) to extract the required data elements from their billing systems for DOH reporting. These ASCs tend to have little or no in-house experience with data collection, electronic file creation and data reporting. As a consequence, DOH staff spend a considerable amount of time with each of these facilities' staff, assisting them with understanding both the technical aspects as well as the substantive content of the required data reporting. These data management activities frequently involve extensive follow-up communications, data re-submissions and re-editing/correcting of data. Due to the format in which the ASCs submit their data, the DOH must also process the ambulatory surgery patient data through extra software, so that de-identified records can be sent to an outside party to obtain the census tract geocoding required for epidemiological studies. The geocoded records are then returned to DOH and reprocessed to link the census tract information to the complete record. For hospital data submitted through HIDI, the census tract data are already in the file record. Data reported directly to DOH will require geocoding.

DOH assumes that most, if not all, of the new group of health care providers required to report their patient abstract data will choose to report their data directly to DOH and will have similar inexperience with information technology and data reporting.

Charge Data and Financial Data:

In addition to the patient abstract data, health care providers will be required to annually report their charge data for selected procedures, as well as their financial data. DOH assumes that health care providers will directly report their patient abstract data to DOH rather than submit data through HIDI, primarily due to the expense of the latter option. DOH assumes that the new group of reporters will require one-on-one technical assistance.

For some health care providers, reporting of their financial data will be a new activity. This new category of reporting will also necessitate the development of an on-line web application to capture and report the financial data.

ASSUMPTION (continued)

DOH states it will require three additional Research Analyst IIIs and one Research Analyst IV to handle the work activities associated with the expanded reporting of patient abstract data, charge data and financial data by health care providers.

Research Analyst IV (one) – This position will supervise the Research Analyst III positions and will work with hospitals, ambulatory service centers and physicians to ensure the timely collection of valid data, and who will edit, standardize and otherwise prepare these data for linkage to the birth and mortality files to develop quality of care indicators (QCI). The RA IV will also be responsible for assisting in the development of the QCI by researching the literature and investigating what other states have done in this area. The position will be responsible for the economic analysis of charge data and for helping to develop valid methods of statistical adjustment so that hospitals, ambulatory surgical centers and physicians with different patient mixes can be validly compared. This position will work with other staff to help design the interactive system for allowing public access to the data.

Research Analyst III (one) - This position will complete data linkages between different data sets (e.g., death files with the patient abstract files), research current outpatient and inpatient mortality indicators and develop approved ones. Most, if not all of these indicators will entail controlling for confounding factors. This position will also develop data sets with the approved indicators by health care provider.

Research Analyst III (one) – This position will work with healthcare data providers to ensure they provide valid, complete and timely data in the format specified by the department. They will work with information technology staff to develop methods of storing and editing the data that ensure quick and easy access to the data by research staff for processing and analyzing the data and developing QCIs. The analyst will review the data for problems, completeness and accuracy, and develop feedback reports to the providers to help them correct problems and ensure the continued flow of usable data. The analyst will standardize the data and assist in linking the data to the birth and mortality files for development of the QCIs and charge information.

Research Analyst III (one) - We project that at a minimum an additional one Research Analyst III position will be needed to review and develop SAS programs to extract required charge data elements, verify data, perform data edits to check data for completeness and accuracy of the financial information, handle communications with the reporting facilities, and publish charge data on the department's website. Unlike the patient abstract data, all of the charge data are directly reported to DOH by the providers. The financial data are currently available for hospitals from the annual hospital survey and the Medicaid cost reports. These sources of data will not be available for the ASCs and the physicians. Because of this, the collection of financial

ASSUMPTION (continued)

data from ASCs and physicians related to charges for procedures will be more staff resource-intensive.

Oversight has, for fiscal note purposes only, changed the starting salary for the DOH positions to correspond to the first step above minimum for comparable positions in the state's merit system pay grid. This decision reflects a study of actual starting salaries for new state employees for a six month period and the policy of the Oversight Subcommittee of the Joint Committee on Legislative Research.

Officials from the **Missouri Health Facilities Reveiw Committee (MHFRC)** state for applications for new or replacement major medical equipment and applications for construction of new hospitals, the applications fees for FY 03, FY 04, and FY 05 totaled $82,299, $432,847 and $385,348, respectively. MHFRC states all application fees go into General Revenue. Therefore, if this bill were passed, there would be an average loss to General Revenue of $300,165 annually.

§197.305(8) references two exceptions to long term care review. It is difficult to estimate the impact of the exception to exclude "facilities of not-for-profit corporations in existence on October 1, 1980" since we do not know the corporate status of such facilities.

The second exception in that section excludes "any residential care facility I or residential care facility II operated by a religious organization qualified pursuant to Section 501(c)(3) . . . which does not require the expenditure of public funds . . . with a total licensed bed capacity of one hundred beds or less." Based on previous experience with religious considerations, we have estimated that approximately 120 additional residential care facility I or II beds would be added to the statewide inventory annually. Since these types of applications would be exempt from Certificate of Need review, there would be a loss of about $4,000 in application fees.

Officials from the **Office of Attorney General (AGO)** assume with respect to provisions concerning ambulatory surgical centers, AGO assumes that new sections allowing centers appeal federal reimbursement allowance assessments with the AHC would create cost for AGO. AGO assumes that it would need 1/2 AAG II to represent the DOS in appearances before the AHC to defend its determinations and to help enforce state liens against outstanding assessments.

AGO states with respect to changes to provisions relating to Certificates of Need, AGO assumes that costs are unknown. The AGO represents the Certificate of Need Board and, because of changes in definition, there may be an increase in litigation. Further, in implementing this statute, AGO would dedicate resources for investigating violations and processing and penalizing

ASSUMPTION (continued)

violations. AGO assumes costs are unknown, but less than $100,000.

AGO states with respect to the new provisions relating to physicians' covenants not to compete, AGO assumes that this proposal will create minimal costs that can be absorbed with existing resources.

Oversight assumes, because the potential for litigation is speculative, the AGO may or may not incur costs related to this proposal. Oversight assumes if a fiscal impact were to result, the AGO may request funds to through the appropriations process.

The proposal states the Ambulatory Surgical Center Federal Reimbursement Assessment is set to expire September 30, 2008. **Oversight** assumes the assessment will be renewed.

FISCAL IMPACT - State Government	FY 2007 (10 Mo.)	FY 2008	FY 2009
GENERAL REVENUE			
Costs - Department of Social Services			
Administrative Medicaid costs	(Greater than $150,000)	(Greater than $150,000)	(Greater than $150,000)
Costs - Department of Health and Senior Services			
Personal Services (7 FTE)	($233,750)	($281,756)	($288,800)
Fringe Benefits	($102,990)	($124,142)	($127,245)
Expense and equipment	($753,417)	($604,514)	($619,777)
Total Costs - Department of Health and Senior Services	($1,090,157)	($1,116,820)	($1,144,890)
Loss - Missouri Health Facilities Review Committee			
Loss of fees	($304,165)	($304,165)	($304,165)
ESTIMATED NET EFFECT ON GENERAL REVENUE	**(Greater than $1,544,322)**	**(Greater than $1,570,985)**	**(Greater than $1,599,055)**

FISCAL IMPACT - State Government	FY 2007 (10 Mo.)	FY 2008	FY 2009
AMBULATORY SURGICAL CENTER FEDERAL REIMBURSEMENT ALLOWANCE FUND (Section 197.245)			
Income - Department of Social Services Assessment on Ambulatory surgical centers	Unknown	Unknown	Unknown
Costs - Department of Social Services Medicaid Program Costs	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON AMBULATORY SURGICAL CENTER FEDERAL REIMBURSEMENT ALLOWANCE FUND	**$0**	**$0**	**$0**

FISCAL IMPACT - State Government	FY 2007 (10 Mo.)	FY 2008	FY 2009
FEDERAL			
Income - Department of Social Services			
Assessment on Ambulatory surgical centers	Unknown	Unknown	Unknown
Administrative Medicaid costs	Greater than $150,000	Greater than $150,000	Greater than $150,000
Total Income - Department of Social Services	Greater than $150,000	Greater than $150,000	Greater than $150,000
Costs - Department of Social Services			
Administrative Medicaid costs	(Greater than $150,000)	(Greater than $150,000)	(Greater than $150,000)
Costs - Department of Social Services			
Medicaid Program Costs - Ambulatory surgical centers	(Unknown)	(Unknown)	(Unknown)
Total Costs - Department of Social Services	(Greater than $150,000)	(Greater than $150,000)	(Greater than $150,000)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**

FISCAL IMPACT - Local Government	FY 2007 (10 Mo.)	FY 2008	FY 2009
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

No direct fiscal impact to small businesses would be expected as a result of this proposal.

DESCRIPTION

HEALTH CARE CONSUMER WEBSITE - This proposal provides that by January 1, 2007, the Department of Health and Senior Services shall implement a long-range plan for making available cost and quality outcome data on its Internet website that will allow consumers to compare health care services. The data shall include information on licensed physicians, hospitals and ambulatory surgical centers. The data shall be made available on the department's website no later than January 1, 2010.

PHYSICIAN SELF-REFERRAL - This proposal provides that no physician shall refer a patient to any health care facility in which the physician has an ownership interest or with which the physician has an employment or contractual relationship unless:

(1) The referring physician will continue to provide treatment to the patient at the hospital to which the patient is referred; or

(2) The physician provides written disclosure to the patient of the physician's ownership interest, employment relationship or contractual relationship with the hospital to which the patient is referred. Violations of this provision shall constitute grounds for licensure denial, suspension or revocation.

An ownership interest includes a direct or indirect interest held by the physician or the physician's spouse or dependent children through equity, debt or other means. To refer a patient under this provision means any act by a physician of providing a request or order for one or more inpatient or nonemergency outpatient hospital services for or establishment of a plan of care that includes one or more inpatient or nonemergency outpatient hospital services for the patient.

AMBULATORY SURGICAL CENTER PROVIDER TAX - This proposal provides that each licensed ambulatory surgical center in this state must pay, in addition to all other fees or taxes required by law, an ambulatory surgical center reimbursement based on a formula set forth in rules promulgated by the Department of Social Services. No reimbursement allowance will be collected in the event the federal Centers for Medicare and Medicaid Services determines that such reimbursement allowance is not authorized under title XIX of the Social Security Act.

The proposal provides record retention and reporting requirements for ambulatory surgical centers. The director of the Department of Social Services will make a determination as to the amount of reimbursement allowance due from each ambulatory surgical center and notify each center of the amount due. Reimbursement allowance amounts due may be offset if requested by the center.

DESCRIPTION (continued)

Reimbursement allowances will be paid to the Department of Social Services to be deposited into the Ambulatory Surgical Center Federal Reimbursement Allowance Fund created in this act.

The proposal contains provisions relating to unpaid and delinquent payments and the Department of Social Services ability to compel payment. The director of the Department of Social Services may deny, suspend or revoke an ambulatory surgical center which fails to pay a center's delinquent reimbursement allowance unless under appeal.

STAFF PRIVILEGES - This proposal provides that no hospital shall refuse or fail to grant or renew staff privileges or condition staff privileges, based in whole or in part on the fact that the physician or a partner, associate, or employee of the physician is providing medical or health care services at a different hospital system or any other health care facility.

COVENANT NOT TO COMPETE - This proposal provides for the utilization of non-compete clauses in certain situations. The proposal defines a "physician employment covenant not to compete" as an agreement or part of a contract of employment in which the physician agrees for a specific period of time, not to exceed five years, and within a particular area to refrain from competition with the employer. This proposal makes covenants not to compete enforceable with other health care facilities as long as they:

(1) Are ancillary to or part of an otherwise enforceable agreement between physician and employer;

(2) Do not deny the physician access to a list of patients the physician treated prior to the physician's buying out or otherwise lawfully terminating the physician employment covenant not to compete;

(3) Provide access to patient medical records with the patient's consent and in an accessible format;

(4) Provide for a buy-out of the covenant by the physician compensating the employer for the remaining amortized cost of recruitment, investments, remuneration and other expenses incurred pursuant to the contract; and

(5) Provide that the physician will not be prohibited from providing continuing treatment to specific acutely ill patients after the contract has terminated.

DESCRIPTION (continued)

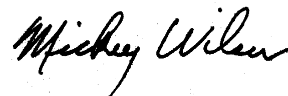
CERTIFICATE OF NEED - This proposal limits application of certificate of need requirements to long-term care facilities and long-term acute care hospitals. Current certificate of need requirements apply to a wider range of health care facilities.

DISCLOSURE BEFORE REFERRAL - This proposal requires a physician to provide certain information to an individual before referring the individual to a health care facility in which the physician has an ownership interest or to a hospital where the physician is employed. This proposal also provides certain exceptions to the disclosure requirement.

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

SOURCES OF INFORMATION

Department of Mental Health
Department of Economic Development
Office of Administration -
Administrative Hearing Commission
Department of Social Services -
Division of Medical Services
Secretary of State
Missouri Health Facility Review Committee
Department of Health and Senior Services
Office of Attorney General



Mickey Wilson, CPA
Director
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